



ACHIEVING BALANCED HEALTH

SHEFFIELD PRIMARY CARE TRUST

FIVE-YEAR STRATEGY

OCTOBER 2007

TABLE OF CONTENTS

Chapter	Page No.
Foreword	4
1. An integrated strategy	6
2. Our main objectives for the next five years	8
3. Vision and Values	10
4. Where are we starting from?	11
The current state of health in Sheffield	11
Progress made by Sheffield's NHS	11
The current quality of our services	12
How we are performing	13
How we are improving the patient experience	14
Our current financial position and	15
5. Where do we want to be?	16
Responding to the <i>Achieving Balanced Health</i> consultation	16
Contributing to city wide strategies	19
Achieving our public health priorities	20
Improving life expectancy	29
Delivering national targets and standards	34
6. How are we going to get there?	36
By developing as a commissioner and getting fit for purpose	36
Clinical engagement	43
Practice Based Commissioning and Service Redesign	44
Through managing the reforms in the NHS system	45
Developing new approaches to service delivery	46
By involving the public in designing our services	48
Improving productivity	50
Improving the quality of services	51
Our five year activity plan	52
Our five year financial plan	58

7.	What will be different? Better outcomes for the city	64
	Inclusive and healthy communities	64
	A great place to grow up	67
	Successful neighborhoods	68
	Contributing to a strong economy	68
	Supporting environmental excellence	69
	Emergency readiness	69
8.	What will be different? Better outcomes for patients	71
	Staying Healthy	71
	Cancer	71
	Diabetes	74
	Drug and alcohol misuse	77
	Heart disease	81
	Older people	85
	Respiratory diseases	90
	Sexual health and teenage pregnancies	94
	Stroke	97
	Tobacco control	100
	Maternity Services	104
	Children and young people	107
	Learning disabilities	111
	Mental health	118
	Primary care	122
	Commissioning primary care	122
	Dental services	122
	General medical services	127
	Optometry services	131
	Community pharmacy	134
	Improving access	137
	Prescribing	140
	Urgent and unscheduled care	142
	Intermediate Care	146
	Planned Elective Activity	149
	Specialist services	152
	Long term conditions	155
	<i>Overview</i>	155
	<i>Self care</i>	158
	<i>Enablement</i>	162
	<i>Neurological Conditions</i>	165
	End of life care	167

9.	How we will develop ourselves to deliver the strategy	170
	Our workforce	170
	Our provider services	172
	Organisational development	172
	Better facilities	173
	Use of Information Management and Technology	175
	Governance and risk management	176
10.	Taking the strategy forward	178
	Developing and delivering the strategy	178
	Measuring how we are doing	179
	Communicating the strategy	180
11.	Glossary of terms	182
12.	References and annexes	185
	Annex 1 - Report on the outcome of the <i>Achieving Balanced Health</i> consultation	186
	Annex 2 - List of meetings held as part of the consultation	194
	Annex 3 - Twenty questions for Sheffield PCT to consider from the consultation	197
	Annex 4 - Life expectancy in Sheffield and percentage of deaths by causes	200
	Annex 5 - Five year finance plan	204
	Annex 6 – Patient Involvement and Public Engagement Strategy	205

FOREWORD

Sheffield Primary Care Trust (PCT) is the National Health Service organization responsible for both obtaining health services for the citizens of Sheffield and with contributing to improvements in the health and wellbeing of the population of our city. We were set up in October 2006 as a result of a merger of the four former PCTs in Sheffield and as a new organization entering our second year we felt it vital to produce a clear statement of direction to guide our work. This five year strategy is our route map to help take us forward.

Our overriding aim is to work to improve the health of all of the people of Sheffield. It is unacceptable that our city has a 14 year gap in life expectancy between the least well off parts of the city and its wealthiest parts. We commit ourselves to working with Sheffield City Council, local NHS organizations, the independent and voluntary sectors and with the residents of Sheffield to narrow that gap.

We are tasked with spending £800m a year to secure improvements in the health of the 521,000 people of Sheffield and to obtain better health services for them. This is an average spend of £1,535 per person per year. We recognise that residents of Sheffield can not choose another organisation to do this task on their behalf. As a result we need to ensure that we are responsive to individual needs and concerns. We commit ourselves to seek to optimize our engagement with the people of Sheffield as we plan and deliver services on their behalf.

Part of the reality of being part of a National Health Service that is free to all and accessible on the basis of need is that we have to live within the means given to us by taxpayers. Sheffield's health services have faced a difficult past few years in working to deliver balanced budgets. Much of this hard work is now starting to pay off. We commit ourselves to not spending more than we receive and delivering value for money for you.

Taken together our three overall goals are:

- to improve health in order to reduce the gap in life expectancy and health outcomes in our city;

- to develop services that will be based more around the needs of individuals;

- to develop sustainable services including those that the NHS delivers in partnership with other organisations.

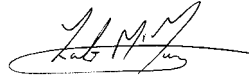
Through our work we want to achieve balanced health for Sheffield.



Tony Pedder
Chairman



Jan Sobieraj
Chief Executive



Dr Zak McMurray
Professional Executive
Committee Co-Chair



Dr Richard Oliver
Professional Executive
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1. AN INTEGRATED STRATEGY

Although we have only been in existence since October 2006 we are building on the work of the four former PCTs in Sheffield. Our strategy has also been developed in the light of Sheffield City Council's City Strategy and the city's Health and Wellbeing strategy as well as the Sheffield First agreement developed by the city's Local Strategic Partnership.

To help us shape our strategy we launched the *Achieving Balanced Health* consultation in March 2007 and over the 13 weeks to June collected the views and comments of over 3,300 people. These have helped us in setting out our objectives and we see this process as the start of a new and ongoing relationship with the people of Sheffield.

For this to be a strategy that delivers we need to take account of the lessons learnt from our approach to turning around the finances of the local NHS in the past two years. We have also been put through a "Fitness for Purpose" programme by the Department of Health and we have identified some areas where we can further improve in how we work as an organisation. One aspect of that is to further strengthen our relationships with local NHS, independent and voluntary sector organisations with which we work to deliver services. One of the clear messages from our consultation is that people who use health services do not recognise organisational boundaries and want services that are integrated and are better tailored to meet their needs. An aim will be to develop more common objectives with the organisations in the city both inside and outside of the NHS that are working to improve the health and wellbeing of the people of Sheffield.

We have engaged with people who work in the local NHS and who deliver services to patients as part of our work. We recognise that the delivery of our strategy will require us to further involve staff, as well as the public, in designing services. An important feature of our work will be to use the new system of Practice Based Commissioning where family doctors are using budgets delegated by the PCT to help design better ways of meeting the needs of patients. We want to extend this clinical engagement as part of our work.

We recognise that taking this strategy forward will be challenging. Although we have worked hard to take on board people's views as we developed this strategy we will have not addressed everyone's issues. Also it may be that not everyone will agree with our proposed direction of travel. Circumstances may change during the next five years, both locally and nationally, and we will have to be able to respond. Part of our job is now to renew our efforts to work with the public, our staff, clinicians and our partner organisations to address concerns they may have about our strategy and to build support for our approach.

The NHS in Sheffield operates in a broad context of a changing society, technological innovations and an increasingly national and international approach to addressing health and wellbeing issues. We will need to develop our ability to keep abreast of these changes, respond to them and help shape the future environment.

There is a range of ways in which the performance of the NHS is measured. To help us judge whether this strategy has been successful we will look to have achieved the following things in five years time:

- An increased life expectancy for people in Sheffield
- A narrowing of the gap in life expectancy between the least well off and the most well off parts of the city
- An increased level of patient, staff and clinician satisfaction
- A balanced financial position
- A reputation as an organisation that is a key part of Sheffield's NHS and its wider civic life

2. OUR MAIN OBJECTIVES FOR THE NEXT FIVE YEARS

Over the five years of this strategy we commit ourselves to meet the following objectives:

Fewer premature deaths and better health in the city

Develop and implement a plan to reduce inequalities in health with a focus on cardio-vascular disease, cancers and respiratory conditions supported by early priority actions on tobacco control, the health of children and young people and local community health programmes. We will focus our efforts in those areas of the city that have the lowest life expectancy. Taken together with the wider work to improve people's health in Sheffield this would contribute to achieving 400 fewer premature deaths in those areas by 2012 and 1,300 fewer by 2017.

Stay in financial health

Maintain and achieve financial balance, staying within our resource limit, to ensure the delivery of efficient and effective services including using the principles of service redesign and regular benchmarking of our productivity.

Involve people more in shaping our services

Improve local health and well-being and health services through regular engagement and involvement with the people of Sheffield to help shape the delivery of services

Contribute to making Sheffield a healthier place

Help make the lives of the people of Sheffield healthier by working with partners to improve the environment in which people live and make it easier for people to make healthier lifestyle choices, and by developing our own services and providing practical help to people to look after their own health better, support their independence and improve the quality of their lives.

Deliver on our duties

Meet and exceed all national standards and statutory duties and have achieved and maintained an Excellent rating for both the quality of services and the use of resources in the Healthcare Commission's annual health check.

Make sure services are safe

Ensure that both the services we provide and those that we commission from other providers are safe and effective underpinned by ongoing quality assurance programmes.

Increase patient satisfaction

Improve the quality the services that people receive, treating services users with respect regardless of their age or their background and use measures of patient satisfaction to monitor our progress.

Become a world class commissioner

Become recognised as one of the leading health commissioning organisations in the country through involving the public, our partners and our staff in a systematic approach to identifying priorities, designing care pathways and procuring high quality services for the people of Sheffield through developing and supporting practice based and joint commissioning arrangements. We will seek to match the performance of the top 25% of PCTs in England.

Make a contribution to Sheffield as a whole

Foster and maintain partnership working with the City Council, the private sector and the voluntary, community and faith sectors including full participation in the Sheffield First partnership and harnessing our efforts with those of the wider community to help achieve our goal of improved health outcomes including more effective joint commissioning of services and the alignment of our priorities with those of our partners in the city.

Develop the NHS system for the benefit of patients

Develop good relationships with the organisations from whom we commission services to achieve sustainable services that respond more to patients, are more designed around their needs and give them more choices about where and how they will be cared for and that also gives options to the PCT as a commissioner about the organisations that can provide services which meet our specifications.

Develop our organisation

Enable the PCT to deliver our strategic vision through better involvement of our staff in the design of our services, improved training and development for all of our employees and better effective use of information technology.

Be ready for emergencies

Protect the public by having a planned, prepared, and where possible, practiced response to incidents and emergency situations, which could affect the provision of normal services

3. VISION AND VALUES

Sheffield PCT has developed a set of Aims and Values based on a consultation with the organisation's staff and key stakeholders. This ran from 10 August to the 7 September 2007. This statement replaces a provisional set of aims, objectives and underlying principles agreed in October 2006 after the establishment of the PCT.

Our Aims are:

- To build on excellence
- To base decisions on evidence
- To promote an environment that supports innovation
- To ensure value for money
- To support and develop our workforce

These are supported by the values that:

- We will ensure that the health and wellbeing of Sheffield people is at the heart of everything we do.
- We will ensure active engagement with public, patients, staff and clinicians
- We will work through partnership to achieve mutual benefit
- We will respect individuals
- We will always work with integrity and honesty

These statements put Sheffield people at the heart of everything the PCT does. The aims are concise but take account of the need to recognise what is already excellent in the organisation, that innovation has to be supported not just encouraged and that a well supported and developed workforce is key to the delivery of the PCT's functions.

This is the beginning of the process to gaining shared values in our organisation. The next stage is to identify the further actions required to begin to embed these aims and values into the culture of the PCT.

4. WHERE ARE WE STARTING FROM?

This section sets out the starting point for our work and describes the current health of the city, the quality and performance of the services we commission, how patients currently experience our services and the state of our financial health.

THE CURRENT STATE OF HEALTH IN SHEFFIELD

The health of the people of Sheffield has in many ways never been better. Mortality rates from the common diseases - in particular coronary heart disease and cancers - have fallen dramatically in recent years, and as a result life expectancy has increased equally dramatically. Indeed life expectancy for men in Sheffield is now greater than the England average, almost certainly for the first time ever in the history of the City. The recent increases in life expectancy - a two year increase for men and a 1.4 year increase for women over the space of five years - have almost certainly not been equaled at any time since the Victorian era. The latest data for life expectancy at birth is for the three year period 2004/06 where it was 77.4 years for men and 81.3 years for women

However, enormous inequalities in health remain within the city. Although when we compare the worst off one fifth of the city with the city average (the measure chosen nationally for assessing inequalities within the population) there has been a reduction in inequality in recent years, if we take our analysis down to an individual neighbourhood level, then enormous disparities remain. All cause mortality rates vary three fold across the city. There is a 14 year difference in life expectancy between the best off and worst off neighbourhoods. There is a five fold difference in the rate of admission to hospitals for mental health problems. Whatever measure one chooses to use, there are enormous differences between the best off and worst off neighbourhoods. This is not a picture of a healthy city.

This presents us with very substantial public health challenges that we need to address over the next five years. In addition the size and make up of the population of Sheffield is changing. These changes are described in the section on our public health priorities. We need to take account of these changes in developing our plans and priorities for the next five years and for the longer term.

PROGRESS MADE BY SHEFFIELD'S NHS

In recent years the NHS in Sheffield has worked to improve the services delivered to patients. Some examples of the results of the use of the additional funding made available to the NHS are:

Improved coverage of services provided by GPs, especially those linked with preventative work and the management of long term conditions, as measured by improved scores in the Quality and Outcomes Framework.

Reduced referrals to secondary care and the provision of more front line care in neighbourhood settings away from hospital

Reduced length of stay for people needing to go into hospital and lower overall waiting times for people who need diagnosis or admission to hospital.

Faster access for people who need cataract procedures through direct referral by optometrists.

Increased life expectancy in the city.

THE CURRENT QUALITY OF OUR SERVICES

The quality of the services commissioned by the PCT is measured using the Core and Developmental standards of the Healthcare Commission and this includes the PCT's performance against national targets.

For 2006/07, the PCT declared compliance with 35 out of 44 core standards, meaning that the PCT scored either 'not met' or 'insufficient assurance' with nine standards. This was due to the merger of the four PCTs and the need to implement new structures, processes and policy within the single PCT. Action plans have been developed to address outstanding actions and we expect to be fully compliant by March 2008.

Accordingly we are planning to declare full compliance with the core standards for 2007/08 and for the developmental standards we are currently working to achieve a status of 'fair'.

For commissioned services, the PCT is ensuring that the core standards are part of service level agreements and contracts. Contract monitoring for major secondary care contracts in the future will include monitoring of core and developmental standards action plans.

Targets are set for key infection control indicators such as MRSA and C. Difficile for secondary care providers and monitored by the PCT on a monthly basis. The PCT also monitors performance via contracting meetings and membership on both the Infection Control Committee and the Healthcare Governance Group.

The PCT is currently not compliant with the national NHS hygiene code and action plans have been developed to achieve compliance by March 2008. This includes both our provider services and contracted services.

For commissioned services, the Healthcare Commission will be undertaking unannounced visits to acute hospitals this year. Following these visits the PCT will monitor subsequent resulting action plans,

The NHS Litigation Authority (NHSLA) sets standards that should be met by all NHS organisations. The NHSLA will be introducing new standards in April 2008 which are currently being piloted in a number of NHS sites. There will be three levels of compliance:

Level 1 – Assesses whether effective risk management systems and processes have been documented. (Policy)

Level 2 – Assesses whether the systems described at Level 1 have been implemented. (Practice)

Level 3 – Assesses whether the organisation is monitoring its compliance with the systems and acting on the findings. (Performance)

The PCT is working towards level 1 of the new standards and will aim to achieve compliance with these for service provided and contracted services by April 2008.

For commissioned services, there are equivalent standards for acute Trusts and the key secondary care providers - Sheffield Teaching Hospitals and Sheffield Children's Hospital are currently working towards level 1.

HOW WE ARE PERFORMING

In 2007/08, the PCT is making good progress against our main targets. This includes the 18 weeks treatment targets, 48 hour access to GUM clinics and drug users sustained in treatment. These targets are expected to be achieved.

A challenge for the PCT is infection control and in particular – reducing the number of MRSA blood stream infections. The cumulative actual for the first four months of this year is 21. This is almost half of the PCT's annual target of 43. The PCT's contract performance lead is working closely with the Sheffield Teaching Hospitals NHS Foundation Trust to address this.

A further challenge for the PCT is meeting its four weeks smoking quitters target for 2007/08. The PCT has implemented an action plan to ensure performance in this area is maximised.

An area of significant under performance is 'Convenience and Choice' and more specifically the national target for patients being offered choice. When surveyed 24% of patients recalled being offered choice compared to a target this year of 90%. An action plan has been implemented to address this

By the end of March 2007, the position was:

We had achieved recurrent financial balance.

On access to primary care services:

100% of people were able to obtain an appointment with a GP within 48 hours of requesting one;

On access to hospital services:

All people referred by their GP to an outpatient clinic were seen within 13 weeks;

No one was waiting longer than 26 weeks to be admitted to hospital for treatment

For all cancers 99.9% of people were seen within two weeks from an urgent GP referral to first outpatient appointment

For all cancers 99.7% of people were seen within one month of a diagnosis (decision to treat) to starting treatment

No one was waiting longer than 13 weeks for a Coronary Artery Bypass Graft or an angioplasty after being scheduled for surgery

For emergency services:

98% of people were seen within four hours of presenting at an Accident and Emergency department with their condition assessed and treated and either discharged home or admitted to hospital where appropriate

96.6% of Category A – 999 – ambulance calls were responded to within 19 minutes against a target of 95%.

The level of MRSA infections for the year was marginally lower than the targeted level of 63.

HOW WE ARE IMPROVING THE PATIENT EXPERIENCE

A core part of our work is to improve the experience people have of using health services including those services that are delivered in partnership with other organisations.

Since 2004 Sheffield's PCTs have undertaken the National Patient Survey required by the Healthcare Commission. There have been improvements in the survey results in many areas of work over this period and areas where Sheffield has performed above average nationally. However, there are areas where the public tell us they need to have a better experience. Dissatisfaction is mainly

with access to services and waiting times in surgeries and clinics. Although there have been improvements, patients think the quality of out of hours services could be better. Within the Quality and Outcomes Framework and contract monitoring arrangements by which we monitor the work of GPs, the GP access and choice surveys told us exactly the same thing. The PCT will work with GPs to improve patient experience in these areas.

The PCT also collates information that we receive from compliments, complaints, incidents and contacts via the Patient Advice and Liaison Service. This helps us to assess themes for improvement and staff within the PCT work to ensure patients will have a better experience in the future when this happens.

As a commissioning organisation the PCT is also starting to monitor patient experience in other organisations that provide services to the population of Sheffield such as NHS Trusts and the Voluntary Community and Faith sector. Wherever possible citizens, patients and carers will be involved in monitoring and reviewing patient experience.

OUR CURRENT FINANCIAL POSITION

The PCT developed a financial plan for 2007/08 with the objective of delivering year end financial balance and allowing the repayment of remaining historic debt. Based on month 5 results, the PCT continues to forecast overall delivery of the plan, but assesses that this will be challenging due to the significant in year risks and uncertainties which need to be managed.

Our financial target has been directed essentially to achieve recurrent savings this means fundamental changes to the way we provide and support services to our population. These changes have not only resulted in appropriate significant reductions in administration and management costs but also more efficient and effective ways in helping people manage their illness and provide treatment when needed. The outcomes include reductions in the numbers of patients admitted to hospital as an emergency, if admitted the length of time in hospital reduced, and an increasing level of services provided in the community by local GPs and specialist nurses.

These changes now represent the models of care going forward with a view to contributing to a more patient focused service that gains the maximum benefit for our population from the resources available.

5. WHERE DO WE WANT TO BE?

Our purpose as an organisation is to make change for the better both in terms of improved health for the city as a whole but also for the services delivered to individual residents of Sheffield. We want to be in a position in five years time where we have demonstrated that we have listened to and acted on the results of the *Achieving Balanced Health* consultation, that we are working well with our partner organisations in the city to make Sheffield a better place to live and work, that we are delivering our health priorities and are meeting the national targets and standards required of us.

RESPONDING TO THE ACHIEVING BALANCED HEALTH CONSULTATION

To help set our future direction the PCT launched a public consultation under the banner of *Achieving Balanced Health* on 2 March 2007 and this ran through to 8 June. We wanted to get the views of current and potential users of our services about how we can take health services in Sheffield forward. Part of the background to this was the Government's vision for primary and community services described in *Our health, our care, our say* that was published in 2006 as well as the Wanless report on *Securing good health for the whole population*. We wanted to get the views of the people of Sheffield on how we can better provide care closer to home and develop a greater focus on helping people living healthier lives in the long term.

The outcomes of the *Achieving Balanced Health* consultation have informed the development of the PCT's five-year strategy. We have not been able to address all of the comments made in the consultation but we will continue to use the results as an important reference point as we develop our plans. As importantly we will build on the consultation to develop better ways of engaging with current and potential users of NHS services to help shape the design of our services.

There were four main themes in the consultation:

- self care,
- developing more local services,
- views on having alternatives to hospital services,
- improving access to and use of emergency and urgent services.

We have in response received some powerful messages from the people of Sheffield. There has been backing to pursue our goals of reducing health inequalities through earlier interventions to improve health and improving services so that they are based more around the needs of individuals. Achieving improvements in services will be supported by more involvement of service users in their own care, developing clearer and more consistent pathways for accessing care and redesigning services to release resources to enable us to make more progress. But there have also been, rightly, challenges about how we will follow

through on our good intentions and how we will continue to involve people in developing our services.

Some changes will take time, for example where there could be options to provide more services closer to home and away from the main hospital sites in the city and we will work with our patients and our providers to help shape these. Such changes may also need investment and we will have to look at our ability to fund new services within our overall commitment to making sure that services are affordable and sustainable.

The *Achieving Balanced* Health consultation process was launched with 80 people representing a variety of community, voluntary and faith sector organisations present. This was followed by a deliberative event that brought together 78 members of the public chosen by an independent organisation as a cross section of the community.

The main vehicles for obtaining public views were then:

- Sending 100 information packs out to all those invited to the launch who were unable to attend.

- 20,000 questionnaires containing the four main consultation themes.

- A website specifically for the consultation, which included PCT papers and general information. Links were also developed between the PCT website and Local NHS Trust and Local Authority websites.

- A mail out to 1,000 organisations including GP Surgeries, Dental Practices, Pharmacies, Libraries, Nursing Homes, Sure Starts and many Voluntary, Community and Faith sector organisations.

- 8,000 letters to new patients registering with GPs in Sheffield, informing them of the consultation.

- Presentations by senior PCT managers at 76 public meetings and stakeholder events

In response 1,200 questionnaires were completed. Over 1,000 people attended the 76 public meetings. In addition there was a telephone poll of another 1,000 randomly selected residents. Specific efforts were made to reach seldom heard groups including focussed events in Wybourn, Darnall, Tinsley, Arbourthorne and Park; sessions at Howden House; events with the Chinese, Afro-Caribbean, Asian and Somali communities and specific events with homeless clients and women refugees. The comments made at all of these events have been analysed along with those from the questionnaire.

The common themes can be summarised as:

- There was support for work to address health inequalities but concern that this be through “levelling up”
- There was support for the need for greater self care but the public has challenged the PCT and its partners to provide better information that is tailored to local neighbourhoods and cultural communities as well as better signposting through a care system that can appear complex to users and carers
- More mobile health facilities in the city that could bring information and services to neighbourhoods were supported as well as services being delivered in non-traditional settings
- Allied to this there was support for the development of better access to local advice and health support workers
- People in the city were willing to consider alternatives to GP services such as obtaining more services from pharmacists or through a local helpline. There were mixed views about NHS Direct.
- More services within GP surgeries to avoid the need to visit hospital were supported if these were of quality equivalent to current services and did not lead to a duplication in resource use
- Alternatives to A&E would be welcome, such as primary care satellite services out of hours but people said they would continue to use A&E if access to urgent care could not be improved in the community
- The experience of people with physical disabilities , mental health problems or learning disabilities was that they at times found it hard to access some services and that assistance from the local NHS to reduce or remove barriers would be welcome
- Possible barriers on the basis of language and culture were also seen from within some communities
- Fragmentation of services between organisations was seen as an issue with people wanting organisations to work more effectively together

More detail on the key themes from the feedback is at annexes 1 to 3.

A theme running through the consultation was that this was the start of an ongoing discussion with the people of Sheffield, their elected representatives and organisations within the city about how to shape the delivery of health care in the future. During the consultation we received feedback that the public would welcome the opportunity for more engagement in the design of services. We will commit to both improving our approach to engagement and also developing it as an integral part of the work that we do. Further details of our approach are described on page 46.

We recognise that this strategy document will in itself not have addressed all of the issues raised in the *Achieving Balanced Health* consultation. We have logged

all of the comments made and we will work on the basis of identifying those issues that we can deal with, those that we can not deal with and explain why and identify those issues that will take more time to address. In response to the issues raised in the consultation we are:

- already looking at ways to develop our approach to self care and this work is described on page 153;
- reviewing access to primary care services, including at evenings and weekends, and drawing up an action plan. This is described on page 131;
- developing an approach to improving access to urgent care in the community and this is described on page 137;
- working with GPs and hospital colleagues to develop new ways of delivering services – through improved care pathways – and working through the balance of care between hospital and community settings and this is covered on pages 40 to 43;
- building on the involvement of children and young people in the design of services through the 0-19 Partnership described on pages 65 and 104;
- taking forward changes to mental health services designed to improve community access and are looking at proposals to improve services for people with dementia. These issues are covered on page 114 and we will be working with Sheffield Care Trust and the City Council to develop the city's mental health services further;
- stepping up our efforts to reduce health inequalities both in terms of improving life expectancy and reducing the burden of ill health as well as addressing barriers to accessing services for health or cultural reasons will be a central part of the work that we do. Our overall approach is described on pages 23 to 33 and within the sections on individual service areas.

The issue of transport to and from health service sites was also raised in the consultation. We will be looking at how we can better include transport issues, including car parking and bus or tram access, when we are planning service developments and working with provider organisations.

These are examples of our approach. Where we have not specifically mentioned areas referenced in the consultation within this document we will continue to follow them up within our internal work in the PCT. The outcomes of the consultation will also inform our work to engage with the public and service users. We have also made the commitment of returning in 12 months time to meet with the groups that were consulted with to report back on how we are doing. The Achieving Balanced Health consultation marks a start, not an end, to our work with the residents of Sheffield to involve them in shaping our future services.

CONTRIBUTING TO CITY WIDE STRATEGIES

We are fully committed to helping achieve the vision set out in the Sheffield City Council's strategy that:

Sheffield will be successful, distinctive city of European significance at the heart of a strong city region with opportunities for all

As part of the City's strategy there are priorities to develop healthier communities within Sheffield. The main goal is *to reduce the gap between the communities with the poorest health and the city average*. This informs our objective of increasing the life expectancy of people in Sheffield with a focus on the least well off parts of the city. The future priorities within the Sheffield First Partnership's strategy are to:

- Reduce health inequalities
- Improve the health and wellbeing of the most vulnerable communities
- Ensure that Sheffield is a healthy city through tackling wider determinants of health
- Ensure that we respond positively to the city's changing and growing population profile as our city becomes more diverse and the number of older people increases
- Reduce the persistent inequalities experienced by some groups of people within the city
- Promote good community relations across Sheffield

We commit to playing a full partnership role with the City Council in helping to achieve these priorities and to incorporate these into our priorities as well. Through membership of the Local Strategic Partnership, Sheffield First, we will further develop our contribution to this city wide agenda given the need to address the wider determinants of health including employment, education and housing.

ACHIEVING OUR PUBLIC HEALTH PRIORITIES

In seeking to improve health and reduce health inequalities, the potential agenda for the PCT is vast. If the organisation is to be effective, it must prioritise between all the many different areas for service redesign or re-commissioning, or investment. This is because to do otherwise risks us spending time and resources in areas that yield less than the greatest possible health benefit for Sheffield.

Demographic change

We need to start by looking at how the population of Sheffield will change over the next five years and afterwards. The most recent Office of National Statistics (ONS) estimate of the Sheffield population (mid 2005) is 520,700. In comparison there are 536,200 Sheffield residents registered with Sheffield general practices. Over the next few years the make up of the population will change. In particular there will be more people in older age groups, as the "baby boom" of the late 1960s and early 1970s ages, and as a result of reduced mortality rates. In addition, the ethnic mix of the population is changing as a result of immigration

and a higher birth rate in ethnic minority populations. Overall the Sheffield population is expected to increase significantly over the next decade. The ONS predicts an additional 10,000 population by 2012 and a further 10,000 by 2017.

There are a relatively high proportion of people in the 20 to 24 year age bracket in Sheffield, due to the large number of students attending the universities in the city.

Over the next five years the major impact on demand for health services will come from the increase in the number of people in the 65-69 age brackets. This is expected to increase from 23,000 persons in 2007 to over 26,000 in 2012. Over this five year time frame, the number of people in older age brackets (70 and above) will not change significantly.

However in the subsequent five years from 2013-2018, there will be significant increases in the older populations, with the number aged over 70 increasing from 52,300 to 68,800 persons. Included in this is an increase in the number of people aged over 85 from 11,900 to 12,700.

Birth estimates

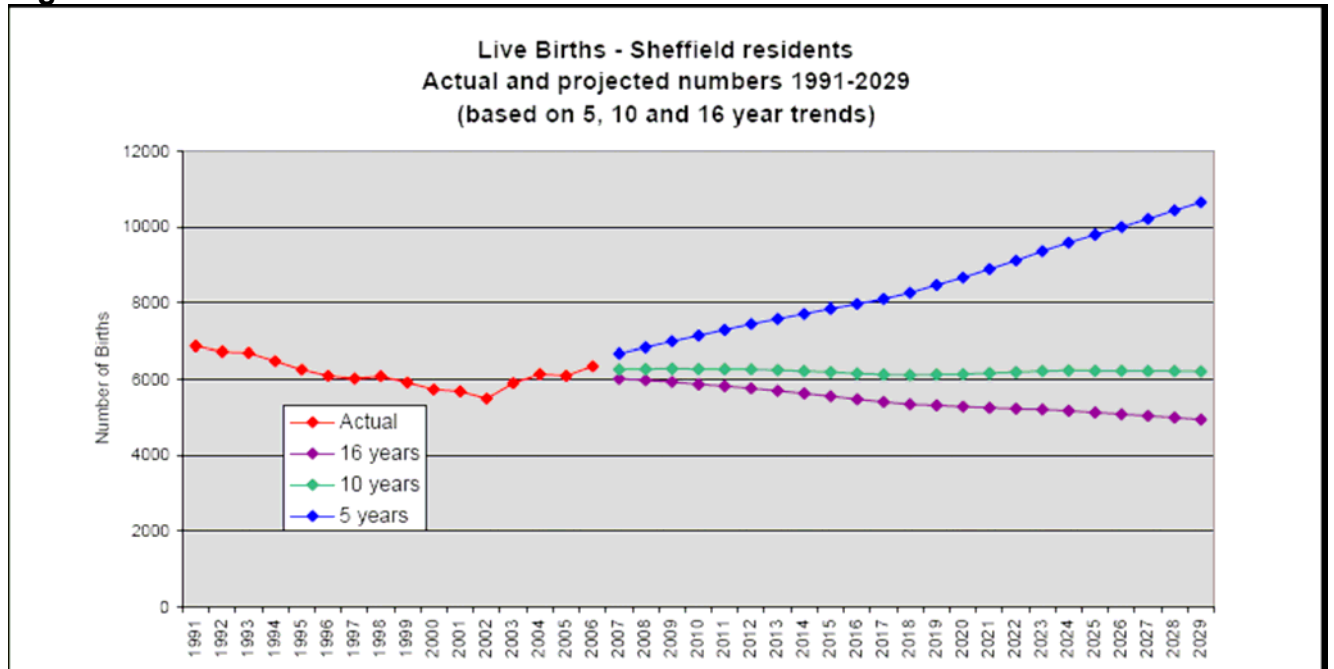
Estimating the number of births in the city in future years is not straightforward. In the past, the ONS has produced birth estimates based on age specific fertility rates applied to the future population age structure, but it no longer does so. Birth numbers have fluctuated significantly (though with a general downward trend) as the impact of the post war (late 1940s and early 50s) baby boom generated rises in birth numbers in the late 60s / early 70s (when they had children) and again in the 1990s. However these cycles have now largely smoothed out, and other influences are becoming much more significant. Chief amongst these is the increasing proportion of the population from ethnic minorities, particularly in the younger age groups, who tend to have fertility than the white population, but other factors include the tendency for women to delay child bearing to later in life, and the impact of the economy and house prices on young couples' decisions to start families (and how big those families are).

We have generated estimates of future birth numbers locally by projecting forwards recent trends in fertility to the future female population. However, as the chart shows, there has recently been a clear upturn in birth numbers in Sheffield, so that projections forwards vary markedly depending on whether they are based on the last 5, 10 or 16 years. The first of these gives us a significant projected increase in birth numbers (because it is based entirely on the recent rising trend), while the latter two lead to stable numbers or a further decline in numbers, respectively.

Overall, given our knowledge of the make up of the Sheffield population, it is likely that we will see a steady increase in birth numbers over the next few years, such that the number of births in the City will increase from the current level of

6350 (approx) to around 7000 by 2012 and 7500 by 2017. This clearly represents a significant increase, which needs to be taken into account as we develop our plans for the future.

Figure 1.



Ethnicity

The proportion of the population who are from black and other minority ethnic communities is increasing dramatically. In the 1991 census only 7% of the population was from ethnic minorities, but this had increased to 13.5% by 2005. Furthermore, the proportion of the population in lower age groups from the black and ethnic minority populations is higher still, such that they account for 25% of primary school entrants and nearly 30% of births. The ethnic minority populations are diverse and changing. Some have their own particular health needs which need to be addressed.

Impact of demographic change on health service need

In predicting the prevalence and incidence of disease, and the consequent demands on health services, it is necessary to take into account not only the expected demographic change in the population, but also underlying changes in the prevalence and incidence of conditions which would occur irrespective of changes in a structure. Combining these, projections have been calculated for a number of conditions which are more common in older people. The intention is to gain an understanding as to the impact on demand of the ageing population. Overall results are shown in the following table.

Condition	2007	2012	2017
Stroke prevalence	10,850	12,900	15,820
Stroke admissions	945	920	920
CHD prevalence	23,250	25,070	27,520
CHD admissions	2490	2620	2860
COPD prevalence	10,245	10,585	11,110
COPD emergency admissions	2010	2210	2530
Diabetes prevalence	16,780	23,100	32,340
Diabetes emergency admissions	270	280	310
Dementia prevalence	6170	6330	6720
Arthritis prevalence	94,600	98,200	102,800
Primary hip replacements	480	670	950
Primary knee replacements	590	880	1330
Mental health emergency admissions	520	360	240
Cancer emergency admissions	1660	1660	1690
All emergency admissions	56,470	64,480	74,310

CHD – Coronary Heart Disease

COPD – Chronic Obstructive Pulmonary Disease (Severe breathing problems)

All figures are absolute numbers for the Sheffield population overall

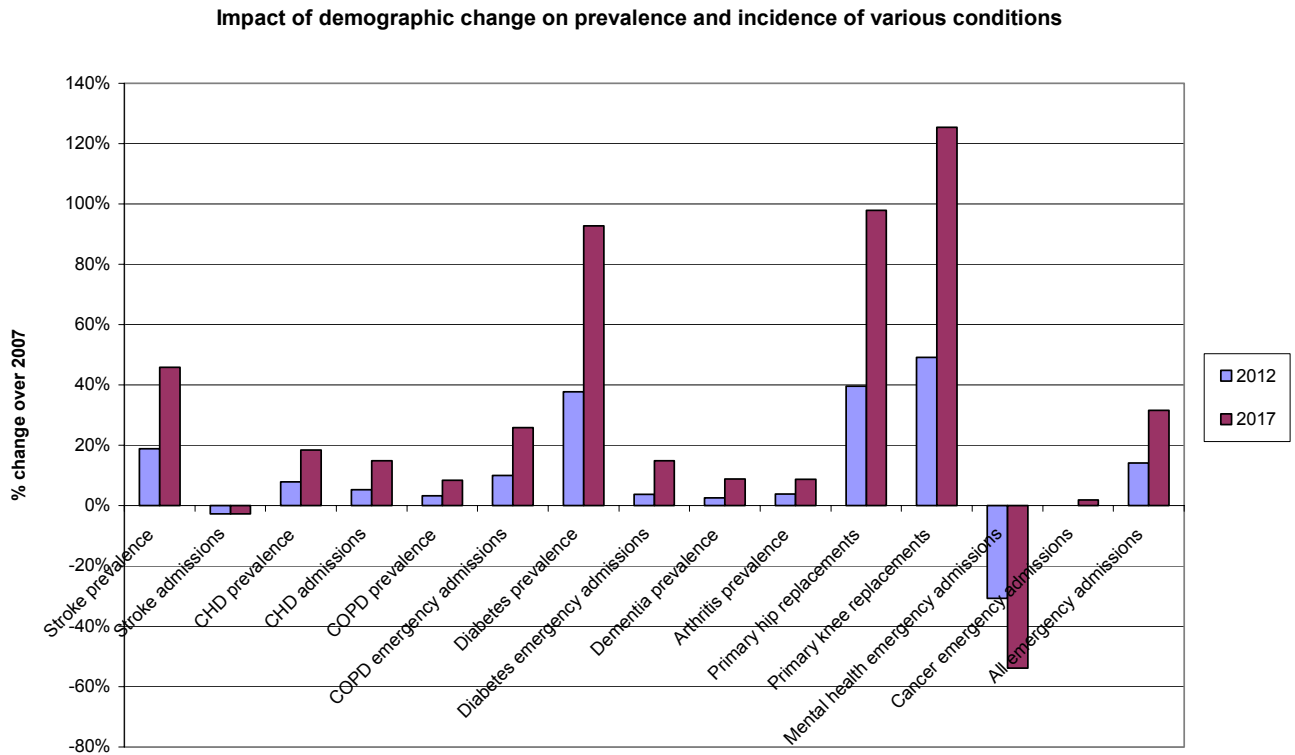
These figures do need to be accompanied by a ‘health warning’. Because they are generated by projecting forwards recent trends, there is an implicit assumption that those trends will continue, and this may not be true. For example, the recent falls in emergency admissions for mental illness may well not continue – which would mean that the figures above underestimate future admissions levels. Similarly, the recent rising numbers of knee replacements may well have had an element of ‘catch up’ (due to knee replacement being a relatively new operation), and again the trend may not continue (as the majority of people who would benefit from the operation have had it). The projected numbers of knee replacements may therefore be an overestimate.

By far the largest predicted changes are in the numbers of primary hip and knee replacements – particularly if we look ahead to 2017. There are also large increases predicted in the prevalence of diabetes and stroke. Although increases in other conditions are not predicted to be as large, they are still significant. The percentage increases (or decreases) predicted by 2012 and 2017 are shown on the chart. Clearly, we need to prepare for these.

We will need to further develop our predictions and work through the implications for our services. However, as the Chief Executive of the NHS England has said “investment alone will not meet the challenges that these drivers [for change] represent. If we are to provide better care for the increased number of elderly people with long term conditions, then we need to radically re-think how we help individuals to manage their own health care”.¹

¹ David Nicholson, NHS Chief Executive’s annual report 2006/07

Figure 2.



Choosing between different areas requires making an assessment as to what overall health gain will result from improving services in those areas. This will depend on a combination of how big the problem is, and what gain we can reasonably expect to follow from the changes that we would want to make. At the same time, if we are to free up resource for investment, and make the whole health service in Sheffield sustainable, we will have to not only redesign services, but also pursue the 'Fully engaged' scenario described by Wanless. In essence, this means encouraging and enabling the public to take control of their own health and moving towards a more preventive, rather than treatment based health service.

Identification of the major health issues for the City is based on a number of different considerations.

Mortality

Although mortality rates generally are decreasing, and life expectancy increasing, there are still areas of concern. As elsewhere in the Country, the major causes of death are vascular disease, in particular coronary heart disease, cancers and chronic respiratory disease. Although we have already met national targets for the year 2010 for reductions in CHD and cancer mortality, these are still areas where we have more deaths than would be the case if the national mortality rates applied locally. A recent analysis of the number of additional deaths occurring in

Sheffield over and above those that would have occurred had we the same death rates as England overall has shown a large excess for CHD for both men and women. The details are shown in the following table.

Male - Cause of death	Excess deaths	Female - Cause of death	Excess deaths
Coronary Heart Disease	40.1	Coronary Heart Disease	52.3
Lung cancer	32.3	Musculoskeletal diseases	46.6
Other cancers*	26.7	Chronic obstructive airways disease	23.3
Musculoskeletal diseases	14.0	Lung cancer	23.2
Diseases of nervous system	12.8	Mental and behavioural disorders	19.2
Pneumonia	11.9	Other cancers	10.7
Stomach cancer	9.6	Diseases of nervous system	6.9
Mental and behavioural disorders	7.0	Stomach cancer	5.5
Chronic obstructive airways disease	5.5	Breast cancer	4.2
Other accidents	5.3	All causes <1	3.3
Genitourinary diseases	3.8	Other digestive diseases	2.1
Stroke	3.0	Endocrine, nutritional, metabolic diseases	1.4
Stomach/duodenum ulcer	2.9		
All causes <1	2.4		

*'Other' – other than lung, colorectal, stomach, breast, oesophageal.
Analysis of mortality data for 2001-5.

This clearly shows that CHD, cancers (in particular lung cancer), chronic obstructive airways (pulmonary) disease (COPD) and musculoskeletal disease are all major contributors to excess deaths in Sheffield compared to elsewhere in the country.

We have conducted a similar analysis looking at the causes of death that contribute most to the gap in life expectancy between the areas of the City covered by the Enhanced Public Health Programmes (the most deprived one third of the City) and the City average. This shows that for both men and women the top three contributors to the life expectancy gap are CHD, lung cancer and COPD. For women, these are followed by stroke, other respiratory disease, other cancers, and pneumonia, while for men the next causes are suicide and undetermined injury, cirrhosis, other accidents and other cancers. In this analysis of contribution to life expectancy gap, deaths in earlier years (such as accidents and suicides in men) carry much more weight than deaths in later years. Full details are shown in Annex 4.

From the point of view of mortality, we can therefore clearly identify CHD, lung and other cancers, COPD and other respiratory disease and musculoskeletal disease as important areas of concern.

Morbidity

Data on morbidity is far less comprehensive than mortality data (because all deaths are categorised and counted, whereas episodes of morbidity are not). It is therefore necessary to rely on local intelligence to identify what are the big causes of morbidity within the City that need to be addressed. In some cases these link to causes of death identified above.

There is a broad consensus that mental ill health, chronic musculoskeletal and neurological conditions, alcohol dependency, chronic respiratory disease and diabetes are all very common within the Sheffield population, and are all major causes of ill health. These do link to the mortality issues identified above: mental ill health and alcohol dependency are linked to suicide and cirrhosis, while diabetes is a major risk factor for CHD and stroke. In addition to these, the aging of the population is leading to an increasing prevalence of co-morbidity.

Sustainability of health services

Analysis elsewhere in this Strategy document shows that continuing to provide health services in Sheffield as we have done in the past is not sustainable. Wanless identified the need to move to a 'Fully engaged' scenario in order to make the NHS overall affordable. Furthermore, if we are to be able to release resources for investment, we need to reduce demand for services. This means that we must pay attention to the causes of ill health, and prioritise interventions at an early stage in the 'care pathway' that can prevent the worsening of a condition and reduce the demand for more complex or expensive interventions at a later stage.

The avoidable causes of ill health that are most prevalent in Sheffield (as elsewhere) are smoking, physical inactivity, overweight and obesity, and poor diet. These all link directly with the major areas of mortality and morbidity identified above. Additional determinants of poor health include environmental pollution (in particular air pollution), poor housing, unemployment, underemployment or poor quality employment, poverty, and bad working conditions.

Prioritising early stages of care pathways may in some cases be very effective, and more cost effective, than interventions at a later stage. Thus for example early brief interventions for alcohol dependency have been shown to save five times their cost in terms of later treatments. Early supportive and preventive work for people with mental ill health can help them to cope with conditions that will otherwise worsen to their significant detriment and to the cost of mental

health services. For physical illnesses, early intervention may include teaching people self management so as to enable them to manage their own conditions to their own benefit, and leading to the avoidance of health service interventions.

Benchmarking against national spend

Another indicator of areas that the PCT ought to consider investing in is our spend on different specialties as compared to the national average. This is available as data on 'Programme Budgeting' (analysed elsewhere in this document). Although such comparative data needs to be treated with caution, not least because we cannot be confident that categorisation of spend is consistent across the country, and because the most recent data relates to 2005/06, it does give us an indication as to where we are investing less than the national average.

The most recent Programme Budgeting data shows Sheffield to be investing substantially less than the national average in:

- maternity and reproductive health
- learning disabilities
- healthy individuals (public health)
- infectious diseases
- substance misuse
- musculoskeletal problems
- poisoning
- neonatology

Priorities for the PCT for the next five years

Identifying priorities for the PCT is as much a matter of judgment as a matter of science. Any priorities that are identified will have to be kept under regular review, and if and when circumstances or evidence changes, different choices may be made.

Nevertheless, considerations of mortality, the nature and causes of health inequalities in the City, our knowledge of morbidity in the City, and considerations as to what will be necessary to create sustainable health services in the City lead to a small number of priority areas. These are identified in the table:

Priority	Rationale
Coronary heart disease	Largest single cause of mortality; excess deaths compared to England; major cause of life expectancy gap.
Chronic respiratory disease	Major cause of mortality; excess deaths compared to England; major cause of life expectancy gap; high morbidity levels; local understanding that there is significant potential gain from service redesign.

Stroke	Major cause of mortality; major cause of life expectancy gap; high morbidity levels; expected National Strategy to be published soon.
Tobacco control and smoking	Single largest preventable cause of death; accounts for 60% of health inequalities; major risk factor for vascular disease (including CHD and Stroke) and cancers (which in turn are a major cause of death and excess deaths); reduced levels of smoking will lead to a substantial decline in demand on health services.
Diabetes	Major risk factor for CHD and stroke, as well as being significant cause of morbidity in itself; steadily increasing prevalence; local understanding that there is significant potential gain from service redesign.
Alcohol dependency	Risk factor for suicide, accidental death, cirrhosis, all of which are significant contributors to the life expectancy gap; major cause of morbidity; increasing prevalence; underinvestment in treatment services in Sheffield; significant potential for 'invest to save'.
Children and young people	Health of children and young people identified locally as a public health priority; health of the population (and hence demand for health services) in future will be determined by health and habits of current generation of young people.
Addressing inequalities in life expectancy through targeted work in priority areas.	Inequalities in mortality, life expectancy and morbidity can only be effectively tackled by working at local level with affected populations and health service providers to improve lifestyle and access to health services; all identified risk factors for the major diseases are concentrated in areas of disadvantage, so that if we are to address these, we must concentrate on these areas; programme budgeting data suggests we under invest in 'healthy individuals'.
Mental health	Suicide is a contributor to the life expectancy gap for males; mental ill health is very prevalent; need for more 'upstream' (preventive / early treatment) work to reduce morbidity and demand on services; local understanding that there are gains to be made from service redesign.

Our analysis is that if we make these areas our priorities, we will have the best chance of making the biggest impact on health and health inequalities in the City over the next five years. The actual work that needs to be done to deliver improved health under each heading will, of course, vary. For some of these

areas we already have plans in place, though they may well need refining over time. For others, these plans need to be developed. However in each case, we think that doing things differently to the way they have been done in the past has the real potential to save lives, particularly in areas of disadvantage in the City, and so contribute to reducing the gap in life expectancy. An analysis of life expectancy, and the relationship between premature loss of life and the life expectancy gap, is contained in the next section.

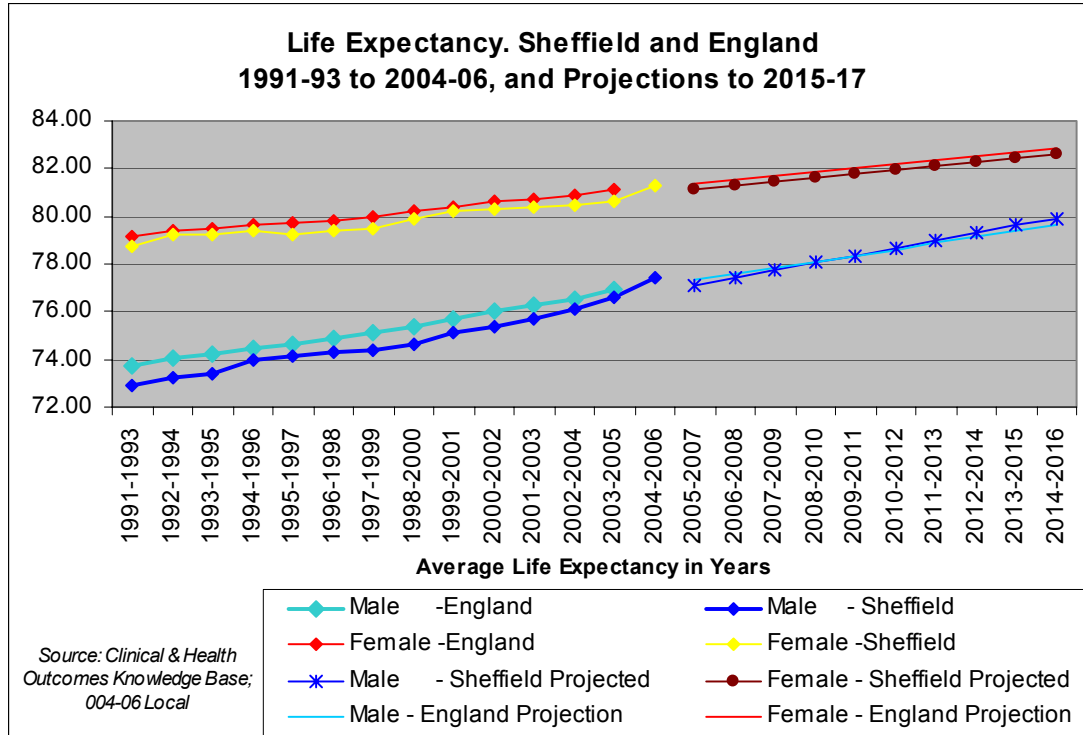
IMPROVING LIFE EXPECTANCY

Life expectancy in Sheffield has increased steadily over the last decade, as in the rest of the country. For the three year period 2004/06 it was 77.4 years for men and 81.3 years for women. Although for both men and women Sheffield life expectancy is marginally less than the England figure, the gap between Sheffield and England has been narrowing for men so that male life expectancy in Sheffield is now on a par with England. If current rates of change are maintained, male life expectancy in Sheffield will be greater than for England from 2010 onwards. If current trends continue, Sheffield (and England) will just fail to hit the Public Service Agreement (PSA) targets that by 2010 life expectancy should be 78.6 years for men and 82.5 years for women.

For women, life expectancy in Sheffield has been increasing in parallel with that for England. Projections indicate no further reduction in the gap (four months) between England and Sheffield over the next 10 years.

The gap between male and female life expectancy has reduced from five and half years 10 years ago to four years. It is projected to decrease further to less than three years in 10 years' time.

Figure 3

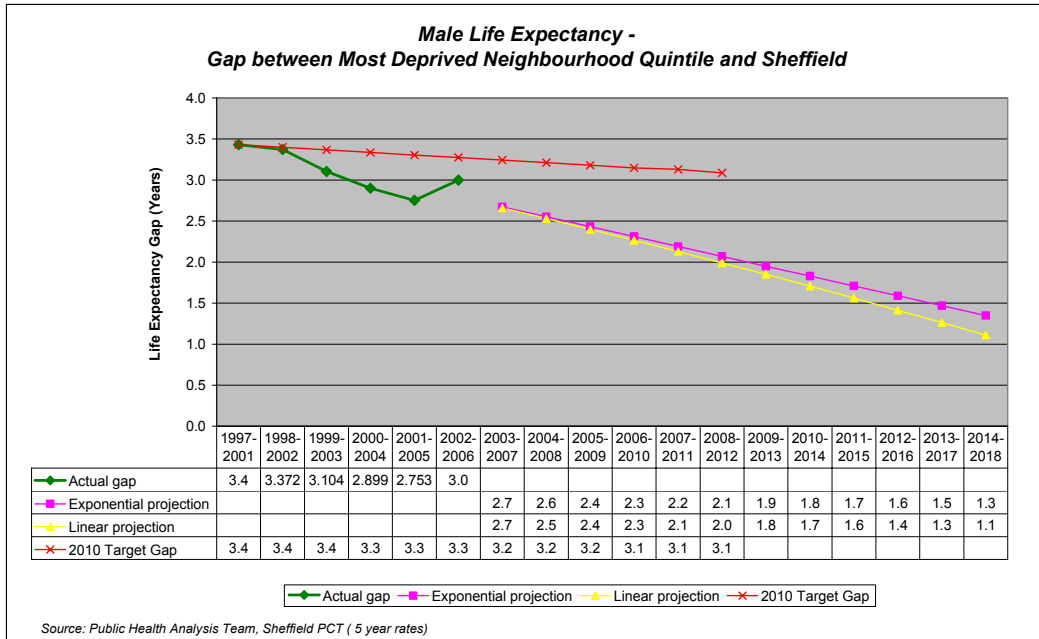


Variation within Sheffield

There is very substantial variation in life expectancy between different parts of the City, which reflects socio-economic deprivation. Overall life expectancy is substantially higher in the west and south west than in the north and east. The smaller units that populations are broken down into, the greater range between the highest and lowest life expectancy. Thus if we look at quintiles (one fifth of the City’s population) the gap between best and worst is about six years, whilst for electoral wards it is about 10 years and neighbourhoods approximately 14 years.

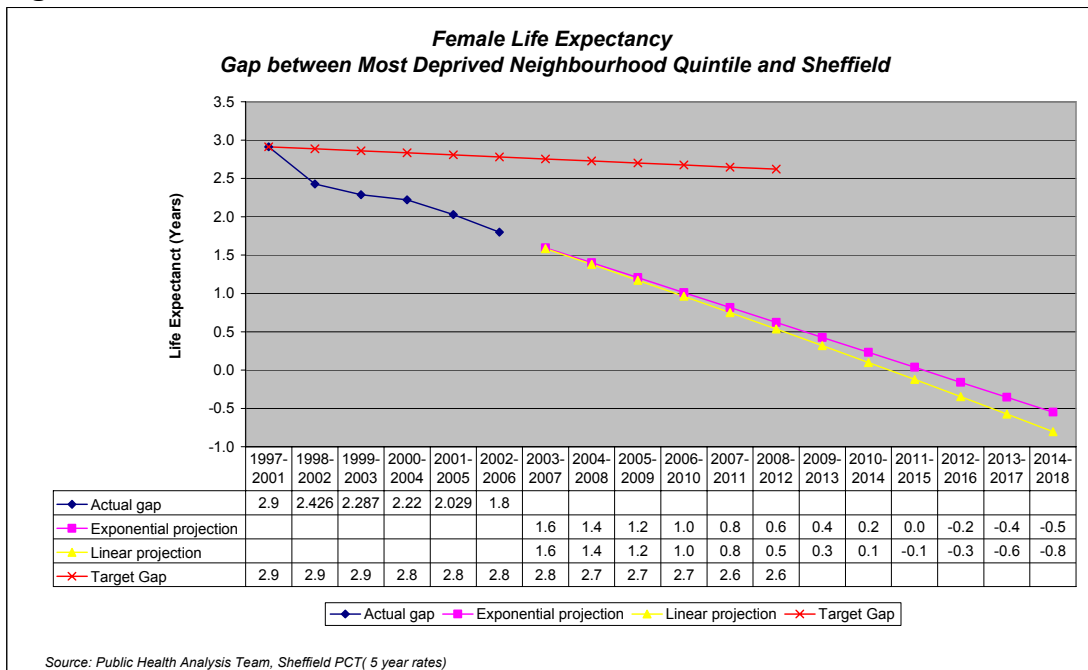
The Government’s preferred measure of health inequality is the gap between the most deprived quintile and the average. According to this measure, the gap in male life expectancy in Sheffield is progressively narrowing, having reduced from 3.5 years in 1997/2001 to 3.0 years in 2002/2006 (the latest period for which data is available). If existing trends continue the gap will have reduced to 2.2 years in five years’ time and 1.6 years in 10 years’ time.

Figure 4



For women, the current gap between the most deprived quintile and the Sheffield average is 1.8 years, having reduced from 2.9 years in 1997/2001. Forward projections show that if present trends continue this gap will have reduced to 0.8 years in five years' time and will have disappeared in 10 years' time.

Figure 5



However although there may be a progressive reduction in the gap between the worst quintile of the City and the average, we can expect to continue to see a substantial gap in life expectancy when measured at ward or neighbourhood level. Unfortunately the small populations do not allow for robust projections into the future of life expectancy for wards or neighbourhoods.

Premature Loss of Life

Conventionally, deaths before the age of 75 are considered to be premature. Just over one quarter of deaths in the City occur to people aged less than 75, though this proportion is decreasing as the population becomes healthier and life expectancy increases. However these premature deaths are disproportionately seen in the more deprived parts of the City. One quarter of all premature deaths in the City occur in the most deprived quintile (one fifth of the population). In the most deprived one third of the City (the area covered by the enhanced public health programmes) the proportion of all deaths that occur at age less than 75 is 40%.

Although continuation of existing trends will lead to a reduction in premature mortality across the City, the aim of this strategy is to ensure that the reduction in mortality is disproportionately seen in the more deprived populations.

A forward projection suggests that the number of premature deaths in the City will fall from 1645 in 2006 to 1348 in 2011 and 1123 in 2016 (falls of 297 and 522 deaths per year, respectively). Similarly, if present trends continue, the number of premature deaths in the most deprived quintile of the City will fall from 423 in 2006 to 316 in 2011 and 243 in 2016 (falls of 107 and 180 deaths per year, respectively).

Thus continuation of present trends would already see a disproportionately higher proportion of the reduction in premature death coming from the most deprived quintile (MDQ). We want to 'stretch' this further, and therefore are setting ourselves as a target that the number of premature deaths in the most deprived quintile should be reduced further, as shown in the following table.

					'stretch'		'stretch plus'	
	Sheffield	fall	MDQ	fall	MDQ	fall	MDQ	fall
2006	1645		423					
2011	1348	297	316	107	296	127	276	147
2016	1123	522	243	180	223	200	203	220

2006 figures are actual numbers of deaths, 2011 and 2016 figures are projected.
MDQ = Most Deprived Quintile

Present trends suggest that the number of lives saved (premature deaths before the age of 75 avoided) in the one fifth of the population that lives in those parts of the city that have the lowest health and deprivation indices will build up to over

100 per year over the next five years, and to 180 over ten years. Cumulatively, over those time periods this adds up to approximately 300 lives saved by 2012 or one thousand by 2017.

We want to do more so that this can increase to an additional 40 lives per year in those areas, by making sure that health improves faster in those areas than the average for the city. This will amount to an additional 100 lives saved in that five year period, Or 200 over the ten year period, so that the total lives saved would be 400 by 2012 and 1,300 by 2017.

DELIVERING NATIONAL TARGETS

The PCT will deliver the national targets required of it by the Department of Health. The Department's Operating Framework for 2008/09 has not yet been issued and so this strategy will need to be revised to address any additional targets.

We will continue to focus on existing targets especially:

Primary Care Access with a focus on improving access, when appropriate, to health services 'out of hours'. Current 2007/08 targets relate to normal GP working hours and include access to a GP appointment within 48 hours and access to a primary care professional within 24 hours of making contact.

Waiting times where the target is that by December 2008 no-one should wait more than 18 weeks from GP referral to Hospital Treatment. By March we are aiming to see 85% of all patients admitted within a maximum referral to treatment time of 18 weeks with 90% of non-admitted patients – those needing assessment and tests – seen within 18 weeks. These two 18 week milestones are supported by the following 3 assumptions:

- All outpatients seen within 5 weeks,
- All inpatients are seen within 11 weeks,
- All patients waiting for diagnostic tests are seen within 6 weeks

For all cancers 100% of people seen within two weeks from an urgent GP referral and all people seen within one month of a diagnosis to starting treatment.

Reducing levels of MRSA and other Infections with current targets being not to exceed 43 MRSA blood stream infections in a year and not to exceed 585 Clostridium Difficile (CDiff) infections during the year.

Smoking Cessation with a current target of 4385 four week smoking quitters, recording the smoking status of at least 65% of the 16 and over population, and seeing smoking during pregnancy reduced to 14.18% of expectant mothers.

For sexual health in Genito-urinary medicine clinics we are seeking to offer 100% of patients an appointment within 48 hours of contacting the service, with 95% of patients who attend GUM services seen within 48 hours of contacting the service.

For patient convenience and Choice our target is to have facilities in place to support patients being able to choose from at least four providers and

have 90% of patients given booked hospital appointments at the point of referral by their GP or another primary care professional.

For accident and emergency services to make sure that no patient waits more than four hours in A&E from arrival to admission, transfer or discharge with this being met at least 98% of the time every day.

Ambulance Response Times should be 75% of category A – 999 -- calls meet an eight minute response time with 95% of category B calls – less immediate conditions – responded to within a 19 minute response time.

For Mental Health our current targets are to commission a comprehensive Child and Adolescent Mental Health service and to commission crisis resolution home treatment services, early intervention services, provide community development workers and have a seven day Care Programme Approach and follow up and a regular audit of any suicides.

6. HOW ARE WE GOING TO GET THERE?

This section describes the approach we are going to take to develop our abilities as a commissioning organisation to secure year on year improvements in health outcomes and health services. Our guiding principles will be doing the right thing – as efficiently as we can - and doing things well – as effectively as we can - and working with the public – through better engagement. This approach to better efficiency, effectiveness and engagement will be developed throughout our organisation. A supporting approach will be constantly assessing information around health need and current quality, engaging with the public and developing specifications for services that we will then commission. We will seek to use this process to assure ourselves and the public that we are focusing on the areas of greatest health gain. The recent changes to the NHS will in part see the PCT develop a greater focus on becoming a commissioner of services rather than in all cases a direct provider. We will work with Practice Based Commissioning consortia in the development of improved care pathways.

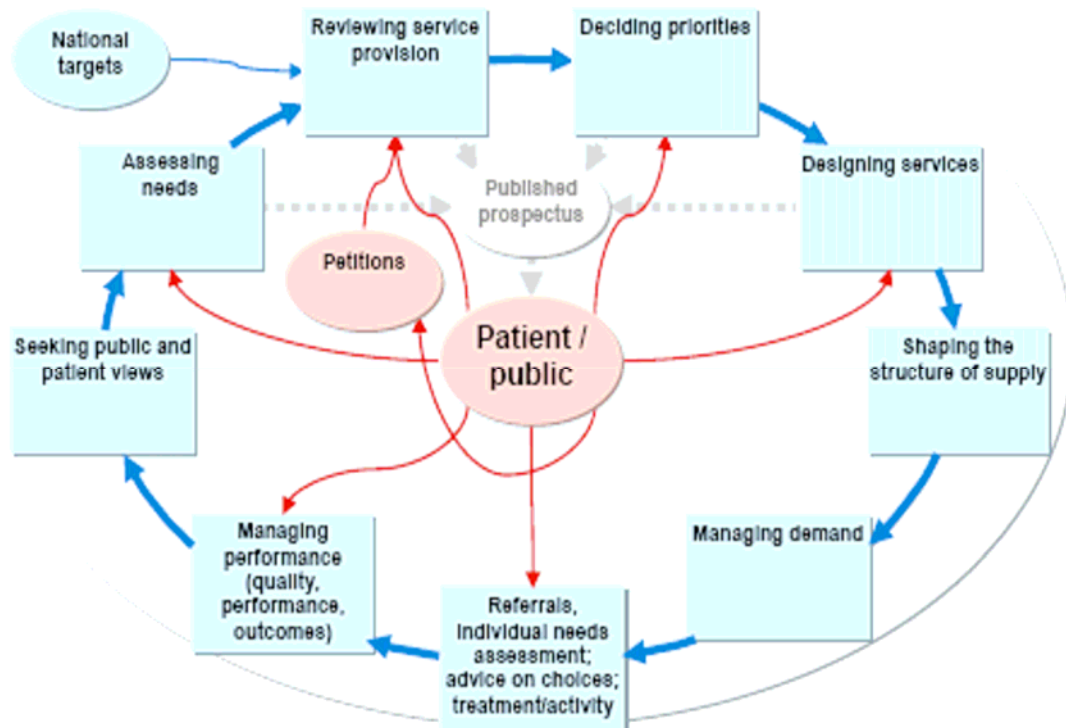
BY DEVELOPING AS A COMMISSIONER AND GETTING FIT FOR PURPOSE

As a new organisation, Sheffield PCT has been explicitly designed as a commissioner. This means that the PCT principally sees itself as the ‘health insurer’ for the people of Sheffield. Like any good insurer, the PCT has a responsibility to understand the needs of its population and ensure those needs are met. Unlike a commercial insurer though, the PCT does not pick and choose who it will provide cover for, and it is responsible for helping to improve the overall health of the population not just for making sure that particular health services are available to meet the needs of individuals when they are ill. The other major differences between the PCT and an insurer are that the people of Sheffield have no choice who their insurer is and nor do they pay directly into the PCT. The PCT will therefore ensure that it connects with and stays connected with, the people of the City.

The PCT currently directly provides a range of services as described on page 168. Over the next 12 months we will develop a strategy to ensure these services continue to be available through appropriate arrangements. As part of this process the PCT will work through the options including whether to remain a direct provider of services or to develop alternative approaches.

Figure 6.

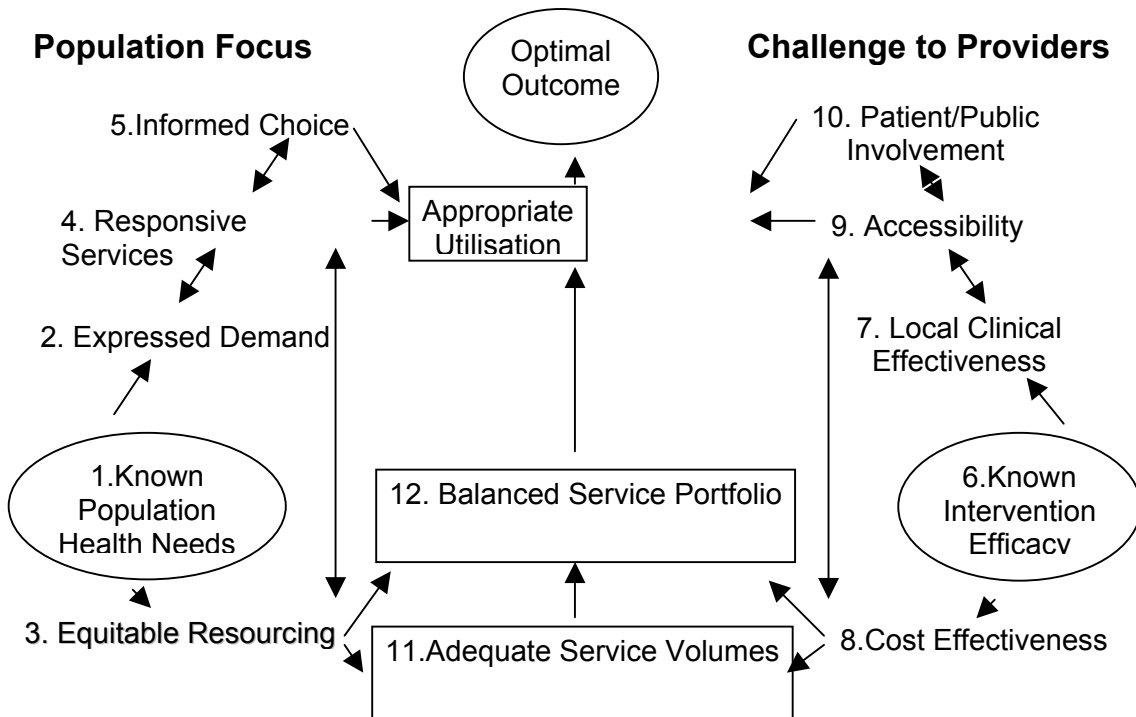
The Commissioning Cycle for Health Services



The structure of the PCT, from Board level downwards, reflects the 'commissioning cycle' that has been set out in national NHS policy. In general terms the cycle is as follows: The PCT's public health function describes local health needs and the evidence base for responding to those needs. Working with primary care clinicians - including GPs - and other partners such as the City Council, local employers, and local communities themselves, the PCT's strategy directorate develops approaches to responding to need and produces service specifications. These specifications then form the basis for the procurement of services in ways that offer choice and ensure the best value for money. The quality, timeliness, and cost effectiveness of the provision of services in response to the original need is then overseen by the PCT's performance function, which in turn informs the understanding of need, specification, procurement and so on around the cycle again. Central to making this work effectively are two further elements. These are the active engagement of patients and the wider public, and putting clinical leaders and decision-makers – the PCT's Professional Executive Committee (PEC) of local clinicians, along with the consortia of Practice-based Commissioners - at the heart of the process.

Figure 7.

Commissioning Healthcare for Best Outcomes



The above diagram is known as the 'Christmas Tree diagnostic', and is accompanied by a description of its numbered component principles. The framework balances the challenges to providers and a population focus which together determine whether optimal outcome can be achieved at population level from a given set of personal health interventions. The 12 parts of the diagram relate to the following points:

POPULATION FOCUS

1. The PCT will work to ensure that the level and type of service available is based on knowledge of the health care need of the population.
2. The PCT will work to inform, educate and support the population to encourage them to take action to improve their own health and well-being, and to access and utilize health services appropriately.
3. The PCT will work to make resources available for the population to benefit according to need, by targeting distribution of its income.
4. The PCT will work to ensure that all patients will be afforded equal access to beneficial interventions according to need.
5. The PCT will ensure that where appropriate, patients are empowered to make choices about their treatment and care plans on the basis of good

information, and are supported to utilise treatments and therapies to best effect.

CHALLENGE TO PROVIDERS

6. The PCT will work to ensure that services are established, modified and maintained on the basis of best current knowledge of the efficacy of interventions, and national guidance.
7. The PCT will work to ensure that service providers maintain high standards of local effectiveness through education and training driven by systems of professional and organisational governance and audit.
8. The PCT will work to ensure that the expenditure on health care is targeted so as to optimise the potential health gain available to residents from resource available.
9. The PCT will work with providers to develop appropriate models and configurations of service, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service.
10. The PCT will work with patients and communities to ensure that services place their needs and requirements at the centre of their operation and that quality assurance system are in place to ensure the acceptability of services to patients.
11. The PCT will commission adequate service volumes to at least accommodate national referral-to-treatment targets.
12. The PCT will ensure a balance of services within patient pathways to avoid bottlenecks and delay

The PCT is ambitious. It believes it can and should become a 'premier' PCT. By this we mean that as this strategy is published we are coming to the end of an initial phase in our development: we are re-establishing financial balance, establishing a structure and have been developing a strategy. The second phase will be about beginning to implement this five year strategy and establishing new ways of working to deliver it, for example through establishing a new performance management system, good and clear partnerships, strong clinical leadership, active patient and public engagement, and achieving good scores when inspected by external regulatory bodies. The third 'premier' phase will be when we can demonstrate a reduction in inequalities, excellent organisational performance, 'world class' commissioning – meaning we are driven by health needs, through public participation and clinical leadership – effective and efficient provision, high levels of patient and staff satisfaction, and the achievement of excellent scores when inspected by external regulatory bodies.

As a new organisation the PCT has also been through a 'Fitness for Purpose' test that compared the organisation against the intentions of the commissioning cycle. The PCT will continue to check itself against the commissioning cycle in three main ways. Firstly by using the Department of Health's Framework for External Support to Commissioners (FESC). FESC sets out a menu of commissioning functions that the PCT could, if it chose, 'buy-in' from external

organisations. Secondly in the light of national Department of Health-led work that is currently underway to define and quantify 'world class commissioning'. Thirdly, through development work with other more local organisations, including the Strategic Health Authority for Yorkshire and the Humber as it works with all 14 PCTs in the region – we can compare ourselves with our neighbours and with the regional average – and with the City Council as we work together on our joint approach to improving health and well-being more broadly, following the lead given by the national publication, the Commissioning Framework for Health and Well-being. In all of this work, the success of the PCT as an organisation is inseparable from the success of Practice-based Commissioning because Practice-based Commissioners are rooted in local communities and in daily contact with individual patients.

Research and evaluation

Research and evaluation is an essential part of the development of health services. Sheffield PCT will actively support research and evaluation. We will work with partners, in particular the two universities within the city, to build on the existing research base and translate the outcomes of that research into clinical practice. We will develop our own research capacity as time and resources permit. All such research will be conducted according to the highest methodological, ethical and research governance standards.

Developing care pathways

The NHS is responsible for people 'from cradle to grave'. Whilst health services do support people throughout their lives - indeed providing support before birth and sometimes even before conception – we all follow a variety of pathways in life that have an effect on our health, not all of which are the responsibility of health services.

Population pathways

The pathways we all travel through life bring us into contact with health risk. Some of these risks are the result of individual behaviour and may therefore require individual behaviour change to reduce or remove; can be influenced by collective local action, whereas some require government action. Risk is not of itself a bad thing nor should we try and eradicate all risk. For example, the number and severity of road traffic accidents involving children should be reduced as far as possible. But we cannot avoid all travel by foot, cycle or car. However, action is required by children and their families – learning to cross the road safely, cycling safely, the use of child car seats, driving safely; through collective local action – safe crossing points, safe routes to school schemes, school crossing patrols, speed limits and their enforcement, schemes for the provision of safety equipment, cycling proficiency training, and; through government action such as seatbelt legislation and vehicle safety requirements, as well as the granting of local powers to enforce pro-safety policies. Along this

quite literal pathway, the role of health services is to make the case for certain actions and behaviours and identifying the consequences of not managing risk as effectively as possible. The actions are for others to take.

The emergency and sometimes long term response to avoidable levels of child accidents on the road produces a high cost for health services, quite apart from the children, their families and everyone else involved.

Individual pathways

There are many challenges in providing healthcare. Two of the most complicated challenges are variation in care and a focus on institutions. Within the longer and broader pathways referred to above there are the specific pathways along which we travel as patients, whether during a traumatic or emergency situation or as the result of a long-term or even life-long medical condition.

The more we are able to develop and deliver evidence-based pathways of care for the management of common and not so common conditions, the greater the positive effects we will have in reducing the variations that patients experience. There may be good reasons why one patient stays in hospital for more or less time than another. Similarly there may be good reasons why one patient receives a different dose of a particular medicine from their GP. The point of pathways is not to reduce everything to an average but to describe a preferred approach, consistent with the evidence of what constitutes good clinical practice, so that differences in practice are made transparent and can be explained or changed. Our overall pathway approach is summarized in Figure 4.

The more we are able to focus on the pathway, the less we will be driven by a focus on an institution – usually on a particular service in a particular building. Whilst many elements of the management of many conditions require highly specialised intervention by highly skilled and highly trained specialists, our aim is to concentrate the most specialised resources on the most specialised needs. Pathways help health services to move away from having to ‘default’ patients to a particular service because ‘that’s what we’ve always done’. Clarity about pathways also offers the prospect of providing patients with choices – not only about where and by whom, but what their treatment might comprise in the first place.

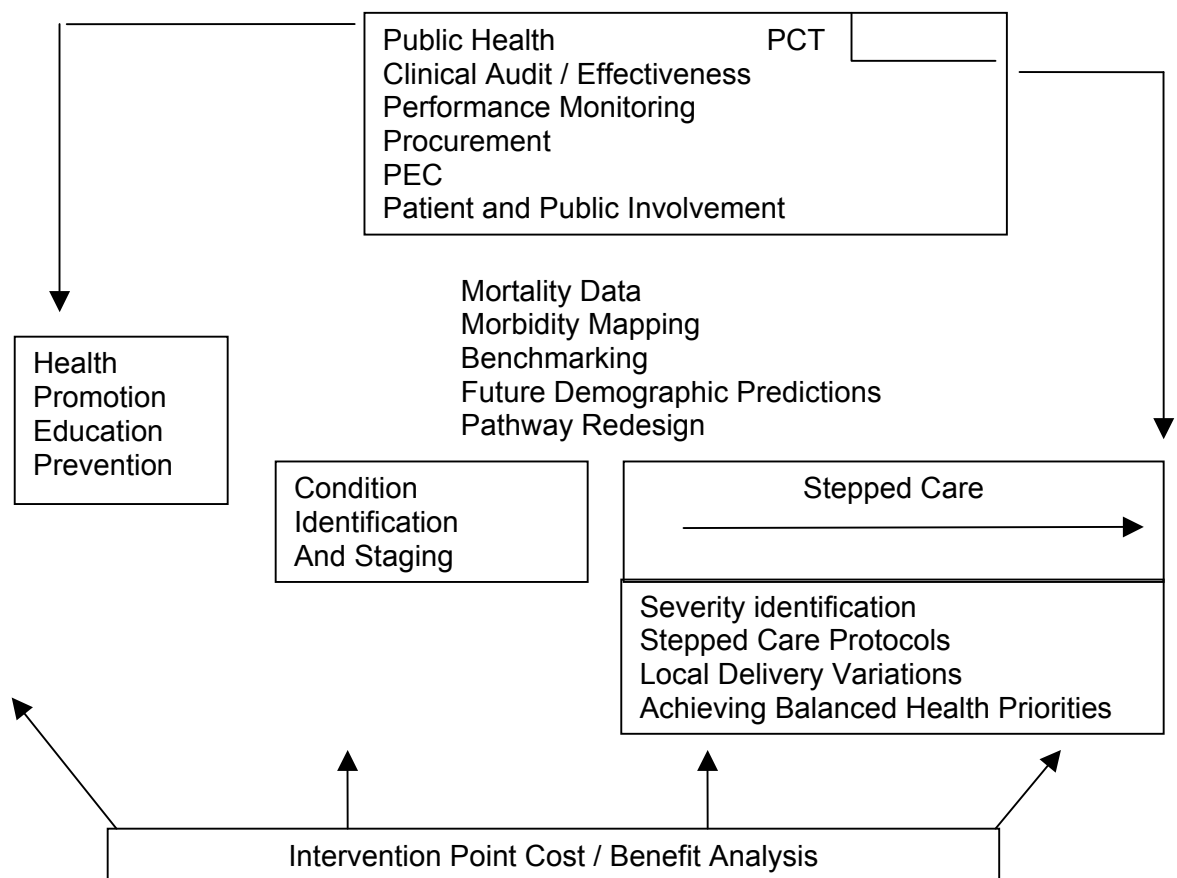
Individuals often receive services from both the NHS and local government. There is an increasing focus on looking at people’s health and well being as a whole and we will work with the City Council, and provider organizations, to develop better approaches to treating both physical and psychological health problems. Where packages of care are developed for individuals that involve our work with other partners we will seek to ensure that these are better co-ordinated and the “hand offs” between agencies are reduced.

For individuals with long standing relationships with health and social services there is scope to develop an individualised approach to designing services. Enabling clients to have resources to make direct payments for some activities exist within social services but there are not equivalent arrangements within the NHS. There are pilots to develop individualised budgets within some PCTs. We will learn from these pilots and identify the scope to take forward this approach within our services.

The work of the PCT Professional Executive Committee and the clinical leaders from Practice-based Commissioning consortia on the development of common local pathways, agreed with clinicians in local hospitals and other local health and social care services are central to improving patient choice, reducing variations and crucially, making the best use of the resources available to us.

Figure 8.

THE GENERIC CLINICAL PATHWAY



CLINICAL ENGAGEMENT

Clinical engagement and leadership is secured in three ways; through the Professional Executive Committee (PEC) of the PCT, through the Clinical Network and through Practice Based Commissioning (PBC).

Professional Executive Committee (PEC)

The PEC will be an integral player in delivering the PCT's strategy. The PEC will effectively be the 'clinical engine room' of the PCT. The PCT had developed a shared PEC Chair role through two local GPs which will ensure four full days per week of high level clinical input, with both PEC chairs attending the PCT's Senior Management Team (SMT) and Board meetings. Both Chairs will work closely with the PCT Chief Executive and Chair to ensure clinical input and support at the highest level of the organisation.

The PEC members will each give a further six sessions per month to the organisation. Although PEC members are clearly not there to represent their professional groupings, they do have a clear role in bringing a broad clinical perspective to discussions. PEC will pull in clinical expertise and advice from outside and within the PCT when required. Conflict of interest may be an issue in many discussions the PEC will seek to develop close collaborative working with the PCT Management Team and Board. It will work to create a cohesive clinical group working to each individual's strengths and expertise.

PEC is central to ensuring that the wider clinical perspective is heard and considered as part of PCT decision making leading to clinical change. There is a clear role in leading and supporting clinical innovation and redesign both from within the PCT, into our PBC consortia and other provider organisations.

The PEC is part of ensuring strong and robust clinical engagement across all interfaces with our providers, partners and the public. Our Practice Based Commissioning (PBC) consortia will be key partners in achieving system reform, with PEC Chairs and members having strong formal links with all our consortia. Our PEC Chairs will also formally link to our independent contractor representative bodies as well as enhancing our traditional links with our secondary care trusts and PCT providers.

PEC will have a rolling programme of pathway redesign and clinical protocol development with our secondary and primary care colleagues. The PEC Chairs will be joint clinical leads and will co-ordinate the progress with defined management support from the PCT. We will also work closely with PBC consortia to facilitate their redesign priorities.

We will facilitate links with any new prospective providers within the emerging market. Clinical engagement with our public will continue to be a priority, building on the Achieving *Balanced Health* consultation.

Clinical Network

The Clinical Network is led by PEC clinicians but provides an opportunity for all primary care clinicians to contribute to changes in clinical practice through the development of clinical protocols. These describe the criteria for access to services and define how the care pathway should be accessed, for example by specifying which diagnostic tests should be undertaken before referral to secondary care. Draft protocols are published on the PCT intranet to enable all interested clinicians and managers to comment before final protocols are sent to PEC for approval.

We are working with consortia to develop new care pathways for the management of certain conditions. We have already agreed pathways to manage menorrhagia, a limited list of benign skin conditions and helicobacter testing as a part of a dyspepsia pathway. Pain clinic provision is being developed as well as a foot and ankle pathway and a programme for initiation of insulin in the community. The PEC has prepared city wide protocols for management of anticoagulated patients and a scheme for monitoring patients on Disease-modifying antirheumatic drugs (DMARDs). The intention is to substantially increase the range of protocols to cover the most common reasons for referral and admission.

PRACTICE BASED COMMISSIONING AND SERVICE REDESIGN

Practice Based Commissioning (PBC) is the main vehicle through which the PCT will achieve its objectives, particularly with regard to financial balance, service redesign and reduction of health inequalities. Of the 94 general practices in Sheffield, 92 have signed up to the 2007/08 PBC Incentive Scheme Local Enhanced Service (PBC IS LES). The majority (89) are working in consortium arrangements, with seven consortia across the city. A key element of the PBC IS LES is the commitment to lead one city-wide service redesign project and to produce one clinical protocol to support the Clinical Network. The service redesign areas are:

Central PBC Consortium	Diagnostics, including unbundling the NHS tariff
Hallam PBC Consortium	Dermatology
Health Alliance PBC Consortium	Urology
West PBC Consortium	Rheumatology
SONIC PBC Consortium	Insulin initiation in primary care
Parson Cross PBC Consortium	Chest medicine
South Sheffield PBC Consortium	Orthopaedics

The scope of each project is currently being agreed with the consortium leads. These projects will be more complex than the clinical protocols as they will specify the facilities, skill mix and care pathways for new services, rather than the criteria for accessing existing services. These will go through the same intranet based consultation process as the clinical protocols.

From 2008/09, the PCT will work with the consortia to help them further develop a population based approach to commissioning with a particular emphasis on addressing key public health issues and reducing inequalities. We will explore the scope to develop a public health area alongside the existing service redesign areas. Our current process for agreeing service development proposals does include the impact on public health issues but we will look to see if this can be strengthened in support of the PCT's overall goal of increasing life expectancy and reducing health inequalities.

The consortia will also be encouraged to develop more strategic relationships with key partners such as the local authority and we will look to facilitate links between local commissioning for health and social care services, especially those for children and young people.

THROUGH MANAGING THE REFORMS IN THE NHS SYSTEM

The recent reforms to the structures of the NHS have been driven by the intention of making the NHS more responsive to the views of patients and the public. The PCT is responsible for commissioning services on behalf of the residents of Sheffield and we will seek to involve you more in shaping the nature of the health services in the city and to give you more in control of the care that you receive.

An element of the new system is the arrangements to develop more involvement of primary care staff in helping to shape the services on offer to patients through the breaking down of the PCT's budget to GP practice level. The development of this practice based approach to commissioning will be a means by which we can engage more effectively with primary care clinicians to improve the delivery of local health care so that as a PCT we become more responsive to the needs of the people served by the NHS.

Under the new system of funding hospital services, known as payment by results, money follows the patient and the decisions individuals make about where they are cared for will impact on the funding of those organisations providing health services.

New sorts of providers have been established in the NHS with the creation of NHS Foundation Trusts. Both Sheffield Children's Hospital and Sheffield Teaching Hospitals have obtained this status and Sheffield Care Trust is currently applying to become a Foundation Trust. New providers are also developing who can provide the NHS with additional capacity, including

Independent Sector Treatment Centres (ISTC) that are able to treat NHS patients for diagnostic and surgical procedures. Already a number of people have chosen to have their NHS treatments carried out at an ISTC, including the one in Barlborough.

Within community services the new contract for general practice enables new providers, known as Alternative Personal Medical Services (APMS), to provide NHS services. As a PCT we now have a greater range of options for obtaining services for our residents.

It is in all of our interests that the existing NHS providers in the city continue to develop and thrive but individuals can choose to be treated at any provider willing to meet the standards that the NHS sets for clinical quality, patient safety and value for money.

We will need to develop our approach to commissioning in the light of these individual choices and ensure that patients are offered a choice of provider. As a result NHS, independent and voluntary sector providers will have to continue to develop the quality of their services in order to attract patients. By the same token we will explore alternative means of provision should we have fundamental concerns about the quality, safety or efficiency of any of the services that we currently commission from existing providers.

Through our approach to identifying and specifying the pathways of care for services we will also look to see if there are options for the delivery of particular parts of a patient service, for example building on our arrangements with the voluntary sector or social enterprise organisations.

Our services must be based around the needs of people and treating them as individuals but we can take a more systematic approach to the processes by which care is delivered. By taking the concept of the management of a supply chain – all of the organisations involved in the service that gets to the person who needs it – to healthcare we can work to reduce the variation in our services and improve their quality. Increasingly the role of the PCT will be to manage the local NHS system through the network of services, and partners in Sheffield and through the relationship with residents and patients. Our success as an organisation will depend on all parts of the local system contributing to improving the supply of services to the residents of Sheffield.

DEVELOPING NEW APPROACHES TO SERVICE DELIVERY

One of the results of the *Achieving Balanced Health* consultation has been that there is support in principle for the development of new forms of health services that would enable people to get their NHS care with fewer visits to hospital or with more services provided in people's homes, at a local GP surgery or another community setting. This would see more community services that are more responsive and flexible. Achieving this vision will take time and may be

challenging to some of the current arrangements for the way our services are delivered. The pace of change will also depend on our success in managing activity more effectively and freeing up resources for investment in new services.

During the course of this five year strategy we will be working with our partners inside and outside of the NHS to develop our approach to delivering more care closer to home. This will be linked with the work of practice based commissioners to develop new services and with the preparation of a plan to develop our primary care and community facilities.

Areas that have been identified as having the potential for shifting into community settings include:

- simple diagnostic tests
- more assessments by GPs followed by direct access to hospital based tests or specialist treatment
- outpatient activity
- outpatient follow up activity
- day case surgery
- “step down” care after an initial admission to hospital
- more care for those with long term conditions

Work nationally, and here in Sheffield as outlined later in this document, also suggests scope for developing services that would enable more care to be provided by people themselves through greater education on the management of conditions, home monitoring systems and the use of telephone and computer links with care staff.

The NHS Institute for Innovation has identified an approach for taking this forward consisting of:

- Better integration between the individuals who provide care and between the organisations that they work for
- Designing services around patient groups to ensure that individuals get the services that they need
- Reducing the complexity of services and the opportunities for things to go wrong through having fewer steps in the process – sometimes referred to as “lean” design – along with reducing the variation in the ways services are delivered
- Increasing the skill levels of all the staff contributing to care
- Using technology to help maintain individual’s independence
- Developing approaches that enable people to manage more elements of their care themselves
- Looking at a wider range of providers to give services to people

We want to take this approach and refine it to make sense for Sheffield. If we are to achieve the ambitious aims we have set ourselves to improve the efficiency of services to the top 25% of the country then we will need to make changes that enable more services to be provided in the community. We acknowledge that we still have work to do to draw up a plan that would describe our detailed approach to community services. However this five year strategy sets out the overall frame within which we will develop the picture for future services.

BY INVOLVING THE PUBLIC IN DESIGNING OUR SERVICES

We will ensure active engagement with patients, the public and staff, build on what is already good and work through partnerships to design changes to our services.

The Trust Board has agreed an approach to engagement which focuses on three areas:

- focusing fixed resources on engaging the population that are seldom heard to help us develop and shape the services required to meet the health inequalities agenda. We need to explore more creative approaches to achieve this and build on partnerships both within the PCT and across other stakeholders including the Local Authority and the voluntary sector.
- continuing to support the readily engaged as they have developed appropriate skills and networks. In order to maintain these important links, within a fixed resource, we need to clarify the most effective methods. Work in progress with Sheffield Hallam University (Knowledge Exchange Project) will give us this information and will feed into the development of the Engagement Strategy.
- lay involvement in the development of services and that we ensure that patients are part of the strategic procurement cycle.

These three areas feature in a wider engagement strategy that has been developed to support the delivery of our five year goals. This is attached at Annex 6. We will use information learnt over the period of the Achieving Balanced Health consultation to inform us and strengthen our approach to effective engagement.

To address health inequalities we need to engage appropriately when looking to shift resources and services to address those inequalities. A focused approach is essential to ensure that we can clearly evidence that we have proactively involved and engaged in a meaningful way that has demonstrable outcomes, and that when we commission services from other providers we gain assurance regarding the appropriate patient experience and engagement in those services. Because of the diversity of Sheffield's population and the challenges, we need to develop alternative approaches to engagement. The Achieving Balanced Health consultation has been a creative approach to engaging the Sheffield community regarding the future of health and wellbeing services in the city. This approach of

wide consultation/ deliberation events backed up by a web based feedback facility aims to capture as many people as possible to gain a view of how we should and can deliver services to balance the current health inequalities in Sheffield.

We currently receive information regarding the patients experience from a variety of routes ranging from compliments and patients surveys, to service reviews, Overview and Scrutiny Committees, PALS contacts and formal complaints.

We will develop robust indicators that capture both how we engage but also what is the experience people have of our services, which then feed into the contacting and performance monitoring discussions. We will respect the potential emergence of diversity in the range of providers of services including the third Sector market and Social Enterprise organisations.

We will base our approach on focusing engagement on the seldom heard and finding less resource intensive ways of maintaining contact with the readily engaged.

We have developed a Patient Involvement and Public Engagement (PIPE) service is to ensure that citizens, patients and carers in Sheffield are appropriately engaged in:

- The business of the PCT
- the planning of the services that we are responsible for;
- developing and considering proposals for the changes in the way those services are provided;
- the decisions that are made that affect how those services operate;
- the monitoring and evaluation of those services.

We have used a variety of approaches to engagement with some examples of good practice with the main focus on the introduction of the Patient Advice and Liaison Service (PALS) and the award-winning schemes run under the Expert Patient Programme (EPP).

A key outcome identified from the Fitness for Purpose review has been that despite many examples of effective engagement work, there is a lack of consistency across Sheffield of capturing not only how we involve and engage with patients, users of the services, and their carers, but also the general public, including the taxpayers, the unemployed, the seldom heard groups, socially excluded people, children and young people, asylum seekers and the people who do not, or cannot, access our services. Because of the diversity of Sheffield's population we need to develop additional and alternative approaches.

There are also examples of partnership working with other key stakeholders within the City which, in essence enable us to achieve a joined up approach to

engagement when required. However, we need to ensure we can demonstrate the effectiveness in order to develop services.

There has been key work undertaken over the last six months since the formation of the PCT which has identified ways of involving effectively but because of the diversity of Sheffield's population and the challenges, we need to develop additional and alternative approaches to engagement.

We have strong information relating to knowledge regarding communities and the PIPE team uses this when working in partnership with staff in other PCT teams / organisations e.g. enhanced public health programme. We are aware that there are gaps and we are currently working with Sheffield Hallam University in a Knowledge Exchange Project to evaluate what has worked and should be continued and what possible gaps there might be in our engagement. Learning from this will drive the further development of the objectives for the strategy.

IMPROVING PRODUCTIVITY

We will seek to get better value for money from the services that we commission and provide and to obtain more productivity within the local NHS.

Improving Productivity to the National Average

Using national data from the Department of Health, were Sheffield PCT to improve productivity to that of the national average there is scope to save £3.5m on Outpatient first attendances, £8.9m on outpatient follow ups, £7.4m on elective admissions and £11m on Emergency Admissions. The source for these data is the NHS Comparators website <https://nww.nhscomparators.nhs.uk/NHSComparators/Login.aspx>)

Improving Productivity to the top Quartile Performers

We believe that we should be aiming for better than matching the national average. If we were to achieve top quartile performance – matching the top 25% nationally in the NHS – then we would release additional resources to help fund developments in the city.

The NHS productivity website (<http://www.productivity.nhs.uk/>) identifies four measures

- Managing variation in surgical thresholds
- Managing variation in emergency admissions
- Managing variation in outpatient appointments
- Increasing low cost statin prescribing

The latest data for the third quarter of 2006/07 – shown in the table below - suggest that were Sheffield PCT to improve productivity to that of the top quartile

performers there is scope to save £6.9m on Outpatient First Attendances and £2.9m on Emergency Admissions. There is limited scope for savings in managing variation in surgical thresholds - £400,000 and we are already above the national average for low cost statin prescribing so have not identified a further savings target.

Matching the upper quartile of PCTs in England

Metric	England Benchmark	Sheffield's Performance	Sheffield's Position out of 152 PCTs	Potential Savings if UQ achieved
Managing variation in surgical thresholds	100	77	44th	£400,000
Emergency admissions for 19 conditions	100	91	55th	£2,911,000
Relative level of outpatient appointments	100	125	132nd	£6,903,000
Percentage of low cost statin prescribing	66%	69%	69th	£0

UQ = Upper Quartile

We will be developing approaches to realise these productivity improvements as part of our commissioning plan and in discussion with Practice Based Commissioning consortia and in our contract discussions with providers.

IMPROVING THE QUALITY OF SERVICES

We will work with the organisations from whom we commission services to improve both the quality of the patient experience and the outcomes obtained for patients. The PCT has a representative on the Clinical and Healthcare Governance groups of the two Foundation Trusts in the city: Sheffield Teaching Hospitals and Sheffield Children's Hospital. These groups have a key role in monitoring clinical quality standards at a number of levels. Working with the PCT's contracting teams we are also developing quality monitoring systems with the Sheffield Care Trust and the Yorkshire Ambulance Service

Compliance with the Healthcare Commission's core standards for better health is a requirement within legally binding contracts of Foundation Trusts and within service level agreements for other providers. All NHS organisations are subject to reviews and inspections by the Healthcare Commission and the PCT will monitor relevant action plans to ensure quality standards are implemented. In addition to ensuring that developmental standards are being met, the PCT is also working towards establishing a number of key clinical quality indicators to ensure

that the providers demonstrate continuous quality improvements year on year.

Compliance with the national Clinical Negligence Scheme standards is also monitored through the relevant Governance Groups.

Clinical quality standards that include a number of the core standards for better health are monitored through the contractual frameworks of Dentists and Community Pharmacists and the Quality and Outcomes Framework within General Practice. Optometrists, although there is no contractual requirement, have agreed quality standards that practices are working towards and are monitored on an annual basis by the PCT.

A priority is to achieve a reduction in the numbers of Hospital Acquired infections and the maintenance of the NHS Hygiene Code. All services commissioned by the PCT are subject to potential infection control inspections by the Healthcare Commission this year and the PCT will monitor any subsequent action plans. The PCT is working with secondary care providers at all levels to ensure that hygiene and cleanliness standards are being implemented. There is joint working with infection control teams in primary and secondary care to ensure that policy and procedures are agreed and joined up across the health community.

The PCT also has representation on STHFT Joint Infection Control Committee. Key indicators are monitored relating to Hospital acquired infection – MRSA and Clostridium Difficile. These are monitored on a monthly basis by the PCT. In addition, all patients with a diagnosis of MRSA bacteraemia undergo a root cause analysis and action plans are shared and monitored by the PCT.

OUR FIVE YEAR ACTIVITY PLAN

We have modeled the likely levels of outpatient and inpatient hospital activity for the PCT for the five years from 2008/09 to 2012/13. The model covers hospital activity at all providers for both adults and children. The approach has been to create a model which, as a starting position, projects what will happen if, over the next five years, nothing significant changes in the way services are designed and delivered – but then factors in the likely impact of the improvements in service delivery and efficiency which the PCT believes that it should be possible to bring about.

The following assumptions are built into the modeling.

Underlying demand. Subject to the two adjustments below, the model assumes that the underlying demand for hospital services will be at the outturn levels experienced in 2006/07 – in terms of referrals, Did Not Attend (DNA) rates, outpatient follow-up ratios, outpatient-to-inpatient referrals rates and emergency admission rates.

Adjustments for demand management. The activity model assumes, at this stage, that the planned full-year effect in 2008/09 of the PCT's current demand management strategies will be delivered and for each year after that. However, the PCT's financial projections make a more prudent assumption, taking account of year-to-date performance during 2007/08.

Adjustments for demographic change. Detailed modeling has been carried out using age-banded population projection data to estimate the likely impact of changes in the population size and make-up over the next five years. These estimates have been factored into the model at specialty level as described earlier. Predicting numbers of births is particularly difficult, and the birth forecasts built into the model may need revisiting.

Achieving the 18 week wait target. Our assumption is that to achieve this on an ongoing basis we will need to commission an outpatient clearance time of two weeks and an inpatient clearance time of four weeks. We are therefore assuming that by December 2008 provider Trusts' total waiting lists for first outpatient appointments and elective inpatient admission will need to have fallen to levels linked with these clearance times. We have assumed that the plans for waiting list reduction set out in the current contract will be met in full by 31 March 2008.

Use of Independent Sector providers. The model assumes that full use will continue to be made of the PCT's commissioned capacity at the Barlborough ISTC.

We have not yet made allowance for the following factors at this stage of the model:

Health need / health inequalities There may be areas where we should be assuming a growth in the underlying demand for hospital treatment, because of epidemiological trends. Equally, our efforts to combat health inequalities may initially result in increased referrals from some areas of Sheffield.

Clinical treatment patterns There may be significant changes over the five-year period in the way in which certain clinical services are delivered. Certain interventions may come to be used less; new ones may be introduced with potential for significant impact on service activity levels.

Diagnostic services Many diagnostic services are outside the scope of Payment by Results; PCTs pay for them as part of outpatient or inpatient episodes of care. We have only limited data about our use of these diagnostic services, and the model does not address trends in their use. However, reducing waits for diagnostic services will be a crucial part of achieving the 18-week target, and it may well be that – as part of the

service redesign initiatives described above, the PCT will wish to change diagnostic care pathways, bringing more diagnostic services onto a GP-direct-access, community-based footing.

Impact of improved access to services We are moving to a new environment where there should be very rapid access to NHS-funded services. This could affect demand in several ways:

- At present, more than 10% of referred patients are never seen in clinic. It might be reasonable to expect that, with short waiting times and electronic appointment booking; this proportion will fall – which could mean a significant increase in outpatient activity.
- Shorter waiting times for elective and diagnostic services may, of themselves, encourage patients and clinicians to lower thresholds for referral and treatment.
- Access to NHS-funded care in local private sector hospitals may encourage patients who would currently fund their own private treatment to use the NHS-funded service instead. This could result in a significant increase in NHS-funded activity.

We will continue to develop our understanding of how Sheffield PCT’s use of different healthcare services compares with other PCTs, particularly with ‘peer’ northern city PCTs. We already know that Sheffield PCT’s use of acute hospital services benchmarks high against other PCTs. Much of the thrust of the PCT’s five-year strategy will be to reduce the use of acute hospital care, partly through management of demand, partly through more local delivery of community-based services.

Potential impact of service redesign

We have looked at the national benchmarking information (from the Department of Health and from the NHS Institute for Innovation and Improvement) and assessed the extent of the reductions in hospital activity Sheffield PCT might be able to achieve, firstly by reaching the national average level of performance and secondly by moving to ‘best practice’ performance. The reductions for different types of services are shown in the table below.

	Reduction needed for Sheffield PCT to achieve national average level (median)	Reduction needed for Sheffield PCT to achieve national best practice level (lower quartile)
Outpatient referrals	18%	27%
Outpatient follow-up attendances	19%	28%
Elective admissions	17%	29%
Emergency admissions	14%	26%

We believe that, by managing demand appropriately and by building up community services as alternatives to hospital, it will be possible for the PCT to achieve significant reductions in usage of hospital services. In respect of outpatient activity and non-elective admissions, we are therefore aspiring to move over time to the lower-quartile performance levels shown above. In respect of elective admissions (planned treatments and operations) achieving such a reduction in hospital activity is probably neither desirable nor realistic, but we do aspire to shift the balance of provision to a more modest extent, so that more day case procedures can be provided in future, including those in non-hospital settings.

We also know from benchmarking information that Sheffield PCT patients tend to have longer stays than average in hospital. Some of this long length of stay leads to higher charges to the PCT in terms of excess bed days. We do not have precise data to compare Sheffield PCT expenditure on excess bed days with other PCTs, but we are currently spending more than £15 million each year on excess bed days – and we are convinced there is significant scope to reduce this.

In very broad terms, our assessment indicates that, by the end of the planning period, the PCT may be able to achieve recurrent reductions in expenditure on acute hospital services

- of around £21 million by moving broadly to the national average levels of hospital usage
- of around a further £20m (£41 million in total) by moving broadly to national best practice levels.

However, achieving such reductions will undoubtedly necessitate the development of significant new out-of-hospital services which would have to be planned, staffed and funded and the costs of these clearly need to be built into an overall financial assessment. We recognise achieving change on this scale would be challenging but as an organisation we aspire to be matching the performance of the top 25% PCTs in the country.

Results of modeling

Predicting hospital activity levels so far into the future is difficult and it important to bear in mind that there is a significant margin for error in the modeling calculations. However, based on the PCT's aspiration to move to best practice levels as outlined above, the year-by-year activity levels indicated by the model are shown in the first table below, with the percentage change year-on-year in the second table.

Planned level of actual patient activity, 2006/07 to 2012/13

Year	Outpatient First Attendances	Outpatient Follow-Up Attendances	Elective Inpatient Spells	Non-Elective Inpatient Spells
2006/07	186,787	494,811	77,372	64,832
2007/08	186,256	481,761	75,821	63,360
2008/09	173,282	459,350	72,492	60,412
2009/10	159,553	421,109	67,632	57,478
2010/11	150,477	396,089	66,530	54,364
2011/12	141,493	371,398	65,523	51,348
2012/13	132,569	346,933	64,604	48,316

Year-on-year percentage change in planned patient activity, 2006/07 to 2012/13

Year	Outpatient First Attendances (% change)	Outpatient Follow-Up Attendances (% change)	Elective Inpatient Spells (% change)	Non-Elective Inpatient Spells (% change)
2007/08	-0.3%	-2.6%	-2.0%	-2.3%
2008/09	-7.0%	-4.7%	-4.4%	-4.7%
2009/10	-7.9%	-8.3%	-6.7%	-4.9%
2010/11	-5.7%	-5.9%	-1.6%	-5.4%
2011/12	-6.0%	-6.2%	-1.5%	-5.5%
2012/13	-6.3%	-6.6%	-1.4%	-5.9%

The three charts below show in graphical form what would happen to activity levels over the five year period

- if the PCT achieved no change through service redesign
- if the PCT achieved a move to national average levels of hospital usage
- if the PCT achieved a move to national best practice levels of hospital usage.

The charts cover outpatient attendances, elective spells and non-elective spells. For the reasons outlined above, the elective spell chart suggests a smaller-scale reduction than would be achieved by moving to national average of lower quartile benchmarks.

Figure 9

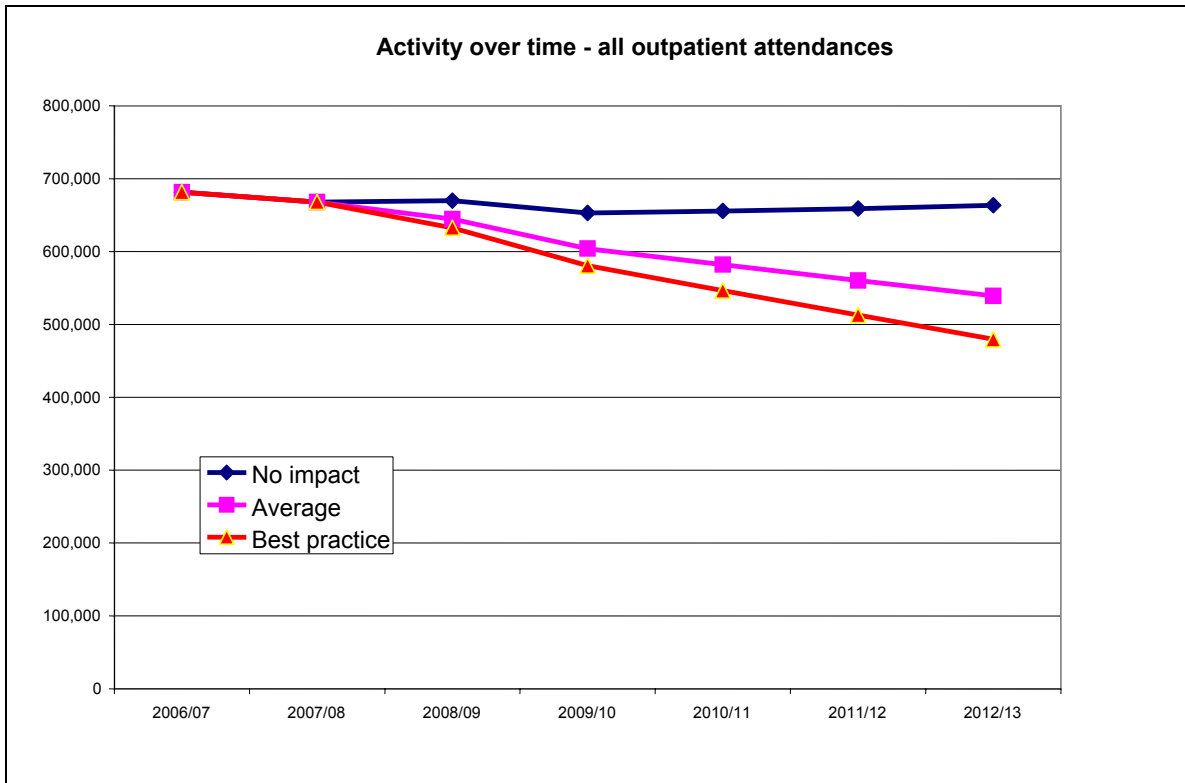


Figure 10

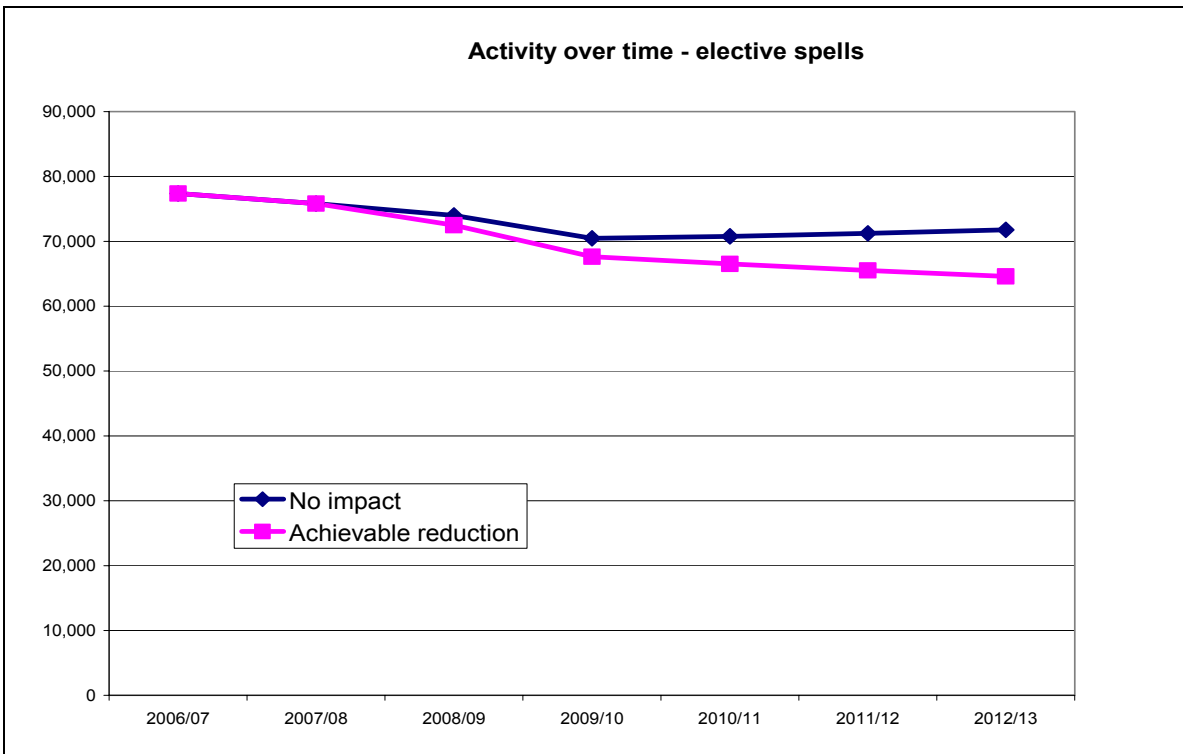
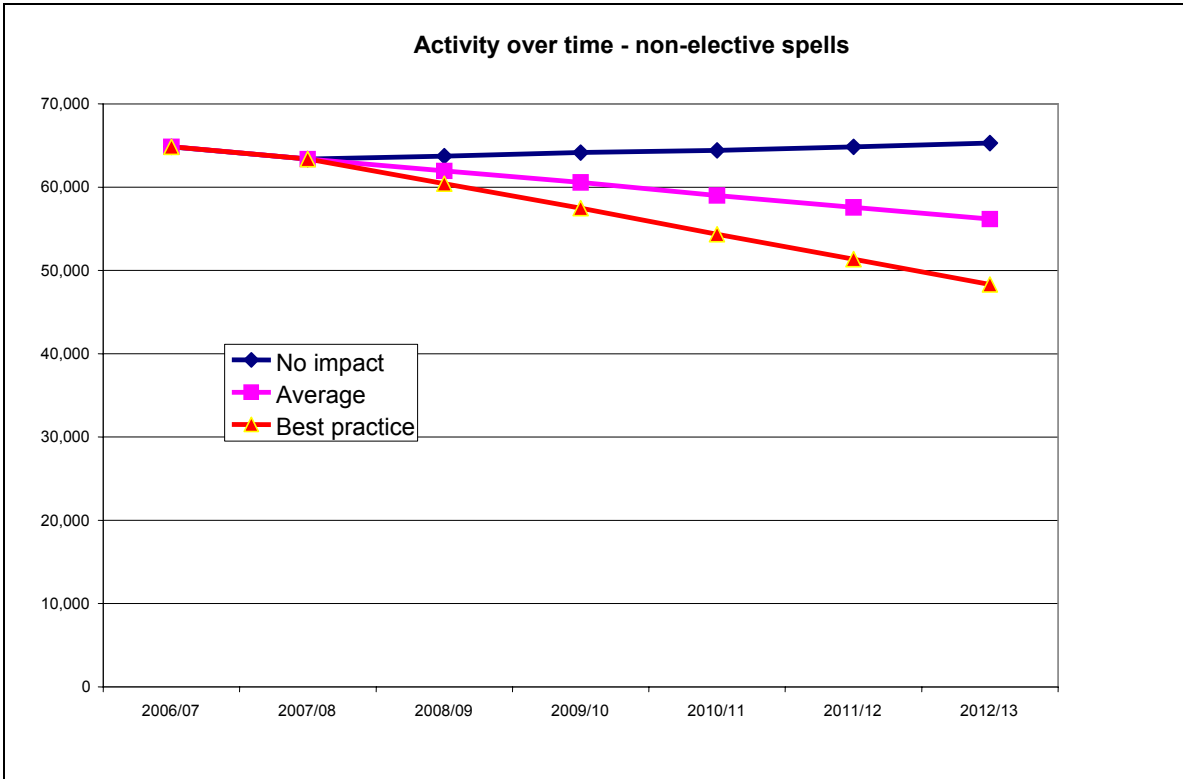


Figure 11



OUR FIVE YEAR FINANCIAL PLAN

The five year strategy is underpinned by a forecast of the activity to be commissioned by the PCT and the related commitment of resources over the next five years.

The financial modeling that has been undertaken to date, suggests that the PCT is unlikely to remain in recurrent financial balance unless it continues to identify areas for service redesign which can release resources. The current model shows that £21m of such savings will be required as a minimum and it is assumed that these will be principally achieved through moving the PCT broadly to the national average levels of hospital usage. In order to invest in the key priorities identified elsewhere in this strategy, additional redesign and efficiency savings will be required, unless the outcome of the national Comprehensive Spending Review (CSR) later this autumn provides a settlement which is more favorable than that currently assumed in the model (and set out below.) Much more detailed work will be needed once the results of CSR are announced.

The initial financial plan for the five years from 2008/09 to 2012/13 has been developed based on the following key assumptions:

- That the PCT ends 2007/08 in financial balance, having cleared its historic debt and re-instated deferred investments totaling c£22m. If this is achieved, as currently modeled, this will result in c£32m of recurrent revenue resources being available to deploy from 2008/09 onwards, to “cushion” the impact of the expected much lower growth funding under CSR.
- That the PCT continues to commission services in a similar pattern to 2007/08. At this time, there is insufficient information to quantify in detail the financial impact of the proposed service changes outlined elsewhere in this document. Further work is therefore required to incorporate the financial consequences of proposed developments and to appraise and prioritise specific service developments. The finance model does, however, reflect the activity model described above.
- Growth in allocation (i.e. cash uplift) is estimated at 3.5% each year. If the actual allocations from the Department of Health are materially different, this will have a major impact on the plan, associated with any changes to e.g. the Market Forces Factor and Payment by Results regime.

There is currently no detailed data on the level of growth in resources the PCT can expect to receive. This will be influenced by the overall settlement for the NHS from the Comprehensive Spending Review and the consequence of any policy to move PCTs closer to their capitation or “fair shares” targets. Sheffield

PCT is currently 4.1% over target and so can probably expect lower growth than the national average. However, forecasts of population changes indicate that over the 5 year period, the overall population is forecast to increase by 1.68%. Within this growth, the number of people aged 65 and over is forecast to increase by 6.83%. This will impact on the overall age-weighted population of the PCT (using the current resource allocation formula the age weighted population would increase by 2.9%). This may in turn impact on the target allocation of the PCT and any resulting growth uplifts, dependent on:

- Changes to Sheffield PCT age-weighted population relative to changes to the age-weighted populations of other PCTs
- The application of the resource allocation formula (currently under review)
- The agreed national pace of change policy

Inflation estimates have been modelled as follows:

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Primary Care	Variable	2.0%	2.0%	2.0%	2.0%	2.0%
Prescribing	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%
Secondary Care	2.5%	2.0%	2.0%	2.0%	2.0%	2.0%
Continuing Care	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Corporate budgets	2.5%	2.0%	2.0%	2.0%	2.0%	2.0%

A model has been developed to forecast likely secondary care activity levels based on a number of assumptions. These include:

- Impact of meeting the 18 week target by December 2008 and maintaining waiting times at this level thereafter.
- projections of the likely impact of demographic changes on the levels (and cost) of secondary care activity.
- growth in elective referrals – the objective will be to reduce through strong referral management / clinical protocols. Work led by PBC consortia has commenced on clinical pathways and protocols across a range of specialties but the potential impact has not been incorporated into the financial plan at this stage.
- growth in non elective admissions – the objective will again be to reduce (excluding the impact of demographic changes). The plan assumes that

initiatives/investment in place in 2007/08 as part of the turnaround process will continue. Further work will be needed, linked to implementation of both the unscheduled care and intermediate care strategies which are currently being developed.

- attendances at A&E will grow at a rate of 6% per annum which is the historic rate of growth – although as above, the objective will be to reduce the level of growth.
- the investment in call connect with Yorkshire Ambulance Service is included, but no additional growth in investment is assumed.
- there will be continued pressures in areas such as secondary care drugs and specialized commissioning. Together with critical care, specialised services are seen as an area where potentially there will be major cost pressures over the next few years. At the moment the model includes a “marker” £10m new investment in each year as this is the estimated level of new investment in 2007/08. This represents a very significant call on predicted annual growth of c£30m from 08/09.
- 2008/09 includes a further c£3.5m investment for continuing care, being the full year effect of the new guidance from October 2007. However, substantial further work is needed to understand the actual costs and this could represent a significant under investment.
- The plan currently shows very limited investment in primary or community care, building in only those investment pressures which are known to exist at this time. The PCT does expect the level of investment in these areas to increase as a result of service redesign, with a consequent reduction in secondary care investment, but as yet the modeling work has not been completed to understand the likely shift in resources. In addition the PCT is likely to incur additional costs as the programme of improving the infrastructure in primary/community care through LIFT or other initiatives is continued. Some early initial estimates have been included for the first 3 years of the model.
- A general reserve has been instated for each year, equivalent to 0.5% of the anticipated Revenue Resource Limit to allow for unforeseen pressures.

Findings from the financial model

Position before Savings:

The model suggests that the PCT will enter the period in recurrent financial balance, but that from 2008/09 onwards the predicted growth in the allocations will not be sufficient to cover the anticipated recurrent increases in costs in relation to inflation and other unavoidable pressures. Hence, the recurrent reserve built up going into the period will need to be utilised to fund these residual pressures. This is summarised below:

Recurrent Reserve	2008/09 £'000	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000
Recurrent reserve b/f at start of year (before savings)	32,303	11,824	8,218	-1,425	-8,870

Growth	28,829	29,838	30,882	31,963	33,082
Inflation	-21,257	-22,785	-23,948	-25,289	-26,647
Unavoidable recurrent Investments	-28,051	-10,659	-16,577	-14,119	-14,119
Hence pressure to be funded from recurrent reserves	-20,479	-3,606	-9,643	-7,445	-7,684
Recurrent reserve/(deficit) c/f at end of year (before savings)	11,824	8,218	-1,425	-8,870	-16,554

Savings to Deliver Financial Balance:

Further savings will, therefore, need to be generated to secure financial balance. Work has been undertaken to assess the savings that could be generated were the PCT move to benchmark averages in relation to GP referral rates, the ratio of 1st outpatient to follow up outpatient appointments, the rate of emergency admission to hospital and the average length of stay in hospital. Recurrent savings of moving to benchmark averages are estimated at £21m by the end of the planning period. Assumptions have been made in relation to the investment required in alternative services to support delivery of the target savings and the timing of when these savings could be achieved. The financial impact of the successful move to these benchmark levels is summarised in the table below.

Additional savings to create an Annual Investment Fund

As noted above, further work is required to incorporate the financial consequences of proposed developments and to appraise and prioritise specific service developments. This means that, in order to generate resources to fund investment in key priority areas, the PCT will need to identify additional opportunities for service redesign or efficiency. The PCT's target is to secure an additional £4m per annum to establish an annual investment fund. The aspiration is for this to be achieved substantially by moving to national best practice levels for hospital activity, but this could also be facilitated by a better than expected CSR settlement and other efficiency savings. The £4m per annum shown in the model is a net saving after allowing for investment to achieve the change in hospital practice, which makes it a very challenging target.

Recurrent Reserve after service redesign savings	2008/09 £'000	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000
Recurrent reserve c/f at end of year (from table above)	11,824	8,218	-1,425	-8,870	-16,554
Savings need to deliver financial balance (cumulative)	4,000	8,000	12,000	16,500	21,094
Investment to secure the above savings	-800	-1,600	-2,400	-3,200	-4,000
Revised recurrent reserve	15,024	14,618	8,175	4,430	540
Net savings needed to deliver					

Investment Fund	4,000	8,000	12,000	16,000	20,000
Investment Fund	-4,000	-8,000	-12,000	-16,000	-20,000

Based on the assumptions outlined above, the model predicts the following financial positions. (A more detailed analysis is contained shown in Appendix 5)

Summary Financial Position	2008/09 £'000	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000
Revenue Resource Limit	833,453	867,272	905,360	938,297	968,446
Net Expenditure before savings	837,473	864,086	901,201	937,573	974,791
Service redesign savings	-8,000	-8,000	-8,000	-8,500	-8,594
Year end financial position Surplus/(deficit)	3,980	11,185	12,159	9,224	2,249

The table above indicates that the model currently predicts a surplus of 1% to 1.5% of resources in years 2 to 4 of the financial plan period. It may be possible to bring forward some investments to earlier years of the plan and thus utilize resources at an earlier stage, but this would be dependent on the PCT being confident that recurrent balance remains a realistic forecast for year 5 of the plan.

The financial modeling to date has only been undertaken at PCT wide level. As more detailed work continues on the financial plan, in parallel the PCT will be working, with the engagement of PEC clinicians and PBC consortia, on the model which looks at the distribution of resources across PBC consortia and to individual GP practices.

Summary

Based on current assumptions, the PCT will be able to generate a surplus in each year of the 5 year period, but the recurrent position will be eroded by the recurrent financial pressures that the PCT will need to absorb. Thus recurrent financial balance across the full five year period is only secured after assuming the achievement of £21m service redesign savings sufficient to address the underlying position. Investment in new strategic priorities will be dependent on either the delivery of additional savings and/or a better than currently modeled settlement through the Comprehensive Spending Review.

The PCT has undertaken some initial sensitivity analysis on the financial model included in this strategy document. Relatively small changes in the assumptions can lead to a major impact in later years of the plan. For example, should the cash uplift prove to be 5% not 3.5% (but inflation on average is 2.5% and not 2%) the surplus in year 5 would be £49m if no additional investments were made. On the other hand, if cash uplift were to be 3% but inflation on average 2.5%, the PCT would have a £12m deficit by year 5, which would mean further savings requirements during the next 5 years.

7. WHAT WILL BE DIFFERENT? BETTER OUTCOMES FOR THE CITY

This section describes what will change as a result of our strategy in terms of better outcomes for the city as whole and better outcomes for patients. We will be judged on the improvement in health outcomes for the residents of Sheffield. The NHS has an impact on individual's health – and that of the city as a whole – through our public health activity, health promotion and delivery of services. However to make the progress needed in the city on improving life expectancy and reducing the burden of ill health will require the NHS to work together with partners in the public and private sectors. This will include addressing the wider determinants of health such as employment, housing, and education. Only through a concerted effort across these areas and between organisations can we fully make the impact we are seeking.

We are building on existing relationships with NHS partners, the city council, private sector employers and the community, voluntary and faith sectors. We want to widen these and deepen them. An aim that we will pursue will be to get the agreement of some common objectives within the strategies of the major statutory organisations within the city around the work to improve health outcomes.

An important building block of our work is the Sheffield First agreement which is the Sheffield First Partnership's – the local strategic partnership - statement about how it will deliver improvements for the people of Sheffield in the areas of health and wellbeing, successful communities, the economy and the environment. This agreement is due to be revised in the next 12 months and we will contribute to this work in the following areas.

INCLUSIVE AND HEALTHY COMMUNITIES

The aim of our programmes is to reduce health inequalities over the next five years by developing a systematic approach to the identification of those at highest risk, and increasing access to a range of services at an early stage in the one third of the city that is most socio-economically and health deprived.

We are developing 'Enhanced Public Health Programmes' (EPHP) in the one third of the City that has the worst health and well being indicators. This is being done in partnership with the City Council, and constitutes the 'Healthier Communities' block of the current Sheffield Local Area Agreement.

These programmes are intended to lead to a substantial improvement in health in the poorest areas of the city; through a combination of health promotion activities as well as increasing access to and uptake of appropriate health services and initiatives focusing on the wider determinants of health .They are being led by PCT public health staff, working in close cooperation with local communities. It is intended that this will lead to a reduction of health inequalities in the City.

In the short term we are proposing a focused programme of activity as part of each EPHP. This will involve identification of those at risk, increasing access to a range of services including primary and secondary prevention and clinical services, and developing community capacity to empower local communities and enable them to deliver health promotion programmes in their local community.

Health inequalities between Black and Minority Ethnic (BME) communities and the rest of the population are well documented. A recent health needs assessment in Sheffield's BME population highlighted much higher levels of diabetes and coronary heart disease, greater levels of emergency admissions to hospital, and much lower uptake rates of key health screening and prevention services. EPHP neighbourhoods have identified targeted interventions with BME groups as part of the programme.

All the EPHPs utilise Neighbourhood profiles to inform the needs assessment for the business plans, including disease trajectories comparing the Sheffield Average and least and most deprived neighbourhoods

There has been an improvement in the health gap between these neighbourhoods and the Sheffield average when measured using a "Basket of Indicators." The majority of indicators for EPHP areas have improved at a faster rate than Sheffield as a whole between 2004 and 2006.

The following areas of work will be further developed and enhanced:

Identification of at risk individuals.

- People at highest risk of future illness or disability and people with the lowest levels of well being are often unidentified and often have poor access to services. Frontline practitioners should identify people who might be at high risk before they become ill. This can be facilitated by the use of specific tools and information systems, and is to a certain extent encouraged by the 'Quality and Outcomes Framework' (QOF) of the General Practice contract. However this will not be enough, since many people will not realise that they are at risk, and so will not seek help. A key part, therefore, of EPHPs must be to work with community groups to help local populations understand who is likely to be most at risk, and encourage them to access services.

Increasing accessibility of services

- We must increase the accessibility of services, so that once an individual has been identified as either having diagnosed vascular disease or being at risk, he or she can be supported to prevent the further development of the disease. This will include such services as Cardio vascular rehabilitation schemes, smoking cessation and physical activity programmes, but also working with GPs and others to ensure that primary and community health

services are as accessible as possible given local population characteristics and needs.

Community Engagement & Community Capacity Building.

Enhanced Public Health Programmes are intended to respond to communities' own understanding of their health and aim to empower individuals and communities to make healthy life choices as well as improving access to health care. Real improvement in well being in deprived communities can only come from the communities themselves. Some progress has already been made.

- Each EPHP has been developed with and by local community representatives, with the support of the PCT public health service and other agencies; engaging communities directly in both identifying the key health challenges for their community and in developing and delivering solutions to the challenges identified. In order to support individuals to contribute to this process, the Programmes have included significant capacity building activity including the delivery of Introduction to Community Development and Health (ICDH) training.

Sheffield's Community Development and Health Programme has demonstrated success in empowering local people and improving their health, with many participants going on to further employment, voluntary work and education. There are plans for further development of this work funded through a successful recent regional lottery bid.

In addition, we will scope the potential for developing a health trainers programme to provide individual support for access to services.

Addressing Health Inequalities

Most of the health problems which lead to early death in the at risk populations (with the exception of suicide) relate directly or indirectly to the risk factors associated with coronary heart disease and stroke. These include obesity, high cholesterol, high blood pressure, smoking, sedentary lifestyle, and poor diet.

If the EPHPs can impact directly on these risk factors at a population level, there will be a reduction in chronic diseases such as CHD, stroke, diabetes and renal disease, a reduction in cancer incidence, and a reduction in deaths. Reduction in these six risk factors will reduce the need for long term care, reduce acute events such as Myocardial Infarction (MI) and stroke, reduce hospital admission, reduce deaths and improve quality of life. Other benefits than can be more difficult to measure these will include improved mental health, increased social capital, and more people in employment, training and voluntary work. These factors will in turn impact on quality of life and mortality rates over time.

We are undertaking modeling to estimate how many lives will be saved. As an example, we estimate that the number of lives saved from premature death due to circulatory disease will be 34 lives per year, or 117 lives over three years. There are approximately 120 premature deaths per year from CHD in the EPHP areas - the single largest contributor to the gap in mortality. Reducing this by over a quarter would make a significant contribution to a reduction in health inequalities.

This estimate of 120 lives that could be saved from reducing circulatory disease in the EPHP areas is based on the following:

- By successfully identifying and treating 9,000 patients for high cholesterol levels and 2,000 patients for high blood pressure the EPHP.
- By increasing the number of smokers who have quit at four weeks by 2,500.
- By delivering an increase of at least 10,000 people aged 50 years and over who participate in moderate physical activity. Additional benefits will be achieved in terms of reduction in morbidity associated with high blood pressure and cholesterol, smoking and lack of exercise.

A GREAT PLACE TO GROW UP

The city's aim is for Sheffield to be a great place in which to grow up and to raise a family – a place where children and young people are encouraged and supported to reach their full potential and to contribute positively and actively to the life of the city. The PCT will play its part in contributing as partners with the city council and other agencies to help every child to achieve the five outcomes of being healthy, staying safe, enjoying and achieving, making a full contribution and fulfilling their economic potential.

A particular focus for the PCT is helping achieve a greater impact in key health issues affecting young people. There has been good progress. We are tackling childhood obesity by encouraging healthy eating, providing active and co-operative play opportunities and Activity Sheffield has developed a strategy to increase participation in sport. Teenage pregnancy rates are still too high, but the most recent figures show improvement, and we have undertaken research to find out how other parts of the country are tackling this issue. We are also making progress in reducing the number of second births to teenage mothers. Partners are working closely together to reduce the number of young people who abuse drugs and alcohol.

Future priorities for the Great Place to Grow Up theme of the Sheffield First agreement are:

- Accelerate educational attainment across all age groups and at all stages of the education system.
- Continue to strengthen service districts to enable us to provide services to children that are tailored to the needs of the different parts of the city.

- Ensure the safety and well-being of all children in the city.
- Further reduce the number of young people not in education, employment or training.
- Provide high quality learning environments.
- Improve outcomes for children from disadvantaged groups, including Looked after Children and some ethnic groups, helping them to achieve and to make a positive contribution.
- Improve the health of children and young people.
- Instill a spirit of, and develop the skills for, enterprise and entrepreneurship in our young people.
- Promote active citizenship and positive contributions by young people.

We will continue to play a full part in helping realize these priorities.

SUCCESSFUL NEIGHBOURHOODS

The PCT plays a full part in the Sheffield Safer Communities Partnership which is the group responsible for ensuring that drug and alcohol strategies are implemented at local level. The officers employed to take forward the implementation of the strategies are known as the Drug and Alcohol Action Team (DAAT). This directorate is hosted by the PCT as the health lead for the partnership and led by the Director of Substance Misuse Strategy. Sheffield DAAT agrees an annual drug treatment plan with the National Treatment Agency (NTA). The aim is to ensure that there is a comprehensive treatment system across the city. Details of the services commissioned and provided are found in the “Staying Healthy” section of this document.

We will work within the Sheffield First partnership to develop our approach to improving the health of offenders. This would have an impact both on reducing health inequalities and contributing to reductions in re-offending. Offenders have a greater incidence of mental health problems and a greater propensity to abuse drugs or alcohol. Both of these have an impact on life expectancy. Drug and alcohol dependency is often a major reason for offending behaviour. Although Sheffield PCT does not commission health services for any residents who are serving custodial sentences – this is the responsibility of the PCTs where prisons are located - there is still a need to ensure that residents have continuity of care after their release.

CONTRIBUTING TO BE A STRONG ECONOMY

As well as having as its main objectives that of funding effective and efficient NHS services and improving the health of the population the PCT is a significant element of the economy of Sheffield. We spend £800m a year in the local economy with the bulk of our funding going to fund hospital, ambulance and community services in the city but we also directly employ 2,000 staff. In addition we have contracts with 394 GPs, 244 dentists, 112 pharmacies and 96 opticians. These contractors in turn employ their own practice staff. We obtain either

directly or indirectly goods and services from a range of local firms and suppliers. We work with universities both in terms of their undergraduate and postgraduate programmes but also in their research activities. We will continue to work with the city council, the business community, and the voluntary and education sectors in Sheffield to contribute to the development of our city as a great place to live and work.

Scope exists to improve work with local employers as a means of developing our approach to promoting better health outcomes, increasing the focus on prevention and getting our public health messages across to local residents.

SUPPORTING ENVIRONMENTAL EXCELLENCE

Although we are an organisation chiefly concerned with delivering health services for patients we too can contribute to work to develop a more sustainable environment in the city. The PCT's work is at an early stage but we will seek to develop an approach that helps us become more environmentally sustainable and which enables us to reduce our carbon footprint. Issues include not only our own direct operations but also thinking about the journeys required by people to access services. We commit to be a full partner in work to develop Sheffield as a centre of excellence on environmental sustainability.

EMERGENCY READINESS

Helping the city be ready to respond to large scale emergencies and major incidents is a core role for the PCT. This was underscored in 2007 when the city faced widespread flooding and the resulting disruption to both essential services and activities of daily life. We will learn the lessons from these events and adapt our plans and procedures including our joint arrangements with other organisations both national and local. Sheffield PCT has identified Emergency Planning as one of the 10 five year objectives of the organisation

Under the Civil Contingencies Act 2004 the PCT is a Category One responder. This gives the PCT statutory responsibility for ensuring that it is planned and prepared in all key areas of Emergency Preparedness, including Business Continuity Planning. In addition, the PCT is required to support independent contractors and other health bodies in developing their plans.

The key responsibilities are:

- To ensure that the PCT is planned and prepared to deal with any emergency situation
- To plan and prepare for a prospective pandemic flu outbreak
- To direct and co-ordinate the development of Business Continuity plans from each Directorate making up the PCT
- To train staff
- To exercise emergency plans

- To routinely review and update plans accordingly
- To develop new plans in line with national, regional and local requirements
- To discharge lead PCT responsibilities for all health organisations across South Yorkshire
- To represent all health organisations within South Yorkshire at the South Yorkshire Local Resilience Forum
- To Co-ordinate the development and delivery of training and exercise events for the Health Community across South Yorkshire.

The PCT has lead responsibility for the NHS in South Yorkshire. This was agreed following a recommendation from the Strategic Health Authority in October 2006. This new area of responsibility for the PCT is in the development stage and will grow following the appointment of the Emergency Planning Manager in August 2007.

The Emergency Planning team have already undertaken much work to develop plans for key areas that need to be covered within the organisation. However, with significant changes taking place in the organisation and its structures, further development in all areas will need to be considered to take these changes into account. Key pieces of work such as:

- planning for a Pandemic Flu outbreak - this will require further information/criteria from the department to continue to further develop draft documents that are currently in place, particularly in the areas of
- 'call centres' and 'antiviral' distribution.
- Business Continuity planning.

The primary objective for Emergency Planning within the PCT over the next five years is to establish and increase resilience, not just in Sheffield but across South Yorkshire. This will be achieved by working together in building robust plans and training all our staff, before then testing the plans by running exercises. In addition, agreements and memoranda of understanding will be developed to ensure that we can support each other in a timely fashion should a crisis arise. Training development will be based on multi-agency working and include blue light services, with joint exercising of our plans.

We seek to involve the public in developing our arrangements. The network of Emergency Planners within South Yorkshire including emergency services also includes the active engagement of various organisations from independent groups to voluntary services. The NHS generally seeks to identify vulnerable groups of people and its communications policies share information not with only staff, but with the general public at large.

8. WHAT WILL BE DIFFERENT? BETTER OUTCOMES FOR PATIENTS

We will also be judged on the improvements that are made to the services delivered to patients - and their families -by the local NHS including those services delivered with other organisations. This next section describes how we will take work forward within individual service areas where we either commission services or provide them directly.

We have grouped the service areas under the headings of *Staying Healthy, Maternity Services, Children and young people, Learning Disabilities, Mental Health, Primary care services Emergency Care, Intermediate Care, Elective Care, Specialist Services, Long Term Conditions and End of Life Care.*

For each service we describe its aims, the current services provided, and the scope for improvement, issues around health inequalities and how we are going to engage with the public service users, their families and our staff.

STAYING HEALTHY

The services covered in this section are cancer, diabetes, drug and alcohol misuse, heart disease, older people, respiratory diseases, sexual health, stroke and tobacco control.

CANCER

Aim of service

The PCT intends to commission services which lead to a reduction in the incidence of cancer, provide effective screening for cancer in line with the National Cancer Screening Programmes, promote early presentation and diagnosis (in keeping with the national targets for access to cancer treatment), effective and cost effective specialist treatment to secure cures wherever possible and prolongation of life of good quality where not, and appropriate and effective end of life care. The PCT also aims to reduce existing inequalities in cancer incidence and mortality as much as is possible, by reducing incidence and mortality in the more deprived areas of the City.

Description of current service

The single largest avoidable cause of cancer by far is smoking. The PCT both directly provides as well as commissions an extensive stop smoking service, as well as engaging in active campaigning to control tobacco use more generally. Public health campaigns relating to healthy eating, increasing physical activity, and reduce sun exposure will also help to contribute to a reduction in cancer incidence.

There are established screening programmes for cervical and breast cancer, and in addition the new national screening programme for bowel cancer will be introduced in Sheffield in 2008.

Treatment services for cancers are provided almost exclusively by Sheffield Teaching Hospitals (and the Children's Hospital for children's cancers). Services are provided according to the national "Improving Outcomes Guidance" documents, and subject to regular peer review. The Teaching Hospital Trust provides both secondary and tertiary services, the latter for the wider sub-region. Palliative and supportive care is also provided within the community by general practitioners and district nurses as well as by St Luke's Hospice and their outreach team.

Description of current position

Overall cancer mortality in Sheffield has fallen dramatically in recent years, such that the national target of a 25% reduction in mortality by 2010 (compared with 1996) has already been exceeded. However cancer mortality remains higher than the national average. Sheffield has achieved the cancer access times targets. All the Sheffield population has ready access to secondary and tertiary care of high quality.

Cancer services in Sheffield are part of the wider South Yorkshire Cancer Network, which is managed by a Network Board, with representation from all PCTs. The Cancer Network is responsible for overseeing the implementation of the "Improving Outcomes Guidance" documents, and has an agreed Network Strategy. A recent health equity audit has not identified any differences in access to cancer treatment by populations in different parts of the City.

Scope for improvement

Mortality from cancer in Sheffield is higher than the national average. Recent evidence suggest that, for example, there are 55 excess deaths from lung cancer per year over and above what would had been the case had Sheffield had the same death rate as England as a whole, (32 male, 23 female). Given that the Sheffield population has good access to excellent treatment services for cancer, major improvement will only come about though reducing cancer incidence. This in turn depends on reducing the prevalence of smoking and other improvements in life style. The major improvements in cancer experience in Sheffield will therefore come as a result of public health activity rather than major new investment in treatment services.

However changes in life style as a result of public health campaigns are slow to achieve, and slow to be reflected in changes in cancer incidence. It is therefore of paramount importance that we continue to work to maintain and improve the quality of treatment services in line with the improving outcomes guidance and

the network strategy. A national campaign on the use of Gardasil – a treatment that can prevent cervical cancer is expected in the next year.

Reducing health inequalities

Cancer mortality in the under 75 population varies substantially across the City. In many neighbourhoods the rate is well below 100 per 100,000 population (in some as low as 70), whilst in others it is well over 200 per 100,000 population. Whilst late presentation (and hence fewer options for treatment and less effective treatment) may play a part in the high mortality rates in some areas, the recent cancer health equity audit suggests that there is no systematic variation in access to treatments across the City. This implies that the large part of this variation is due to variation in incidence rather than the access to or effectiveness of treatment.

The implication of this is that if we are to reduce inequalities in cancer mortality across the City, it will only be done by public health campaigning in those areas with a high incidence in order to improve life styles, in particular reduce smoking.

Engagement with users and improving the patient experience

Investigations for cancer are potentially a very frightening experience and a diagnosis of cancer even more so. Furthermore, some cancer treatment is extremely unpleasant. It is therefore extremely important to work with patients so as to identify ways in which the patient experience can be improved. Within the City there is an established Sheffield Cancer Services Advisory Group which is supported by the PCT. This group seeks to facilitate the engagement of patients with services at the Sheffield Teaching Hospitals. It is important that the PCT should work with them, and other cancer patients, to learn how we might improve services.

Priorities for the next five years

Priorities with regard to cancer services for the next five years should be:

- Vigorous campaigning to control tobacco use, including promotion of the stop smoking services.
- Continued public health campaigning on other life style issues which will have an impact on cancer incidence (healthy eating, physical activity, sun exposure).
- Working with the Cancer Network to implement the Improving Outcomes Guidance and the Network strategy.
- Continued engagement with patients so as to identify ways in which their experience of cancer services can be improved.
- Increased uptake of mammography and cervical screening.
- Developing bowel screening programmes.
- Work to increase the use of gardasil

DIABETES

Aim of service

To provide quality services for people with diabetes in line with the standards of the National Service Framework, to encourage and support self-management, to screen for associated complications and treat according to best evidence of effectiveness in order to achieve optimal management, promote independence and reduce unnecessary use of health services and in particular inappropriate hospital admissions.

Description of current service

Most people with type 2 diabetes receive care in their local general practice; most people with type 1 diabetes receive care from secondary care (Sheffield Teaching Hospitals NHS Foundation Trust – STHFT). Children with diabetes are managed by Sheffield Children's Hospital. People requiring insulin initiation or the management of complications are generally referred to secondary care (STHFT). Community Optometrists provide screening for diabetic retinopathy, community podiatrists screening and management for people with 'at risk' feet, and community dieticians provide support for people with more complex dietary needs.

Description of current position

Sheffield's NHS has comprehensive agreed and updated guidelines in place to support primary care clinicians deliver quality diabetes care in practices, pharmacies and care homes across the city. Primary and secondary care sectors work together to improve diabetes services. The Specialist Support for Community Diabetes Services project involves consultants and diabetes specialist nurses working with selected practices to identify current hospital outpatients suitable for primary care management. The specialist team working with the Public Health development nursing team encourages the development of diabetes skills in the practice staff. The specialist team provides ongoing support for the practices at quarterly case-review meetings. Sheffield was one of the earliest areas in England to provide a systematic screening programme for diabetic retinopathy using digital photography.

Scope for improvement

Some elements of diabetes care are reactive rather than proactive. Access to, and the quality of primary and secondary care services varies across the city, a more rigorous approach is required to address these issues. Mapping of practices with poor performance will indicate where to target resources and training. Specialist clinics do not necessarily need to be located in a hospital environment, there is potential to explore delivering them in primary care

locations, or to explore different ways of working with consortia to deliver the necessary specialist care.

Patients with diabetes are admitted to hospital more frequently and stay in hospital for longer than people without diabetes. Fragmented care in primary care and between secondary care and social care. Patients with diabetes are more at risk from heart disease and other circulatory diseases than people without diabetes. Waiting times for insulin initiation are long

Uptake of eye screening is patchy across the city, with uptake varying between 43% and 80% in different areas. Structured patient education for people with type 2 diabetes needs to be delivered across the PCT. The care planning approach needs to be introduced to ensure people with diabetes have more say over the treatment of their condition and the issues that are most important to them.

Neighbourhood differences

Diabetes impacts unequally, with people of South Asian origin being 6 times more likely, and those of African and African-Caribbean origin 3 times more likely to develop diabetes. Case finding, prevention and early identification activities should be targeted at 'high risk' groups. There are significant differences in uptake of eye screening between postcode areas and outreach and health promotion work is needed focusing on the areas of high incidence and low uptake.

Reducing inequalities

Improved access to and provision of primary care services across the city by identifying and targeting practices with high prevalence of diabetes and with poor clinical outputs (for example high percentage of hospital admissions related to sub-optimal diabetes control or poor QOF achievement). City wide primary care insulin initiation would enable group education for people from BME communities

Engagement with users and improving the patient experience

We will use means including the existing diabetes user group and good relationships with Diabetes UK. Outreach in local community and faith groups in the localities and the involvement of PPI leads

Services delivered closer to the patient and in an environment they know and are familiar with. Patients managed where appropriate, at home rather than in hospital. Reduced length of stay due to improved inpatient management of diabetes control. Reduced waiting times for insulin initiation, freeing up over-stretched specialist capacity to respond to specialist requirements quicker. Care planning will ensure that review appointments are truly patient centred, with the person with diabetes dictating the aspects of their condition that they want to take action upon at that time.

Priorities for the next five years

The delivery of national standards and NICE guidance will be our overall priority. We will work to improve the case finding of people with undiagnosed diabetes, initially to capture those with symptoms of diabetes and those with other cardio-vascular conditions. Integration of our disease and case management approaches will improve the quality of care for people with diabetes who are housebound or in care homes. The provision will be widened of structured patient education for self-management for all people with diabetes in accordance with NICE guidance. This will be supported by improved and more accessible patient information and by access to more diabetes services provided in primary care. This would include delivering a wider range of diabetes care appropriately delivered in primary care, the benefits of which include reduced costs and a better service for patients evidenced by shorter waiting times and not having to travel to a hospital site.

We will improve the identification and targeting of people with diabetes 'at risk' of hospital admission or readmission, with appropriate interventions to reduce their risk of further admissions via Single Contact Access Number (SCAN) supported by improved communication between primary, secondary and social care including the sharing of information between agencies. We will seek to improve the management of cardio-vascular risk through improved delivery of secondary prevention.

We will look to enable the initiation of insulin treatments in community settings, improve the education and support for primary care teams to manage type 2 diabetic patients requiring insulin therapy and increase early recognition of pre-diabetes with appropriate management of associated risk factors.

We will increase activity to help prevent diabetes including better weight management programmes to help reduce the risk of diabetes and the promotion of exercise programmes and healthy eating.

DRUG AND ALCOHOL MISUSE

Aim of service

To reduce the numbers of people within Sheffield using illegal drugs, to promote more responsible use of alcohol in order to improve the health of individuals and the city as a whole as well contributing to reductions in offending and anti-social behaviour.

Description of current service

Treatment services are located in the city centre. This is aligned with a geographical spread of Shared Care GPs located in areas of high demand and pharmacies providing supervised consumption services. The DAAT Community Development Officer also works closely with the 10 safer neighbourhoods areas in Sheffield tackling community issues at local level; satellite clinics are held regularly in areas where concern is greatest.

Description of current position

For Drugs the Sheffield DAAT has performed well in 2006/7. Of the five main targets set by the National Treatment Agency (NTA), four have been exceeded, in some cases by significant margins. The Drug Intervention Programme (DIP) is primarily concerned with getting drug using offenders into treatment. The DIP is performance managed against 6 compact targets. In 2006/07 DIP exceeded four targets by significant margins and narrowly missed 2 targets. Sheffield DIP has been rated as a 'star performer' by the Home Office.

For **Alcohol** Sheffield has a range of alcohol treatment services including open access information and advice, structured counseling, inpatient and residential rehabilitation. There are also specialist staff that work in criminal justice and health settings and with families where there is concern about parental use. There is however a considerable lack of capacity in these treatment services to meet an increasing demand, resulting in long waiting lists and a great deal of frustration for service users and staff. Two innovative pilot education projects are currently running as part of Sheffield's Primary Care Trust Public Health programme.

Scope for improvement

For **Drugs** 66% of Sheffield Problem Drug Users (PDUs) are estimated to use only crack cocaine or use both crack and heroin. This is aligned with Leeds (68%) but higher than England (59%), Y&H (51%) and Bradford (56%). Engagement in structured treatment appears to vary by drug use. One of the main differences for crack compared with opiates is the prescribing treatment available. Provision of structured psychosocial interventions has been increased to ensure capacity for crack users, but there has to be more pre-engagement

work, and greater awareness from the prescribing services to utilise and refer into these treatment modalities.

As well as being less likely to engage with treatment, crack users are less likely to stay in treatment. Local data shows that of those engaging in treatment, people presenting with crack use are less likely to be retained than those without crack use. Further research needs to be completed into stimulant use.

For **Alcohol** although there is on-going work in Sheffield, it is disparate, un-coordinated and under resourced. There is a need to ensure that future work in Sheffield is taken forward within the context of recommendations from the National Alcohol Harm Reduction Strategy for England (2004).

Neighbourhood differences

For **Drugs** the most frequent postcodes of residence for clients in structured treatment are Burngreave S2 (16% of clients), Shiregreen, Firth Park, Old Parsons Cross S5 (15% of clients) and Sharrow S8 (7% of clients). The top two are also the same for DIP presentations, although S2 clients are double that of the second highest neighbourhoods in S5. 29% of DIP clients reside in S2, 13% in S5 and 6% in each of S3 (next to the Burngreave area), S9 Darnall and S13 Woodhouse. The same neighbourhoods have a high attendance at needle exchange S2 (23%), S5 (20%), S3 (9%) and S6 (Hillsborough) with 7%. Housing data is less complete, however indications show the areas of S5 (21%), S2 (15%), S7 (Highfield) (14%) and S6 (9%) have greatest need.

Although no formal analysis has been undertaken, it can be seen from local data that there is a correlation between those areas in Sheffield which have high numbers of problem drug users in treatment, and areas of relative socio-economic deprivation. Thus although substance misuse (because of the relatively small, in numerical terms, numbers of deaths) does not contribute significantly to health inequalities as measured by overall mortality rates or life expectancy, it is nevertheless a contributor to the overall pattern of health inequality in the city.

For **Alcohol** the 35 – 49 years age group is the highest percentage of NHS admissions where there was a primary or secondary diagnosis of selected alcohol related conditions (mental and behavioural disorders due to alcohol consumption, alcohol liver disease and toxic effect of alcohol) by age for England 2005-2006. (HES 2006). Sheffield population of 30 – 44 year olds = 112,382. Estimated percentage of 35 – 49 year olds drinking at hazardous levels is 25.8% = 28,994

Sheffield is fourth in Yorkshire and the Humber for binge drinking. 2000 – 2002 synthetic binge estimates give the following estimates for binge drinking in the old PCT configuration:

Sheffield West	27.6% population over 16 (2 nd in the region)
Sheffield SW	22.8% population over 16 (4 th in the region)
Sheffield SE	19.5% population over 16
Sheffield North	19% population over 16

Reducing health inequalities

To date the Enhanced Public Health Programmes which are being developed in the priority areas of the City have not linked explicitly with substance misuse treatment services. There may be value in making these links. 13% of Sheffield clients in structured treatment are BME, compared to the City's 11% BME population². Sheffield has a specific gateway service into treatment located in Burngreave and a specific BME service is commissioned to provide a citywide service. However, it is of concern that during 2005/6 only one person of black ethnicity completed treatment successfully³.

Engagement with users and improving the patient experience

A Service User Involvement Volunteer Project commenced in February 2006. The project includes accredited and in-house training and places service users within provider services in a voluntary capacity. A Service User Charter has been developed and service users have been involved in a range of initiatives including Hepatitis awareness campaign; Needle-dumping clearance campaign and planning and delivery of training.

A major consultation around the needs of carer's has been completed with all stakeholders and priorities agreed for the next three years. A Toolkit has been produced and circulated to family support services. Carer's training needs were fed into commissioning process and for the first time in Sheffield dedicated carer support services have been commissioned.

The Provider Advisory Group meets monthly and service providers feed into the commissioning process through this group. A number of major improvements have been implemented in the past year that will improve individual/patient experience of services. New provider agreements has been developed to meet standards set out by the NTA and all agreements with service providers were re-written in line with the Sheffield treatment targets.

The treatment budget was re-invested according to need rather than on a historical basis and more robust monitoring procedures developed in line with the

² Office of National Statistics, 2001 Census, 2005 estimate.

³ NTA Exit reasons information, 2005/6 NDTMS data.

new commissioning practices. The Drug Intervention programme (DIP) moved into new premises in April 2006 and all services are now offered from one site; partnership arrangements with the police have been strengthened.

Responsibility for alcohol services has been formally passed to the DAAT. Alcohol Concern has been commissioned to produce an Alcohol Harm Reduction Strategy for Sheffield and this will be published in August/September 2007.

Priorities for the next five years

A single point of assessment and referral into treatment will be established. GP shared Care and pharmacy based services extended taking into consideration the 'desert' areas in the City alongside the areas with a high number of people in treatment. The DIP model will be further developed to ensure more active engagement with drug using offenders to increase the numbers of drug using offenders entering drug treatment. An Alcohol Strategy Implementation Steering Group will be established to oversee the implementation of the new Sheffield Strategy for reducing Alcohol related harm. Most specifically it will ensure that a treatment system is established and developed over the next five years.

HEART DISEASE

Aim of service

To continue to achieve a progressive reduction in premature cardiovascular deaths and health inequalities in cardiovascular disease. This is to be achieved through continuing to meet hospital and primary care milestones and targets associated with the National Service Framework for Coronary Heart Disease (NSF for CHD); ensuring individuals with established cardiovascular disease and those at high risk of developing the disease are identified and receive full packages of preventative treatments and advice; and through expanding our community-based approaches to disease management for heart failure, atrial fibrillation and cardiac rehabilitation, both as effective alternatives to hospital-based care and as a strategy to help people with these conditions to avoid future unplanned hospital admission.

Description of current service

Through the work of GP surgeries, the PCT provides ongoing preventive care for the majority of people who have established cardiovascular disease and those having heightened risk factors that put them at future risk of the disease. A fundamental part of this is the establishment and maintenance of GP electronic registers, which enable effective patient recall and follow-up, and allows monitoring of patients' progress. A team of specialist and non-specialist community nurses provide disease management and cardiac rehabilitation to people with heart disease in the community. The heart failure team supports people with left ventricular heart failure, and those who have had an admission or are at risk of an admission for all types of heart failure, to ensure optimal management. Disease management includes home visits for the housebound, consultations in practices and clinics, group activity (e.g. cardiac rehabilitation and anxiety management groups) and joint working with other professionals and services. Sheffield Teaching Hospitals NHS Foundation Trust is a regional specialist centre for acute adult cardiac care, and the PCT works closely with the Trust to ensure timely access to and appropriate use of the specialist diagnostic and interventional cardiology services available. The PCT participates in the North Trent Network of Cardiac Care, which is part of the NORCOM commissioning network, through which the PCT commissions specialist (tertiary) cardiac services.

Description of current position

Sheffield has maintained a faster rate of decline in premature cardiovascular deaths (under 75 years of age) than has been seen for England as a whole, and in 2006 had already achieved the target set for 2010 for a 40% reduction in these deaths (from the baseline period 1995-1997). As a city the PCT and adult acute Trust has broadly achieved all of its key NSF milestones and targets since its publication in 2000. Following the successful completion of the former Sheffield

CIRC heart disease prevention programme we have been able to demonstrate acceleration in the rate of decline in premature circulatory deaths, and crucially a narrowing of the inequality gap in circulatory deaths. In the more recent past, where heart disease management was included in long term condition community case management programmes significant falls in hospital readmissions were achieved, including a 21% reduction in hospital admissions for all types of heart failure in 2005/6 compared to the previous year. A Healthcare Commission review of progress with implementing the NSF for CHD in 2005 commended Sheffield in its high level of achievement and quality of service provision; however a more recent review has highlighted work needed to improve aspects of heart failure services in the city.

Scope for improvement

We need build on past successes to continue to meet our key NSF for CHD related targets; and continue to reduce still further premature circulatory deaths and inequalities in the disease. Specifically we now need to expand and improve GP registers of those at high risk of developing cardiovascular disease and those with atria fibrillation; achieve new NSF standards of service for cardiac arrhythmias and families having suffered sudden cardiac death; improve the proportion of patients with left ventricular heart failure having confirmed diagnoses and receiving ACE inhibitor treatments; and increase disease management provision for heart disease patients through extending specialist and non-specialist community-based services. We are currently only able to offer cardiac rehabilitation to less than a quarter of patients, who would benefit from it, and there is evidence that patients with angina do not receive optimal management and treatment; these patients currently account for up to 40% of CHD hospital admissions.

Neighbourhood differences

Although we have made significant progress in reducing inequalities in cardiovascular disease, we still have marked differences across the city that requires further focused effort. During 2006/7 the cardiovascular death rate in Sheffield was 92 (no. of deaths per 100,000 total population, standardised to remove the effect of age). However the cardiovascular death rate in the most deprived fifth of Sheffield neighbourhoods was 131 per 100,000 population, compared with a rate of 56 in our most affluent fifth of neighbourhoods. This is also reflected in differences in the rate of emergency hospital admissions for heart disease (for example, heart attacks) in 2006/7 which was 487 per 100,000 population in the most deprived fifth of neighbourhoods, compared with 248 in the most affluent fifth. However we have been making very good progress: between 2000 and 2005 the cardiovascular death rate has improved (reduced) by 40% in our most deprived fifth, relative to a decline of 24% in the most affluent fifth (28% reduction for Sheffield as a whole).

Reducing health inequalities

Building on past successes, the circulatory disease prevention packages targeted into our priority neighbourhoods and higher risk ethnic minority communities through the Enhanced Public Health Programme, will comprise our principal contribution to narrowing the inequality gap in circulatory disease still further. Achieving a target number of 9,000 additional patients receiving cholesterol lowering treatments and 2,000 receiving blood pressure reduction treatments would result in an estimated 11 additional lives saved every year in these areas of the city over the medium term. Additionally, network-wide implementation of the Cardiac Network's strategy will help to iron out inequalities in service utilisation between health communities, such as in access to ICD implantation and revascularisation procedures.

Engagement with users and improving the patient experience

The programme area will use established heart disease patient involvement structures that have been in place as part of the Coronary Heart Disease Local Implementation Team now for at least ten years, in order to provide the patient, service user and carer with a voice in developing and improving local services. This also provides forums for bringing together key staff groups and service users from primary care and hospital environments to look at issues of common local interest.

More patients with heart disease and heart failure will receive specialist and non-specialist support closer to their home, more will be on appropriate treatments and will be appropriately followed-up in the community. The approach is aimed at reducing hospital admissions and keeping patients in their own home. It would also have a proven effect of reducing anxiety, improving quality of life and reducing demand on primary care services. Providing patients with information and education to facilitate self-care has also been demonstrated to reduce the incidence of heart attacks, reduce episodes of angina, and reduce the requirement for coronary artery bypass grafts and, for those who have attended a cardiac rehabilitation programme, a 25-30% reduction in the risk of a further cardiac event or death.

Priorities for the next five years

- Extend and improve GP registers of those at high risk of developing cardiovascular disease to include all GP practices.
- Building on the success of the Sheffield CIRC programme we will begin a programme of work through the Enhanced Public Health Programme aimed at achieving rapid uptake of full packages of preventative treatments and healthy lifestyles support by those at risk of developing circulatory disease living in our priority areas of high need.
- Further work with the ambulance service to reduce 'call to needle times' for acute myocardial infarction and the use of thrombolytic drugs.

- Build on the PCT's approach to tobacco control to reduce the numbers of smokers.
- We will work closely with the North Trent Cardiac Network to implement the network-wide strategy (2008-2010). Immediate priorities:
 - Achieve an 18-week maximum wait from GP referral to hospital treatment by December 2008.
 - Continue to provide a primary angioplasty service for the rapid treatment of heart attacks in Sheffield and work with partner PCTs to develop a strategy for network-wide provision.
 - Implementation of the NICE Technology Appraisal on Cardiac Resynchronisation Therapy in heart failure.
 - Implementation of the new NSF standards of service for cardiac arrhythmias and sudden cardiac death, focusing on establishing explicit care pathways and an arrhythmia coordinator role; implementing NICE guidance on the use of ICDs, and ensuring timely referral and treatment of people affected by genetic heart disease.
 - Develop a 'Yorkshire & Humber' wide hub and spoke service model for adults with congenital heart disease, offering an appropriate balance between local and specialist services.
- Increase the number of patients able to benefit from cardiac rehabilitation from 230 in 2006/7 to 1400 in 2008/9.
- All patients discharged from hospital with a heart disease diagnosis, and all those considered by a GP to be at risk of an admission, should receive timely follow-up through an appropriate community-based disease management option.
- All patients with heart failure should receive timely follow-up by the appropriate primary care specialist or non-specialist service. Through this and the provision of prescribing support to GPs we also aim to significantly increase the proportion of patients with left ventricular heart failure receiving ACE inhibitor treatment.
- Continue implementation of the North Trent Cardiac Network strategy; to incorporate reviewing medical management options as alternatives to interventional cardiology, including the cost-benefit of angioplasty in the treatment of stable angina, and the impact of improvements in primary and secondary prevention.
- Achieve comprehensive coverage of disease prevention in high risk individuals through the Enhanced Public Health Programme within all priority high need areas of the city.
- Achieve comprehensive specialist services and follow-up for cardiac arrhythmias and genetic heart disease

OLDER PEOPLE

Aim of service

The aim is to develop service provision to ensure that older people in Sheffield enjoy an improved quality of life, health and well being, are independent, participate actively in the community and enjoy the benefits of safe and stronger communities. That will require equal access to integrated, co-ordinated services so that they can have person centered care that meets their individual requirements include their mental health and well being. If we are successful then more people will get more care closer to home with the need for fewer unplanned admissions to hospital or visits to Accident and Emergency departments

Description of current service

Generally services for older people in Sheffield have been delivered by the NHS and the City Council but with some services jointly commissioned by the PCTs and the Council. The PCT and the Council are looking at the scope and range of services for older people and how best they can be commissioned through a Strategic Integrated Commissioning Group (SICG). The future model for service delivery is being explored, taking into account the initial thinking of seven service districts and the integration of local neighbourhood teams.

At present our approach for referrals into specialist mental health services is by a GP, using the dementia and depression protocols into the Community Mental Health Teams (CMHT) through a single point of access.

Description of current position

An increasing number of people in Sheffield are living longer and will have a wide range of both physical and mental health needs. Within five years the 65 to 69 population will rise, from 23,000 in 2007 to over 26,000 in 2012. These increases will be a factor in addressing the rise in emergency admissions in Sheffield as it will impact on demand for services. From 2013 to 2018 the number aged 70 and over will rise from 52,300 to 68,800 people including in this the number 85 plus will rise from 11,900 to 12,700.

The starting point for planning older people's services is over 50 years as early intervention in chronic disease management in primary care not only supports people in their later years to achieve the positive outcomes of independence, living at home and improved health and well-being but also reduces unscheduled and lengthy care in the future. Within three years the 50+ population in Sheffield will begin to rise, breaking the 200,000 mark by 2029. Currently 45% to 50% of GP practice populations are made up of people aged 50 plus. This increase will impact on demand for services as the PCT develops its plans.

A Sheffield Strategy for an Ageing Population has been developed describing the services needed for the 20% of population with complex needs and the health promotion and improved day to day management of people with chronic diseases to reduce the need for more specialist care for the other 80% of people.

Recent developments include:

- Two dedicated Community Stroke Teams, North and South of the City
- Redesign of Community nursing services
- Case managers, providing specialist management of people with COPD and CHD, reducing the need for admission to hospital
- Community Matrons to support people with co-morbidity and complex needs
- Community Geriatricians assessing people in the community to avoid hospital admission
- A&E falls service; prevention of admission and appropriate redirection into community rehabilitations services. Linked to the Emergency Care Practitioners admissions avoidance work.
- Partnerships for Older Peoples Project (POPPs): with the City Council over the next two years to provide the headroom to redesign new services and ways of working
- Rapid response nurses /Hospital at Home Service to provide targeted support to older people at serious risk of hospital admission.
- Support to Care Homes to build up the expertise of residential and nursing home staff to care better for very physically or mentally frail older people who otherwise would be admitted to hospital
- Joint schemes that target groups or communities that are either hard to reach and or BME communities/ neighbourhoods where there are high numbers of vulnerable older people. Within the model of engagement are “well” older people, Expert Elders, as co-partners in making decisions and implementing services that people require.
- A new memory management service (MMS) for people with dementia from July 2007 is delivered in two centres north and south of the city. The target set for this service is that people will be seen in the MMS within 4 weeks of referral from consultation with their GP.

Scope for improvement

The provision of neighbourhood-based integrated services will prevent unnecessary hospital admission and reduce bed-days spent in hospital, supporting earlier discharge and provide care closer to home. To enable us to do this we need to develop closer working relationships with GP teams and PBC consortia.

In Sheffield we already have a strong community infrastructure with the potential to connect considerable numbers of older people to services. As part of the POPP's programme we have recruited a worker to engage with older people to

identify the barriers to access. The outcomes of this work will be key recommendations for improving access, enhancing a patient centred approach to services and access across health, social care and universal services.

Strategies have been developed for people with a functional mental illness and for those with dementia. User and carer involvement in both strategies support significant reconfiguration of services to meet the mental health needs of older people. The implementation of these strategies is now under discussion.

Neighbourhood differences

Looking at the populations of the seven PBC consortia those Consortia with the highest percentages of 50+ patients are Hallam (37.2%), Primary Health Sheffield (36.21%) and Health Alliance Sheffield (35.9%). Current information also tells us that, in 15 practices across the city, 50+ patients make up over 40% of their total patient population compared with some practices in which older people make up less than 1% of the patient list.

In order to deliver the drive for community based care of older people and support to remain in their own home, there needs to be a focus on joint forward planning to ensure that the health and social care can meet the changing needs of older people.

Reducing health inequalities

We recognize the need to maximise the contribution of older people as citizens and ensuring their needs and aspiration are considered in planning and implementing changes to services for older people if we are to improve outcomes for individuals and the city. Areas of focus include improving access to primary care services, better chronic disease management within practices linked to the QOF, developing access to better information to inform choices, improving review of reasons why people use A&E or are admitted to hospitals as emergencies and identifying issues we need to address, contribute to work to tackle the wider determinates of health and identify ways to strengthen disadvantaged and vulnerable communities

Within Black and Minority Ethnic communities older people can often lack up to date knowledge about health services available to them and this can lead to a lower level of access in these sectors. It is important to provide services that suit the needs of BME older people although separate services are not always the best approach. It is about ensuring that information about the availability of the service and the methods of accessing it are tailored to different groups and it is not always about changing the service itself. We recognize that language and translation issues are key.

Engagement with users and improving the patient experience

We work to involve current and potential service users through older people's events to influence service planning such as the Local Area Agreement, eg using POPPs and Expert Elders. The views of people with dementia and their carers have been obtained as part of the Dementia Strategy work including membership of its reference group and the writing of its foreword. Joint workshops were held of people with dementia and staff delivering services to check out ideas and early findings and make joint recommendations

As part of the POPP's programme, external evaluations are taking place to inform national policy, local health and social care planning and service redesign based on patient experiences on a number of services. The methodology is one to one interviews, patient surveys, focus groups and self completed questionnaires. There are also ongoing individual service patient experience surveys for example within the stroke and falls services.

Priorities for the next five years

We will develop city wide intermediate care services to provide swift, targeted support to older people at serious risk of hospital admission, including rapid response nursing short term social care intervention and access to therapy services to promote rehabilitation and re-enablement with referral into mainstreams services after 12 weeks or sooner or discharged from services.

We will continue to work with GP's to promote the benefits of the use of mental health protocols on early detection and appropriate referral into services for assessment with a three-year implementation plan.

We will take forward the implementation of the new national Dementia Strategy with initial steps being the development and agreement of a joint commissioning plan incorporating action from the local review of Carer Breaks for people with dementia. Services will be reconfigured to support the needs of people with dementia by delivering care closer to home and avoiding inappropriate admissions. We are currently consulting on a two phased approach that by 2010 would see two community rapid response teams and a new 24 bed acute assessment ward in place.

We will implement the new national framework for NHS Continuing Health Care that was introduced in October 2007 and will integrate the commissioning of NHS funded continuing care with our wider approach to intermediate care and rehabilitation services so that greater independence can be achieved before people require care in a nursing or residential home.

Discussions this with the City Council and other partners on a strategy for intermediate care began in September 2007 with a view to agreeing changes for inclusion in the commissioning plan for 2008/09 We will refine the Sheffield Falls

Pathway inline for the national *Do Once and Share* team for inclusion in our 2008/09 plans. This will complement existing A&E and falls work, to reduce admission to hospital and improve rehabilitation programmes in the community to reduce the risk of further falls.

We will building on the redesign of community nursing services to utilise the resources released, focusing on supporting patient with long term conditions and avoidable hospital admissions. 22.52 wte staff have also been redeployed into early discharge teams which will enhance the admissions avoidance We will continue to align community nursing teams working with the City Council's locality structure with integration due to be completed by March 2008

We will develop and agree joint commissioning plan to implement improvements for older people with functional mental illness linked to the commissioning intentions of the Dementia Strategy and those for adult mental health services.

We will take forward the implementation of the new framework for continuing care including the new single band for NHS funded nursing care, the local approach to jointly funded packages of care, handling of care at the end of life cases and implementing a joint assessment process.

RESPIRATORY DISEASES

Aim of service

The aim of the services is to build an accessible and responsive service for people with respiratory diseases including Chronic Obstructive Pulmonary Disease (COPD) and asthma. This includes enabling patients to receive evidence base care closest to where they live. The services follow a segmented approach that identifies key characteristics of patient need; evidence based care and provides a systematic approach through a defined pathway of care. The aim is to promote self-care supported by local service delivery. The aim is to positively impact on the quality of life and well being of the patient and their carer. This work is a major strand of the PCT's turnaround activity to reduce unscheduled care admissions to hospital and improve the appropriate use of outpatient appointments.

Description of current service

COPD is a progressive and fatal disease. Treatment and elevation of symptoms by delivering current evidence based care leads to a positive affect on the well being of the patient and better use of services. A new model of care in Sheffield has resulted in a 39% reduction in unscheduled care admissions to STH in the first quarter and 21% in the second quarter of 2007/08. This model is now being run citywide and is being roll out for other long-term conditions such as chronic heart disease and heart failure.

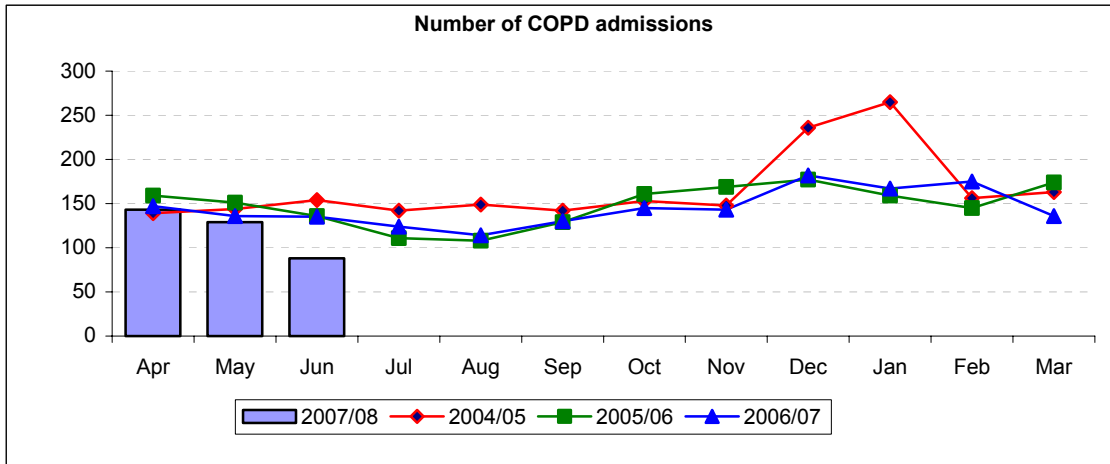
We are working in key GP practices to identify those patients at high risk of hospital admission and developing community clinics in the heart of the areas most prevalent for Respiratory diseases. Following an admission to hospital all patients are seen by a nurse with advanced respiratory knowledge supported by offering local follow up on discharge from hospital and linking patients to key professionals for ongoing case management

Description of current position

Sheffield has a citywide COPD prevalence of 1% however in the less well off parts of the city this rises to 6% and 7%. The respiratory team is engaging with these practices in those areas and is using a chronic disease management approach to identify and assess patients at high risk. Here they assess the patient and contrast this to current evidence based care. Where there are weaknesses the nurse acts as the patient advocated and recommends, makes and promotes change.

Since rolling out the model city wide in November 2006 we are starting to show a significant difference. Unscheduled care admissions for COPD are under 100 for the fist time. For June 2007 we see 88 unscheduled care admissions to STH. See graph below.

Figure 12 Unscheduled COPD admissions to STH



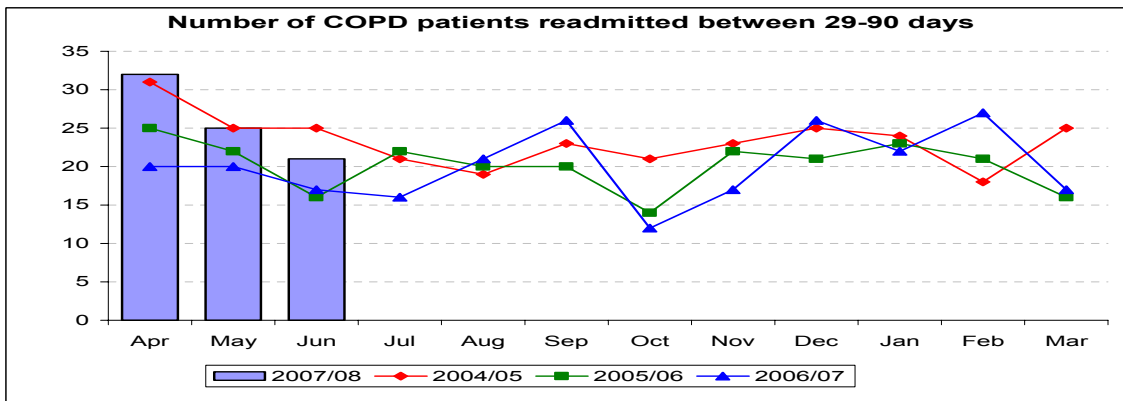
Source Sheffield PCT 2007

COPD unscheduled care admissions reduce in June 2007 to 88 from 135 in June 2006, 136 in June 2005, and 154 in June 2004.

Scope for improvement

We are actively identifying and targeting patients early and linking them with district nurses, case managers and community matrons to activate a package of care. 70% of unscheduled care admissions to STH with COPD are for a first attendance. 30% of patients are having two or more admissions to unscheduled care to STH. What we see in practice is for those 30% that experience multiple admissions often indicates a significant decline in their well-being with acute anxiety, depression and often the patients are in a terminal stage. This group of patients often return for a second admission within 30 days of discharge.

Figure 13.



Although on target with the Turnaround project for COPD and Asthma we have substantial work to undertake for a sustainable service delivery. We are mindful

that we need to continue to ensure good care for people most at risk in the winter months. We also have gaps in palliative care and some patients are having multiple admissions when they decline significantly.

Neighbourhood differences

The prevalence for COPD varies from 1% in the affluent areas of the city to between 6 to 7% in inner city areas. At a local GP practice level there are further variations in outcomes. A recent health equity report indicates those GP practices in the less well off areas have the highest rate of unscheduled care admissions to STH with poor performance outcomes in key indicators around the QOF. For example one PBC consortium has eight practices that make up to 25% of the number of unscheduled care admissions to STH.

Reducing health inequalities

Through having local services that explicitly reflect the needs of the population. By analysing profiles of GP practices to ensure we are targeting the right people. Encouraging people to self care for example early identification of risk of an exacerbation and where to seek advice and assistance locally.

Have a focus on early diagnosis developing local clinics for patients to seek a simple test to assess their lung volume, focus on smoking cessation and active lifestyles, healthier life style advice to enhance quality of life therefore reducing risk.

Engagement with users and improving the patient experience

The original model was created from process mapping between the public, patients and staff. This will continue as we move forward with our service delivery. This is done through listening to their needs and developing services with them at the heart of our decision-making. The two local respiratory clinics are examples of engaging with local patients, their carers and health care professionals.

Priorities for the next five years

We will work to:

- Market the community team and services underway in target areas
- Promote self care and self management
- Work with 32 newly appointed case managers to develop skills in Respiratory care
- Increase the number of GP practices to target where inequalities have been identified continue to work with practice data, district nurse, practice nurse and GP's
- Introduce clearer care pathways that include and of life management

- Community home support for nasal ventilation (NIV) services
- Community intravenous antibiotic service
- Self care and advice leaflets being developed to be posted to high risk patients pre winter
- Expansion and development of Pulmonary rehabilitation and access to yoga across the city
- Target people aged 35 and over who have significant risk for early diagnosis provide advice for change of lifestyle – local cough clinics
- Work closely with Public health and smoking cessation to deliver local segmented programmes
- Strategy and plans to be published
- Research project around the economic and patient value of telehealth
- Developing telehealth across the secondary care primary care interface ready for the winter increase in demand
- Developing an end of life pathway of care for respiratory patients in the community
- Developing anxiety and depression management in the community
- Developing the community respiratory team in these skills
- Developing the wider community nursing team
- Increasing the work in target areas by targeting those patient at risk at a GP practice level
- Opening a second respiratory community clinic in the heart of the area with the highest prevalence of COPD
- Developing access to blood gas analysis in the high risk areas
- Working with our target nursing homes and residential homes by assessing patients offering evidence based care
- Developing tools to help care home staff assist patients with inhalers and COPD care

SEXUAL HEALTH AND TEENAGE PREGNANCIES

Aim of service

The service aims to improve the sexual and reproductive health and reduce health inequalities amongst people who live, work and or socialise in Sheffield.

Description of current service

Our holistic model of working acknowledges the political, social and cultural factors and health inequalities which affect and determine people's sexual health, as well as issues relating to individual experience, emotions, sexuality, sensuality and spirituality. Our approach affirms people's right to sex, which is consensual, mutual and equal, and the importance of pleasure, intimacy, desire, love and fulfilling relationships.

Within the wider aim of working towards sexual health for all, our specific objectives include:

- reducing unintended teenage pregnancies
- the prevention of HIV and other Sexually Transmitted Infections
- the promotion of positive and mutually satisfying relationships
- the provision of excellent Sex and Relationships Education

Description of current position

We are working to reduce the rates of teenage pregnancy in Sheffield and to improve sexual health. Although there is a declining trend since 2002 in the rate of under 18 conceptions, Sheffield is the only place in South Yorkshire with an increase [since 1998] against an overall decline of 10% for Yorkshire and Humberside. 1998 is the base year for the national target of halving the rate of under 18 conceptions by 2010. This target is in the context of a broader strategy to improve sexual health and we have made good progress in access to Genitourinary Medicine Clinics – another national target area. Most recent data from April 2007 shows that 81.9% of people attending GUM clinics were offered an appointment within 48 hours against a target of 100% by 2008. There is a related target of 95% of patients attending GUM clinics within 48 hours by 2008. Most recent data show 70.4% attended within 48 hours.

We are working to reduce the rate of the most common sexually transmitted infections: Chlamydia and gonorrhoea. Rates of gonorrhoea have been declining since 2003 matching the national picture but there are worrying trends in under 25s and men who have sex with men. Sheffield has set a target to reduce the number of new cases identified to 432 by 2008, and is in line to meet this. This will help us meet the national target of achieving a reduction in the rates of new diagnosis of gonorrhoea by 2008.

Sheffield has a target to screen 15% of the 15-24 year old population for Chlamydia by 2008. The service needs to screen about 1070 per month to reach this target, currently the figure achieved is around 700 per month. This supports the national target of increasing in the percentage of people aged 15-24 accepting Chlamydia screening by 2008.

Scope for improvement

Teenage pregnancy rates are not coming down as quickly as in other parts of Yorkshire. Not all 10 high impact changes for GUM 48 hour access have been implemented. Sexual health needs assessment and commissioning strategy in development. GUM and reproductive health services not currently integrated. PSA on teenage conception requires sustained focus by the PCT in collaboration with our partner agencies. Therapies available such as implemon, mirena and gardasil could provide further assistance.

Neighbourhood differences

'Hot spots' exist for teenage pregnancy, demand for abortion for older women and sexually transmitted infections. A comprehensive needs assessment is in progress and will be available in the autumn of 2007. This will assist in better targeting of services.

Reducing health inequalities

Marked inequalities exist in sexual and reproductive health in Sheffield. Rates of teenage pregnancy are highest in the most disadvantaged areas; educational attainment has an impact over and above the effects of deprivation. Certain communities are disproportionately affected by STIs and HIV/AIDS. HIV/AIDS is more common among black African groups and gay and bisexual men. This poses a considerable challenge for health and social services and indicates the need to target prevention activities appropriately.

Engagement with users and improving the patient experience

The strategy aims to empower people to have confidence, personal control and choice in managing their sexual health care and service use, and to improve sexual health services by involving people in their planning and development. The needs assessment includes a user/public survey. The managed sexual health network includes wide representation of clinical staff responsible for sexual and reproductive health care. The network also has a user group developing new ways of involving patients and the public.

The overall aim of the current review is to ensure comprehensive local access to equitable, prompt, consistent and high quality services. This will improve the individual/patient experience and recognise the specific need of marginalized communities disproportionately affected by sexual health inequalities.

Priorities for the next five years

These will be determined from the needs assessment, available September 2007, and linked commissioning strategy, available November 2007.

STROKE

Aim of service

We work to prevention of strokes through improved diagnosis and treatment of hypertension to control blood pressure and through better handling of Transient Ischaemic Attack (TIA) referral, assessment and treatment. This is linked to more effective management of CVD risk including smoking, lipid levels, exercise, blood pressure, diabetes and atrial fibrillation. We commission the diagnosis and treatment of acute stroke in hospital, rehabilitation post-stroke in hospital and in the community, long term support for people with stroke and their careers and palliative care

Description of current service

We work through the 94 general practices in Sheffield, five TIA assessment clinics (the rapid access stroke clinic) and 90 stroke beds at Sheffield Teaching Hospitals, two community stroke teams (early supported discharge). We have developed a career support group and adjustment to stroke / stroke education groups.

Description of current position

We have developed Sheffield hypertension guidelines and conducted a Health equity audit of general practice referral to the rapid access stroke clinic. We have met the Older People's National Service Framework, standard 5 "to reduce the incidence of stroke in the population and ensure that those who have had a stroke have prompt access to integrated stroke services

The National Sentinel Audit of Stroke 2006 describes STHFT in the top 25% of trusts. However, only 76% of patients with stroke were admitted to a stroke unit at some point during their stay. Sheffield practices in 2006 scored highly on controlling blood pressure in patients known to have hypertension in the Quality and Outcomes Framework.

Scope for improvement

Acute, short term care in Sheffield for stroke patients is good; but longer term support still requires development. The Department of Health has published "A new ambition for stroke: a consultation on a national strategy" signaling a major challenge to the nature, capacity and timeliness of stroke services in England. Stroke is now regarded as a medical emergency. Patients with stroke symptoms need to be transferred by ambulance directly to a receiving hospital that is able to provide "hyper-acute" stroke care, including 24 hour access to a stroke specialist, an urgent brain scan with expert interpretation, and thrombolytic treatment. They should then be cared for on a dedicated acute stroke unit.

The Yorkshire and the Humber Strategic Health Authority's "*Health Blueprint: a consultation with people of the Yorkshire and the Humber on the future of health and healthcare in our region*" includes targets about stroke and stroke services. By 2010, we will be expected to have reduced the proportion of people who die after having a stroke and to ensure that 90% of patients who are thought to have had a stroke referred to have their diagnosis confirmed within 48 hours.

Neighbourhood differences

The incidence of stroke increases with age. Stroke still kills 30% of patients within 30 days; a proportion relatively unchanged for the last 30 years. The national targets for reducing deaths under the age of 75 include deaths from stroke. By 2010 the aim is to have reduced deaths from cardiovascular disease by 40%. In Sheffield we have already achieved a reduction in mortality from stroke in people under 75 of one third since 1997.

In addition, the gap between the most deprived 20% and the Sheffield average has closed from 11 per 100,000 to 4 per 100,000 over the last 10 years.

In 2006, six of the enhanced public health programme areas still have death rates from stroke as high as the Sheffield rate was in 1997. They are Sharrow; Lowedges Batemoor Jordanthorpe; Wybourn; Norfolk Park / Arbourthorne; Tinsley / Darnall / Acres Hill; and Flower / Shiregreen / Stubbin Brushes.

However, this group of patients is the minority of those who experience stroke. The demographic changes in the population in Sheffield over the next 20 years will produce an increased number of people aged over 50. If the incidence and prevalence rates of stroke do not reduce, this will produce increased demand for acute investigation and treatment of patients with stroke, and long term support.

The close association between the percentage of households claiming income support and ill health disappears for people over the age of 65. The 2001 census asked questions about state of health. For people over 75 in Sheffield the proportion reporting "not good health" ranged from 60% to 88%. In 36 of the 100 neighbourhoods at least 8 out of 10 people aged 75 and older reported "not good health".

Reducing health inequalities

Through targeting the enhanced public health programme communities listed above for the diagnosis and treatment of hypertension. Afro-Caribbean and South Asian men are at higher risk of stroke; so designing accessible services for them will reduce inequalities. If people survive to the age of 75, they are more likely to have multiple pathologies, to be living alone, and to be women. This group is also at high risk of stroke. We need to consider how we can best meet the needs of this group.

Engagement with Users and Improving the Patient Experience

We will work with patients and their GPs to develop approaches to achieve increased awareness of own blood pressure reading, earlier diagnosis, treatment, and control of hypertension, faster investigation and treatment of TIA along with an higher proportion of stroke patients admitted to Stroke Unit and look to expand capacity of long term support in the community.

Priorities for the next five years

- Case finding patients with hypertension; then achieving and maintaining control of blood pressure.
- Understand the local epidemiology of stroke to inform targeted interventions
- Planning the implementation of the national strategy when published in 2008.
- Identify and agree the long term support services required for patients living with stroke and their carers.
- Using data from the Quality and Outcomes Framework areas of stroke and TIA management to improve services.
- Work with the ambulance service to improve the use of thrombolytic treatments and to reduce 'call to needle time'.

TOBACCO CONTROL

Aim of service

Smoking is still the biggest, reversible cause of ill health and premature death in Sheffield. It is the largest single cause of health inequalities accounting for about 60% of the difference in all middle age deaths between the highest and the lowest socioeconomic groups. Smoking in pregnancy reduces birth weight, and contributes significantly to stillbirth and infant mortality. This is why taking measures to reduce levels of smoking in the city is a priority. Through community-level public health programmes and by providing an accessible local NHS stop smoking service, the PCT's purpose is to make a significant contribution to reducing levels of smoking and smoking-related harm in the city.

Description of current service

The PCT's stop smoking service is currently available on a 'walk-in' basis at around 150 sites throughout the city in pharmacies (64), GP surgeries (76), and dental surgeries (4) and in community amenity venues. Alternatively smokers can self-refer via a free phone number. The service is free of charge and comprises weekly face-to-face support from a trained advisor, together with appropriate medication such as nicotine replacement therapy (e.g. patches). The combination is many times more effective than going it alone, which is the least effective approach. In addition we provide quit support programmes to pregnant smokers through specially trained midwives. Service provision is backed by local public health programmes focused on our most needy areas where levels of smoking are high. These involve PCT and local authority staff working with local voluntary, community and faith groups, and through a process of community engagement and increasing the local accessibility of services we aim to improve health and narrow the gap.

Description of current position

Our most recent large-scale local survey in 2000⁴ found that 26% or around 110,000 in the Sheffield adult population were smokers. Local data on trends is not available, however Sheffield appears to be broadly in line with the national picture, and it is expected that the government target of 24% by 2010 will be achieved (aided by smoke free legislation). In addition we have unknown rates of non-smoking tobacco use in minority ethnic communities. In the financial year 2006/7 the stop smoking service supported 2622 smokers to quit successfully (2738 in 2005/6); however we need to increase this number significantly in order to meet our 2007/8 target (see below). We are one of just a few areas in the region that has managed to maintain a year-on-year decline in the proportion of women who continue to smoke throughout their pregnancy. This proportion was 16.2% aggregated over the year 2006/7 which needs to become 15.2% during

⁴ Sheffield Health and Illness Prevalence Survey 2 (SHAIPS2), published 2002.

2007/8 in order to achieve our one percent per year reduction target. In 2006 the Healthcare Commission in their service improvement review of tobacco control gave Sheffield a top level rating of 4, reflecting the high quality of our local service provision and prevention programmes.

Scope for improvement

We have a target to achieve 4385 smokers quitting with NHS support in 2007/8 (which is expected to continue to increase year-on-year), which requires a large increase over previous years' delivery levels. We have a programme of work to increase the number of smokers using the NHS stop smoking service, with a focus on providing local and accessible services by integrating our approach with community-based public health programmes. We appear to be broadly on course to maintain a one percent per year reduction in smoking throughout pregnancy, though the target will remain challenging and require the engagement of the full gamut of community maternity services if we are to continue this successful downward trend. We can use Quality and Outcomes Framework data more effectively to identify smoking's contribution to patient's chronic ill health. We need to be mindful of possible changes in NICE guidance, for example on the use of Varenicline.

Neighbourhood differences

At electoral ward level smoking prevalence in Sheffield varied from 16% in Ecclesall and Broomhill wards to 46% in Manor ward in 2000⁴. We need to redress this local variation in smoking related risk by achieving rates of access to NHS stop smoking services that is proportionate to levels of smoking. In our priority group of 36 most disadvantaged neighbourhoods the proportion of smokers that are accessing stop smoking services is on par with that seen in the rest of the city. However at an individual neighbourhood level within our priority areas, the rates of access varies from an estimated less than 1% of smokers in Park Hill to better than 8% in Middlewood, Hemsworth and Flower. We need to achieve consistently high rates of service access throughout our priority neighbourhoods, and aim for achieving higher rates of access than in the rest of the city to make a positive impact on reducing local inequalities in health. As a proportion of pregnant smokers, access to stop smoking support is not as good in our priority neighbourhoods as it is in the rest of the city.

Reducing health inequalities

The health impact of stopping smoking accrue very quickly: breathing and circulatory benefits begin immediately, heart attack risk is halved within a year, and lung cancer risk is halved within about five years. By focusing our effort to promote advice and services to help people give up smoking in our most needy areas and minority communities, we aim to achieve these health gains more rapidly here than in the rest of the city, and thereby contribute significantly to narrowing the health inequality gap in the city.

Engagement with users and improving the patient experience

The Enhanced Public Health Programme is a health improvement vehicle that bases its approach on creating opportunities for local engagement and listening to local voices. We will continue to engage with local communities through those approaches in order to further improve the quality and accessibility of local stop smoking services. We will augment that with at least one staff and service user focus group per year to gain feedback on the user experience.

Our plans focus on meeting the expressed need for more information on healthy choices and having locally based services. We will increase the availability of quality information about stopping smoking, and give a higher profile to local stop smoking services to make healthy life choices more immediately accessible.

Priorities for the next five years

In 2008/9 we will achieve a further increase in the number of smokers successfully quitting with the support of the NHS stop smoking service, focusing on highest risk areas:

- Reflecting the consultation support for increasing local resources according to greatest need, we will further concentrate action at community level to recruit to stop smoking programmes within each block of priority neighbourhoods in the Enhanced Public Health Programme, and other areas with high smoking prevalence, including specific programmes to tackle smoking and water pipe use in minority ethnic communities.
- We aim to significantly increase the number of people stopping smoking with the aid of NHS support programmes through local GP surgeries and pharmacies; and through significantly increasing the recruitment of smokers through GP and nurse referral from primary care clinics.
- PCT and City Council will work closely in the local promotion of stop smoking services through public services and in the local media, to respond to the expressed need in the consultation for more information about adopting healthy lifestyles. We will tailor promotional and 'signposting' messages according to local circumstances, and to the receptiveness of individual smokers, by virtue of age, gender, ethnicity, level of addiction and financial circumstances.
- We will continue to work closely with hospital services to increase the referral of smokers from surgical pathways.
- City Council and PCT will continue to work closely to ensure successful implementation of the smoke free regulations through proactive employer engagement, especially those with manual workforces, and by promoting the stop smoking service to employees.

We will work to increase the extent to which maternity services are able to provide effective support to help pregnant smokers to quit, working closely with existing dedicated specialist smoking cessation midwives. As part of this we will

promote the concept of a smoke free home in order to reduce the exposure of children to tobacco smoke and increase the motivation of parents to quit smoking. The focus will be on the former Sure Start areas of the city.

In future years we will seek to set up initiatives to promote uptake of stop smoking services established in our priority areas as part of the Enhanced Public Health Programme will be rolled out in other areas of the city. We will work towards Children's Centres having smoking interventions mainstreamed throughout maternity and early years' services across all areas of the city.

MATERNITY SERVICES

Aim of Service

Maternal Health Services cares for women before, during and after the expected birth of a child. The aim of the service is to improve the health of women and their babies and ensure the best start possible in life for children. There were 6,374 live births in Sheffield in 2006.

There are two main policies shaping the delivery of Maternal health Services; the Children's and Young People and Maternal Health National Service Framework (NSF) and the 2007 publication *Maternity Matters: Choice, access and continuity of care*. Underpinning this was the Department of Health commitment that by 2009 women would be given a wider choice of type and place for maternity care and birth.

The vast majority of births to Sheffield residents take place in Sheffield NHS hospitals, 93.8% in 2006. Maternal Health Services are commissioned from Sheffield Teaching NHS Foundation Trust, and Maternal Mental Health Services from Nottinghamshire Health Care.

Description of Current Service

Maternal health services cover hospital and community care delivered in the main by midwives. It also includes pre-conception care, post and ante natal screening services, as well as health promotion (including smoking cessation and drug and alcohol advice), specialised maternal mental health and early years support from health visitors and other support agencies.

Description of Current Position

Births to Sheffield residents declined between from 6,125 in 1998, to 5,560 in 2002, but since then have risen substantially to 6,374 in 2006. The rise since 2002 means we need to look at different possible scenarios for future birth patterns.

Based on the 16 year trend, the fertility rate is projected to go into decline, with the rate in 2012 projected to be between 48 and 49 births per 1,000 women aged 15-44 and in 2017 to be between 45 and 47 births per 1,000 women aged 15-44. Projections based on the 10 year trend are much more conservative, with the projected rate at between 51 to 53 births per 1,000 women aged 15-44, compared to the current rate of just fewer than 57. However based on the five-year trends projection, there would be a continued increase in the fertility rate from 2006 onwards. On this projection by 2012 the fertility rate could be as high as 63 births per 1,000 women aged 15-44, and just fewer than 70 a year by 2017. This could extrapolate to more than 1,500 extra births per year by 2017.

If the last trend was to occur then there would be a significant need to examine the level of services both in the acute and community setting. The PCT needs to do more work to examine these possible trends and work with provider organizations and the City Council on the potential impact of such changes.

Scope for Improvement

Breastfeeding leads to overwhelming health benefits and cost savings⁵ and has a major role to play in promoting personal health and reducing inequalities. It has both short and long term benefits for both baby and mother. Sheffield currently has a breastfeeding rate at delivery of 75%. However there is wide variation across the city, from less than 50% in some neighbourhoods, to over 90%.

Pregnant women who smoke are more likely to have a premature baby or a baby which has a very low birth weight. Such babies are at higher risk of asthma and bronchitis, and other diseases, and can also have smaller organs. Passive smoking is also harmful to the foetus and newborn.

In common with other smoking behaviour, smoking in pregnancy is strongly related to socio-economic status. The prevalence of smoking in pregnancy varies substantially across Sheffield neighbourhoods, from nil to 40%. It is thus a major driver of health inequality in the city.

Teenage pregnancy is strongly associated with low birth weight, poor neonatal outcomes and reduced life chances for the mother. Although Sheffield's rate is not out of line with other UK cities, it is not decreasing significantly, and is strongly associated with socio-economic status. It is a further indication of the need to raise levels of aspiration.

Neighbourhood differences

In 2006 the rates for breastfeeding intention at delivery varied across the city with Rivelin to Sheaf neighbourhood reporting rate 87.5% compared to only 63.3% in Parson Cross/Ecclesfield neighbourhood.

There is also disparity across the city of low birth weights (under 2500g) which is an indicator of deprivation. In Shiregreen/Burngreave neighbourhood from 2002 to 2006 there was a rate of 10.8 per 1,000 live births, compared to Rivelin to Sheaf had a rate of 7.7.

In 2006 the number of mothers recorded as smoking across the city also varied with a rate 25.6 per 100 live births recorded in Arbourthorne/Manor/Darnall compared to 5 in Rivelin to Sheaf Neighbourhoods.

⁵ Sheffield PCT Public Health Analysis Team April 2007 'Breastfeeding in Sheffield 2006 Statistical Report'

Reducing health inequalities

The variation in low birth weights is the biggest challenge on health inequalities accompanied by work to reduce the number of women smoking in pregnancy. Raising birth weight will accordingly be a feature of our work. We will also work with black and minority ethnic groups to address service issues as in 2006 35% of babies born in Sheffield were born into groups other than white British (or were unknown or not stated). This proportion has decreased in both 2004 and 2005.

Engagement with users and improving the patient experience

Maternity Services Liaison Committees (MSCL) provide a forum, using expertise and experience of professionals in partnership with women using the service, to implement the recommendations of the maternity module of the Children's NSF, Public and Patient Involvement in the NHS, Maternity Matters and Integrated Governance, together with wider strategic involvement in all aspects of maternity care education, provision and policy. Within Sheffield the MSLC is an active forum, with strong links to the Maternal Health Strategy Group.

The MSLC is an independent advisory body and comprises representative clinicians from all specialties involved in maternity care, together with relevant managers, public health and social care input and at least one third user members.

The PCT will continue to work with the MSLC on delivering the priorities set out in the Maternal Health Strategy; by involving mums this will ultimately improve their maternal experience.

Priorities for next 5 years

- To implement the Maternal Health Strategy incorporating the improvement of Breastfeeding uptake across Sheffield specifically targeting young mothers and offering choice
- To increase the number of smokers quitting, especially targeting parents, pregnant women
- To contribute to workforce planning strategy
- To implement Maternity Matters in terms of choice of :
 - How to Access Maternity Care
 - Type of Antenatal Care
 - Place of Birth
 - Postnatal Care

CHILDREN AND YOUNG PEOPLE

Aim of Service

The aim of the service is, through separate and joint commissioning, to deliver the five outcomes as set out in Every Child Matters (ECM) and the Children's and Young People and Maternal Health National Service Framework (NSF), these include :

- **Be Healthy:** enjoying good physical, sexual and emotional health, through living a healthy life style
- **Stay Safe:** protected from harm, neglect, bullying, serious accidental injury and crime
- **Enjoy and Achieve:** academically and socially, through play, leisure and recreation, as well as within school
- **Make a Positive Contribution:** to the community and society, developing self-confidence and being engaged in decision making
- **Achieve Economic Wellbeing:** taking up employment, training or further education opportunities

There are approximately 120,000 children and young people in Sheffield between the ages of 0-19. Of these, about 35,000 require some form of additional support. 10% of these children are classified as 'children in need', and will require some form of direct support and intervention to secure their well-being. About 650 children are 'looked after' by the city, and a further 400 will be on the child protection register.

Description of Current Service

The NSF and ECM has provided the impetus to provide services in a way that seeks to see the whole needs of children and young people across health, education and social care and trying to improve well being rather than just health status. For example educational attainment has strong correlation with health in later years and therefore services in this age group needs to focus on prevention to prevent ill health and poor well being in later life.

Children and Young People Health Services cover the breadth of health need from universal services such as health visiting and midwifery to services for those with complex health needs in terms of disability or severe enduring mental health problems.

Description of Current Position

Acute and Specialised Hospital, A&E and Mental Health Services, up to the age of 16, are commissioned in the main from Sheffield Children's NHS Foundation Trust (SC(NHS)FT). Specialised services at SC(NHS)FT include Tier 4 Mental Health Services, Neonatology Surgical Unit and Intensive Care Facilities.

The PCT in partnership with Children's and Young Peoples Directorate (CYPD) of Sheffield City Council provides Health Visiting and School Nursing. There are also jointly funded arrangements for the Safeguarding, Youth Offending Team, the Support Team for Looked After and Adopted Children and children placed out of city in specialist schools and homes. There are several joint strategy groups focusing on individual areas such as Child and Adolescent Mental Health, Looked after Children, Parenting, Early Years, Safeguarding and Disabilities.

Sheffield has adopted a model of local commissioning and management based on seven Service Districts (SDs) – through these services will be delivered and developed with local engagement to bring together health, social services and education services.

There is a Joint Safeguarding Board that over sees the policy and implementation of Safeguarding across Sheffield.

The Children and Young People's Plan (CYPP) 2006-2009 and the annual refresh sets out the joint planning for services and provides a more detailed set of plans to take forward this agenda

Scope for Improvement

Children who are overweight tend to grow into adults who are overweight and they therefore have a higher risk of developing serious health problems both as children and in later life. Obesity is associated with many health problems including coronary heart disease, stroke, type 2 diabetes, kidney failure, osteoarthritis, and back pain. The strong association between obesity and cancer has only recently come to light. Being overweight can also cause psychological distress. Teasing and bullying about their appearance can affect a child's confidence and self-esteem; it can lead to isolation and depression which in turn can impact on their attendance and attainment levels.

Obesity represents a significant cost to the health service, which nationally is estimated conservatively at £3.3-3.7 billion per year, and obesity and overweight combined is estimated to cost £6.6-7.4 billion a year, (Health Select Committee, 2004).

In the 2005-06 academic year the Sheffield PCT undertook the first year of the Department of Health's weighing and measuring programme of Reception year and year 6 pupils. Sheffield has slightly lower proportion of overweight children and obesity than the national average; however, within the city there are significant variations, with some schools having significantly higher than average prevalence.

The Child and Adolescent Mental Health (CAMH) Service is currently commissioned from SC(NHS)FT to provide a service up to the age of 16. After

this age Sheffield Care Trust provides a service, however, it has been recognised that there is a gap in the provision and needs to be addressed in line with the timetable set out in the NSF to provide a comprehensive CAMH Service by 2010.

The overall commissioning structure is now changing within Sheffield PCT, providing an opportunity to put in place tighter performance monitoring systems and will enable a review of what, in terms of acute and mental health care needs to be commissioned to meet the needs of the population.

Neighbourhood differences

The PCT's Public Health Prospectus has identified the geographical areas where there are inequities in access and health. This has been supplemented with the work being undertaken by CYPD for Service Districts to identify their local priorities. Work is currently underway on this and it is envisaged that the 2008/09 CYPP Refresh will include these local priorities. The projected increase in birth rates in the city will need to be considered in terms of its impact on neighbourhoods and the associated services for children along with the demand for primary and secondary health care services.

Reducing inequalities

The move to joint commissioning through Service Districts will help to reduce inequalities as it will target resources into these areas. The work is underway on those areas identified in the Public Health prospectus to target specific areas and groups to help reduce the known gap.

Engagement with users and improving the patient experience

The CYPP through the 0-19 Partnership Board commissioned a city-wide consultation with children and young people that reported in August 2006 and formed the basis of the CYPP. A Participation Strategy is being developed through the Partnership to ensure that all views of key stakeholders are incorporated in to the re-refresh of the CYPP.

The PCT will build on this strategy to ensure its own strategy is in line with key stakeholders responses.

Work is on-going within SC(NHS)FT to improve the experience children and young people have when they go into hospital or are in contact with one of the services. The NSF sets out standards for services to be provided in an age appropriate setting and is part of the health care commission standards.

Priorities for next 5 years

- To implement the Teenage Pregnancy Strategy, incorporating improvements for sexual health services for children and young people
- To implement the Safeguarding Strategy, including the Domestic Abuse Strategy and put in place a clear and robust system for the PCT staff and commissioned services to identify vulnerable and at risk children and young people and take appropriate action
- To evaluate existing schemes for reduction in childhood obesity with a view to implementing the NICE Guidelines on management of Obesity
- To work closely with the CYPD to develop joint commissioning arrangements to ensure all resources are used effectively and efficiently
- To develop service specifications for main acute health care areas
- To ensure services are delivered in an age appropriate setting
- To develop a clear transition pathway for individual groups of young people
- To implement the CAMHS Strategy, including implementing a Comprehensive CAMHS
- To develop in partnership a strategy for meeting the needs of children and young people with complex needs

LEARNING DISABILITIES

Aim of service

We work to improve the health and well-being of people with learning disabilities, provide specialist health provision that meets the needs of people with learning disabilities and to promote better access and take-up of mainstream health provision and ensure that it is sensitive and responsive to the specific needs of people with learning disabilities. Over-riding all this is the on-going priority to ensure that all our services are of good quality and that all possible measures are in place to ensure protection from abuse or neglect for some of the most vulnerable people in our society.

Description of current service

The PCT has a joint strategic responsibility with Sheffield City Council to ensure the availability of full range of quality health and social care services and opportunities for social inclusion and participation.

Specialist services are commissioned from Sheffield Care Trust including: multi-disciplinary teams of specialist clinicians providing health support services to people with profound and multiple learning disabilities, and their carers; support to primary care services; specialist challenging behaviour and mental health services; respite care services and assessment and treatment services, and the Sheffield Case Register. These services are under the management of the Head of Joint Learning Disability Services in a partnership agreement with Sheffield City Council and a process of further integration of specialist health care and social care services is underway.

Accommodation services for about 300 people with long-term care needs are “legacy” funded by the PCT and commissioned through a partnership arrangement involving three commissioning partners plus other income streams. The Lead Commissioning responsibility rests with the City Council. The model of care and the building stock in which much of this is provided is increasingly proving unfit for purpose and requires complete overhaul. The cost of provision continues to rise faster than available resources. A programme of comprehensive strategic reviews of all these services is underway which requires close PCT involvement in developing measures to address current and future problems.

We seek to ensure continuing health and social care and associated care management responsibilities for people with profound and multiple needs, their families and carers. The PCT has a significant investment in wholly and partially funded continuing care placements and on-going responsibility for assessment and monitoring of services to ensure that they are appropriate to need. This is discharged through joint working with the City Council and other partners working in this field.

Description of current position

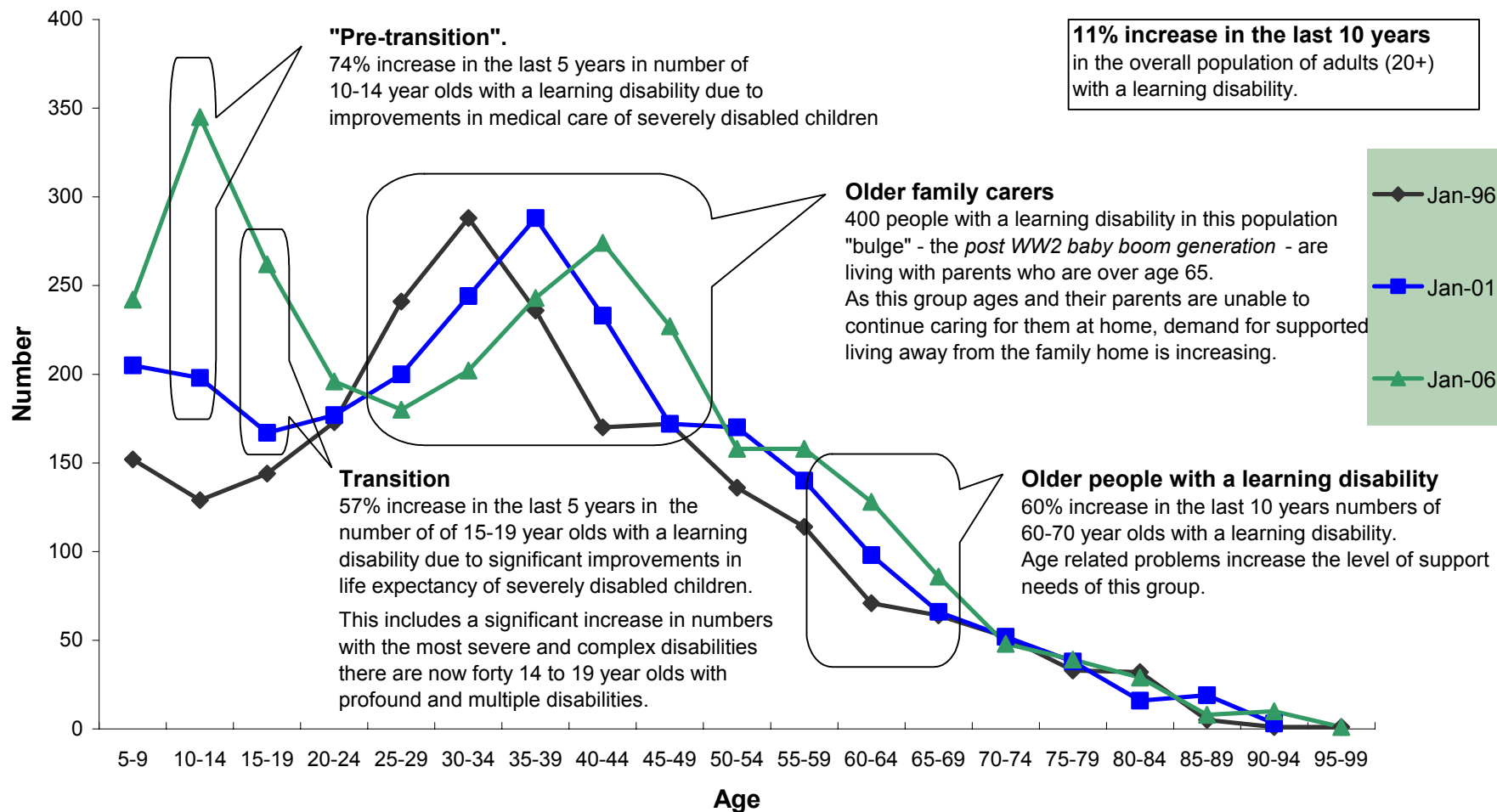
Through a Learning Disability Partnership Board, a great deal of work has gone into improving and modernising service provision to meet the needs and aspirations of people with learning disabilities and their carers across health, social care, housing, social inclusion, day opportunities and employment. Much has been achieved. The Improving Health Group has steered quality initiatives to improve the experience of people admitted to acute care and their families. Health Action Plans are in place to improve access to primary care and prevention services.

The Older Families Project – a small investment from the Learning Disability Development Fund in voluntary sector provision to support older carers (many in their 70s and 80s) to plan for the future. Investing a relatively small sum has brought enormous benefit and peace of mind to older carers by ensuring that their sons and daughters will receive the care they need when the parent dies or is unable to provide care any longer. It is also improving the efficiency of outcomes through long term planning.

Scope for improvement

The number of children and young people with profound and multiple disabilities approaching the adult service will present a very significant challenge to the capacity of services in Sheffield, as will those with severe autism and a dual diagnosis of mental disorder and learning disability. This will have significant issues for primary and acute health services as well as specialist services in the next few years. The position is shown in Figure 14.

Figure 14.
The changing profile of people with a learning disability in Sheffield (1996 to 2006)



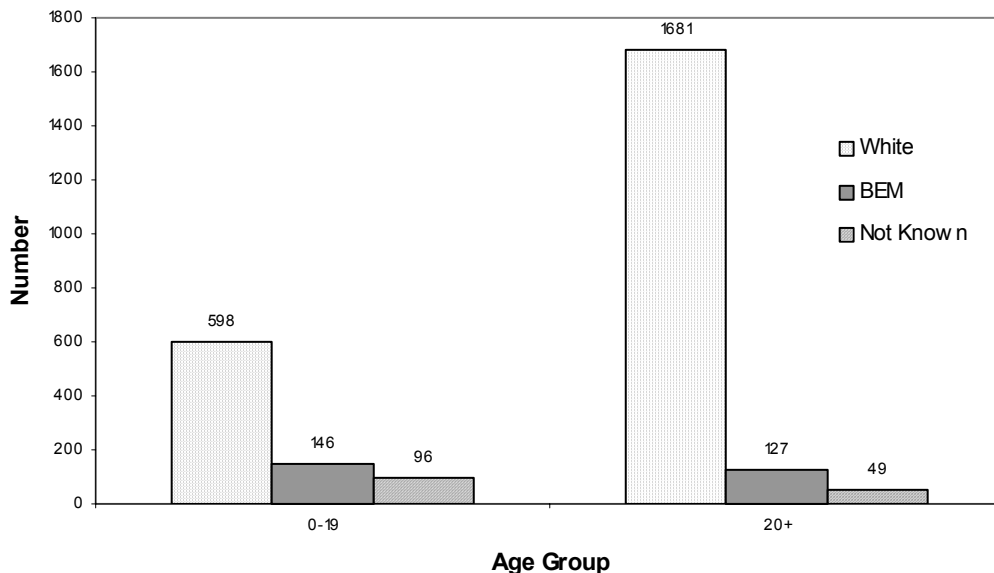
We already have a significant number of people placed in care homes outside the city because of lack of provision of the specialist care in Sheffield. A programme of work is in place to address this issue. 65 people have been identified who could move back to Sheffield if services were available to support them and a pilot project is underway to facilitate 10 returners in the next 2 years and put in place the infrastructure to deliver a continued reduction in numbers placed out of city.

The Sheffield Case Register of children and adults with learning disabilities is probably the most comprehensive in the country and we have access to accurate, comprehensive data to build a picture of future need and demand. We need to plan, adapt and respond to ensure that we have a range of good quality, accessible services to meet the needs of the next generation. We need to address the issue of providing culturally appropriate services to BME Communities and we know that the proportion of children with disabilities from the BME communities is roughly double that of the adult LD population. The position is shown in Tables 8 and 9.

Comparison of the ethnic profile of the Sheffield population of people with a learning disability – children (0-19) and adults (20+).

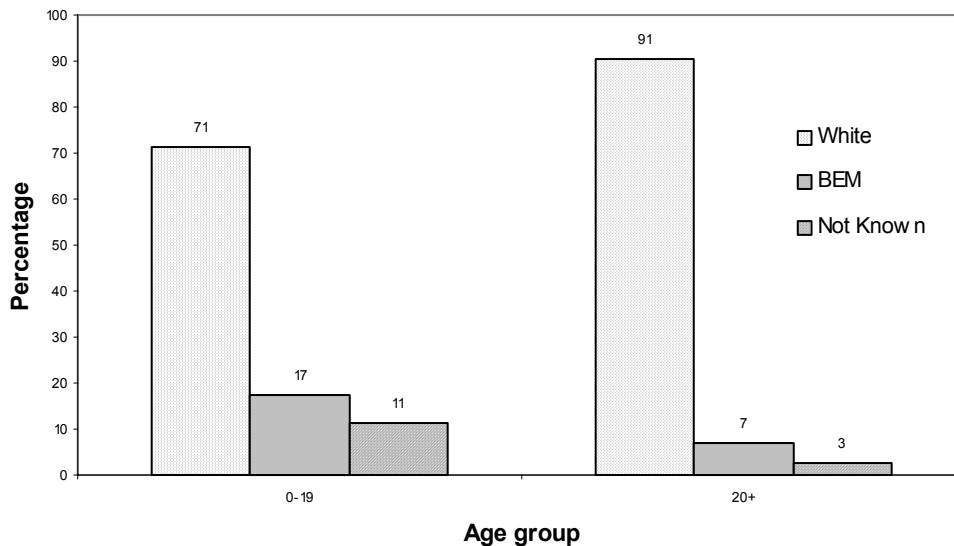
Numbers

Numbers of children (0-19) and adults (20+) with a learning disability from black and minority ethnic communities (Sheffield Case Register, 2006)



Percentages

Percentage of children (0-19) and adults (20+) with a learning disability from black and minority ethnic communities (Sheffield Case Register, 2006)



Note: higher numbers for children where ethnicity is 'not known' reflects

difficulties gathering reliable information in younger/per school age groups.

We have a range of measures in place to ensure the quality and safety of the services we commission but recent high profile cases in other parts of the country have indicated the need to strive continuously for improvement in this area. As commissioners, we need to maintain constant vigilance to ensure that our service users are protected from abuse, neglect or discrimination and enjoy a varied and fulfilled life.

We know that people with learning disabilities suffer health inequalities and inequalities of access to mainstream and specialist health care provision and health protection compared with the general population. Much has been done to address this but further work will be needed to ensure that we can achieve better health outcomes.

The Quality and Outcomes Framework of the GP Contract asks each practice to develop a register of their patients with learning disabilities. We need to work with GPs to use this data to develop a more systematic approach to ensuring that people with learning disabilities get appropriate access to healthcare.

Neighbourhood Differences

The Sheffield Case Register describes the numbers of children and adults with learning disabilities by ward. There are 822 children on the register with a range between five and 56 at ward level with the lowest incidence in Broomhill and Fulwood and the greatest incidence in Brightside, Firth Park and Burngreave. There are 1998 adults on the register in a range from 15 to 204 at ward level with the lowest incidence in Fulwood and Ecclesall and the greatest incidence in Firth Park, Manor Castle, Arbourthorne and Burngreave.

Reducing Health Inequalities

A Health Equity Audit took place last year in Sheffield and this indicated that people with learning disabilities are in general experiencing poorer health and lower access to health prevention, screening and services than the general population. A programme of work has now been developed to address these issues through the Improving Health Group which forms part of the city's Learning Disabilities Partnership Board.

Engagement with service users and improving the patient experience

The Learning Disabilities Partnership Board has developed over the years and now has strong representation with Service Users and Carers via self-advocacy networks and the Learning Disability Parliament. Networks are in place to ensure that user and carer representatives are able to consult with and represent their "constituencies". User and carer representatives sit on project groups for all the key project work streams. We constantly seek ways to build on and improve the effectiveness of our consultation and partnership mechanisms. There is a further significant challenge for the services to ensure that users and carers have a stronger voice in higher-level city-wide partnerships in order to take forward the Inclusion agenda.

Priorities for the next five years

The priorities for joint strategic commissioning are as follows:-

- To produce a joint strategic needs analysis to produce accurate data projecting need and demand and to address financial issues over the next 10 years.
- to achieve a sustainable balance between resources, capacity and available funding, in existing service provision and in provision for future need and demand.
- To develop new commissioning approaches to provide for the needs of those with the most profound and multiple disabilities, using practice-based commissioning and health care procurement
- To promote inclusion and access to mainstream services

- To develop local solutions to provide for specific needs so that Sheffield is self-sufficient in provision, skills and resources and help people to return to the city
- To improve the experience of transition for individuals and families from children's to adult services
- To address existing health inequalities, improve the patient experience and improve health outcomes for people with learning disabilities.

MENTAL HEALTH

Aim of Service

The PCT as a commissioner needs to ensure support for both the large numbers of people dealing with common mental health problems and the smaller numbers with severe and complex mental illness. In terms of common mental health problems, it aims to promote early intervention and evidence-based treatment in accessible settings in order to prevent problems worsening and reduce dependence on specialist mental health services. In terms of severe and complex illness, it aims to ensure effective intervention to assist people to recover and participate in community living. The PCT works with Sheffield Care Trust, Sheffield City Council, voluntary sector organisations and other partners to achieve these aims. Many people receive support from family and other informal carers, and this is recognised.

Description of current service

For people with common mental health problems, formal service provision is mainly through GPs, counselling services and the small mental health teams that the former PCTs developed. Voluntary sector services also have a significant role, particularly in providing longer-term psychological therapy and a “safety net” for people who do not engage with specialist services, day services and schemes to help people to remain in or return to employment.

People with severe and complex mental health problems are cared for through secondary and tertiary mental health services, though some GPs have historically taken responsibility for this area of care and all GPs are encouraged under their new contract to monitor the physical and mental health of people with severe mental illness. Specialist mental health services are integrated with social care provision and co-coordinated through the Care Programme Approach. Services are provided through four sectors corresponding to the former PCT areas, with separate provision for older adults and younger people, and include community mental health teams, day services, out-patient clinics and in-patient beds. Following the publication of the Mental Health National Service Framework, there have been major developments in specialist community teams, including the establishment of four sector-based teams providing early intervention for young people experiencing a first episode of psychosis, North and South crisis resolution/ home treatment teams to support people at home during acute crises and avoid hospital admissions, and North and South assertive outreach teams for people who are hard to engage.

A liaison psychiatry service provides support for people with mental health problems within general hospital services, and this service has been developed in 2007/08 through a partnership between Sheffield Care Trust and Sheffield Teaching Hospitals Foundation Trust.

Sheffield also has specialist services for people who need care in conditions of security, eating disorders and maternal mental health problems, though services provided locally are limited and people sometimes have to use services out of town.

Description of current position

Applying rates of mental illness from an Office of National Statistics (ONS) study to the population aged 16 to 74, suggests that there are over 61,000 people experiencing a neurotic disorder in Sheffield, including 33,000 with mixed anxiety and depression, 16,500 with anxiety, 9,600 experiencing a depressive episode and at least 4,100 with an obsessive compulsive disorder. In addition, there are approximately 1,900 with psychosis and 16,500 with a personality disorder.

There is a large unmet need in primary care: the ONS study suggests that only 24% of those with a neurotic disorder receive any treatment, with 20% receiving medication and only 9% counseling or therapy. This is in spite of the fact that approximately one in four patients in primary care attends with a mental health problem.

Sheffield has a large and growing student population and in recent years there has been concern nationally about services for students with mental health problems. In addition to a good support service there is a need for a better framework that links together the universities and colleges with health, social care and the voluntary sector. We will work with our academic partners to improve this framework.

Secondary and tertiary services also have demand pressures in some areas. There are approximately 1,400 people on the Enhanced Care Programme Approach, against an expected figure of nearer 2,000, with some people with severe mental illness being managed only in primary care. At the same time, some people in secondary care whose illness is severe but not necessarily complex could beneficially be managed in primary care instead.

There is a mixed picture with regard to the achievement of national targets for secondary care, with the assertive outreach service having reached its workload target but shortfalls in crisis resolution/ home treatment and early intervention activity, in the latter case because of delayed investment. There is an issue of whether older people have appropriate access to these sorts of new services.

Scope for improvement

There is scope to improve the management of mental health problems in primary care, with the potential to improve access for patients, offer earlier intervention, reduce waiting times, reduce the stigma associated with receiving mental health services, improve access to voluntary sector and other appropriate services, support GPs in their care of people with mental health problems, improve

communications between GPs and specialist mental health service staff and meet NICE guidelines regarding the development of “stepped care”. It is not yet fully proven; however, that improving access to help with mental health problems in primary care can reduce referrals to secondary care as well as reducing unmet need. There is increasing evidence that improving access to psychological therapy services can reduce worklessness and the associated mental health problems. The “Achieving Balanced Health” consultation confirmed that people want better access to services in the community.

Neighbourhood Differences

It is known that there is a strong link between levels of deprivation and levels of mental illness. The second SHAIPS survey in 2000 showed a variation in levels of “definite depression” from 17 per 1,000 population in Ecclesall to 122 per 1,000 in Manor. However, these differences are not always reflected in use of mental health services: SHAIPS showed, for instance, that levels of “use of a mental health worker” do not vary as significantly. Black and ethnic minority communities have varying experiences of mental health services, with, for example, black and black British people being up to two times more likely to be admitted as in-patients and up to five times more likely to be compulsorily admitted. Sheffield has not, to date, been able to invest to achieve its share of the national target for the recruitment of black and ethnic minority “community development workers”.

Reducing Health Inequalities

The primary care mental health service will be organised so as to reflect variations in levels of mental illness. The community development workers will focus on ensuring appropriate access to services for black and ethnic minority groups. The emphasis on supporting people into education, work and training will help to address poverty amongst people with severe mental health problems and the knock-on effects on health.

Engagement with users and improving the patient experience

The PCT is committed to refreshing the partnership arrangements for mental health, including to ensure the involvement of voluntary sector organisations, service users and carers, and staff. Wider involvement will be promoted by direct contacts with users and carers groups, continuing support for Your Voice magazine and involvement in World Mental Health Day.

The PCT will improve the patient experience by improving information on services, making services easier to access in the community, improving the availability of psychological therapy, promoting social inclusion and mental health promotion.

Priorities for the next five years

The PCT is committed to working with all of its partners to develop a more detailed strategy for mental health and a process for this will be considered by the Mental Health Partnership Board. The PCT will ensure that clear links are made to strategies for children and young people and older people.

The PCT is taking forward the outcomes of its recent consultation on a proposed re-configuration of mental health services, involving a further shift from hospital to community-based provision, before the “Achieving Balanced Health” consultation. It is currently working with other agencies to develop detailed plans and to pilot the changes. A key element of the changes is the establishment of an integrated primary care mental health service. Objectives of the shift of focus to primary care will be the development of a more holistic approach to mental health, including looking at mental and physical health needs together, improving the availability of psychological therapy and promoting equal access to services. Other priorities for the next five years will include improving the support for people in general health services, both people with long-term conditions being managed in primary care and people using general hospital services. There will continue to be a focus on developing effective secondary and tertiary mental health services for people who cannot make use of services in primary care. Social inclusion will be a priority, including addressing issues such as involvement in education, training and work, housing and access to healthy lifestyles.

We will make the following changes:

- Take forward the re-configuration of services, including the establishment of the integrated primary care mental health service, subject to initial trials demonstrating likely improvements.
- Develop improved services for black and ethnic minority communities, including recruiting an additional 4.8 whole time equivalent community development workers.
- Develop a strategy to support people with mental health problems in Sheffield Teaching Hospitals Foundation Trust.
- Provide additional funding to recruit additional staff to and complete the development of the early intervention teams, enabling this service to achieve its workload target of 270 young people.
- Review the crisis resolution/ home treatment service to ensure that this service achieves a workload as close as possible to the current target of 1,200 home treatment episodes.
- Modernise day services to maximise the contribution these services make to social inclusion.
- Explore the options for improving access to services for older people with functional mental illness.
- Improve specialist services where possible to avoid out of area admissions.

PRIMARY CARE

This next section describes the PCT's approach to developing the services that it funds to deliver primary care services provided by General Practitioners, dentists, optometrists and pharmacists as well as the drugs and treatments that we pay for. Primary care contributes to all of the client or disease specific areas that feature elsewhere in this strategy but there are specific issues around these services that we wanted to draw out and highlight.

COMMISSIONING PRIMARY CARE SERVICES

Primary care services are provided by a group of specialists: Dentists, General Practitioners, Dentists, Optometrists and Pharmacists supported by nursing, therapy, clinic and office staff. All of these professionals have been subject to the introduction of newly negotiated contracts as part of the NHS Plan introduced in 2000.

DENTAL SERVICES

Aim of service

The aim of the service is to provide access to high quality dental care in a timely fashion, meeting locally determined needs. Since April 2006 responsibility for General Dental Services and Unscheduled Dental Care services has passed to Department of Health to the PCT through a process of local commissioning. After a period of transition with protection for contract values for practices from 2008/09 onwards the PCT can move from contracting to commissioning for dental services, responsive to local needs and with an emphasis on prevention and a public health approach. Salaried Dental Services are directly provided by the PCT and focus on more specialised care, particularly for disadvantaged groups such as those with learning difficulties and mental health problems.

Description of current service

General Dental Services are provided through 90 practice contracts across the city together with four contracts for Specialist Orthodontic services and an internal service level agreement with the Sheffield Salaried Primary Dental Care Service. There are currently 244 dental practitioners operating from a range of practice premises, which are relatively evenly accessible across the city, as determined by a recent Health Equity Audit. Over 60% of the Sheffield population receives regular dental care and the percentage is particularly high for children at 85%. Whilst the capacity of Primary Dental Care is spread fairly evenly across the city it is not matched to the great variations in levels of dental disease across the neighbourhoods of the city.

The Out of Hours service is provided from a single centre covering the whole population of the city as well as visitors and students. It operates on weekday

evenings, weekends and bank holidays throughout the year and over 100 people per week use the service. Daytime access sessions are provided for those who do not have a regular dentist and there are also walk-in facilities at the Charles Clifford Dental Hospital. Outreach Teaching of Dental and Hygiene /Therapy students takes place at four dental practices and Salaried Dental Service clinics and this will be extended to a further three locations in the coming year. Over half of the general dental practices have Personal Dental Services (PDS) contracts as a result of pilot schemes prior to April 2006. These practices have a greater emphasis on prevention and a public health approach.

Description of current position

Levels of dental disease vary greatly across the city; with a four fold variation in children's dental health between the best and the worst wards, as measured by regular surveys in schools of five-year old children. Dental health in adults varies in a similar way and a postal survey on adult dental health is being conducted in the autumn of 2007 to enable comparisons across the city and the region as well as with national survey results. Of the 90 GDS/ PDS practices approximately 10 are accepting NHS patients at the present time. This is far from satisfactory and it is hoped that with the 2008/9 transition to full dental commissioning, incentives can be incorporated to increase access, particularly for new patients who are finding it difficult to obtain NHS care.

The Salaried Dental Service has been under review nationally and any changes will then need local implementation. Specialist orthodontic services are provided from four dental practices as well as at the Dental Hospital. Their capacity is a reasonable match to the ongoing needs of Sheffield children. However, 25% of the caseload is from outside the city which has to be maintained; the overall effect is to cause extended waiting lists (typically 18 months). However access to orthodontics is reasonably stable at present, now that we have gone through a difficult period in the implementation of the new contract, which created large waiting lists because of the numbers in treatment prior to April 2006.

Services for those with mental health problems are poorly developed at present and are mainly provided by the Salaried Dental Service. A plan for improving such services is under development.

A dental helpline is provided by PCT staff for those without urgent dental problems but wanting to find an NHS dentist. NHS Direct is contracted to provide a dedicated helpline for Sheffield residents by a dental nurse triage service for those patients requiring urgent dental care. This is fully integrated with the Out-of Hours and In-Hours services by referring patients directly to practices by fax.

Scope for improvement

Access to dental services is perceived as difficult by patients and this may be due in part to inappropriate search strategies. Greater publicity needs to be given to patients in helping them find the most effective way of locating an NHS dentist, which is the PCT helpline rather than ringing round dental practices in Yellow Pages. Revised contracts from 2008/9 onwards will include incentives for practitioners to take on new patients. Commissioning principles are being developed as part of the preparations for the agreement on a commissioning plan for dental services for 2008/09 onwards.

New contracts for PDS practices and some adjustments to GDS practices will be negotiated and agreed through 2008. The aim is to introduce them from October 2008 onwards so that dental services can be adjusted to meet local needs. The Health Equity Audit in 2005/6 demonstrated that whilst dental services are spread evenly across the city they are not matched in capacity to levels of need. Further work needs to be done to determine how best to develop services in such areas, particularly in the style of services and their access pathways rather than just replicating traditional treatment services. Improved access in areas of high need by the provision of walk-in services is one possible option.

The Unscheduled Care dental services are currently out to tender and the aim is to provide a city centre location for daytime walk-in services and the evening and weekend services so as to provide consistent availability for the whole of the city.

Neighbourhood differences

In addition to the variation in dental disease already described, dental decay levels, as measured by the dmft index, are as low as 0.8 (dmft) teeth affected, in the south west of the city, whereas the values in the north and east are 3.8 dmft; almost a five-fold difference. The percentage of older people without natural teeth has been falling nationally over the years. The most recent national survey of adults, carried out in 1998, showed that the national average to be approximately 10% whilst in the North of England it was about 15%. It is anticipated that this will drop further in the next survey to be carried out in 2008. A postal survey of adult dental health is to be conducted in 2007 and should help illustrate differences between PCTs in Yorkshire and the Humber and within the city. The Sheffield Health Equity Audit in 2005/6 assessed the use of Unscheduled Care Services and calls to NHS Direct, which came mostly from the east and north of the city indicating the mismatch of service provision and need in those areas.

Reducing Health Inequalities

The main agent for improvements will be the development and implementation of a local plan reflecting the priorities set out in the DH guidance of 2006 – “Choosing Better Oral Health” This will focus on the use of Fluoride as the most effective way of decreasing the incidence of dental decay. Short to medium term

measures may include Fluoride toothpaste, school Fluoride milk and the application of Fluoride varnish in the dental surgery. The outcome of national work on Water Fluoridation will inform any decision about future local implementation.

Engagement with users and improving the patient experience

Specific work has been done at Jordanthorpe to gain patient views on how the new dental service should operate and this model will be applied as the opportunities arise.

National Smile Month held in May each year usually includes members of the dental staff of the PCT manning information points in shopping centres or pharmacies.

Briefing events for dental practice teams have been held during the first implementation phase of the new contract. Further events, such as one planned for January 2008, will be organised to make sure practices are fully informed about commissioning intentions and the requirements of the new contracts, including clinical governance arrangements.

Current work on a patient and public involvement strategy for dental services will be incorporated into the new PCT strategy, overseen by the joint LDC/PCT Dental Quality Improvement Group. Patient feedback on practices is already a requirement of the dental contract clinical governance framework but new approaches are being discussed for the coming year, better tailored to the practice setting.

The Dental Capital programme is awarding grants for practice improvements such as patient facilities and safety. Some of the £900,000 available over 2006/7 and 2007/8 is being used specifically for new dental practices at Deepcar and Jordanthorpe to improve access.

Priorities for the next five years

The main aim is to move from the three year transition period for the new dental contract into local commissioning, more sensitive to local needs, aimed at improving access for patients with high levels of need and with a full range of appropriate treatment for routine care.

Commissioning principles will be developed in autumn 2007 in collaboration with the Local Dental Committee (LDC) and the results incorporated into a Commissioning Plan setting out the priorities for the city. The plan will be the basis of renewing or renegotiating dental contracts in the latter part of 2008, in anticipation of the end of the 3 year transition in March 2009.

The key objectives of the Commissioning Plan will address the following issues

- Improving access, particular for new patients and high need areas, such as the LIFT dental developments at Deepcar and Jordanthorpe
- Commissioning for prevention and a public health approach, as well as treatment activity
- Involving the public and patients in the development of services
- Involving all primary dental care services in a new Oral Health strategy which will include a revised strategy for realising the benefits of Fluoride in decay prevention.
- Involving the dental team in wider public health roles such as smoking cessation
- Building the dental workforce through outreach teaching in primary dental care
- Modernising the Salaried Primary Dental Care Service including the development of a dental Strategy for those with Mental Health problems.
- Reviewing and streamlining patient care pathways for specialised dental care and re-defining the balance of secondary and primary care provision

GENERAL MEDICAL SERVICES

Aim of service

To ensure that the services provided by General Medical Services and Primary Medical Services providers – GPs and their practice staff - meet the requirements within the national GP contract and associated regulations. This includes having quality provision of core services, and to secure appropriate coverage of a range of enhanced services which are designed to either ensure maximum uptake of a service across the city, for example childhood vaccinations. The Quality and Outcomes Framework (QOF) element of the contract is a means by which planned improvements in quality can be identified. We are also working to establish ways in which new services can be delivered in a primary care setting such as the. Monitoring of certain drugs currently done through a hospital attendance.

Description of current service

There are 94 general practices in the city and currently three types of contract used: General Medical Services (GMS), Personal Medical Services (PMS) and PCT Medical Services (PCTMS). The QOF has seen approx £45m paid to GMS/PMS contractors over four years. The QOF is applied to both GMS and PMS contracts, and PCTMS practices are also presently invited to participate in the scheme

There is emerging interest from GPs, through the PBC consortia, in looking alternative contracting routes, such as Social Enterprise. Third party providers have made tentative enquiries, and could provide primary care services through an Alternative Personal Medical Services (APMS) contract. In response to the introduction of new national Quality and Outcomes standards the PCT would determine the criteria that reflect the way these services would work locally, and which, if achieved by practices, provide assurance that services being delivered are of good quality.

Description of current position

The national contract sets out parameters for services including core hours of 8.00am – 6.30pm, Monday to Friday; the option to engagement in schemes to improve access to services through a Direct Enhanced Service (DES), the assessment of the quality of service in key clinical and organisational areas through the QOF and a definition of essential services funded under the core contract. Currently, the National Directed Enhanced Services consists of:

- a Towards Practice Based Commissioning Scheme;
- an Improved Access Scheme;
- an Information Management and Technology Scheme;

- a Choice and Booking Scheme;
- a Childhood Immunisation Scheme;
- an Influenza and Pneumococcal Immunisation Scheme;
- a Minor Surgery Scheme.

These are commissioned across the majority of practices in the city. These are provided in the majority of our practices to varying degrees and level of outcomes. The DES for providing a 'violent patients scheme' is commissioned from 1 practice within Sheffield. A range of locally enhanced services, designed in response to local needs, are commissioned from those practices meeting the service specification that wish to provide the service to their own patients. These are not provided in every practice, which results in some patients having to attend hospital to receive treatment or monitoring where this could be provided in primary care.

A single QOF programme was negotiated with Sheffield's Local Medical Committee for 2006/07 onwards which has established a set of criteria and benchmark standards across the city. QOF assessments undertaken in 2006/07, and proposed for 2007/08, focus on organisational indicators as well as local priorities including smoking cessation, child protection, cytology screening, summarising of clinical records, medication reviews, identification and referral of carers. GP contractors will be assessed in line with the same benchmark standards during 2007/08.

Scope for improvement

We will build on the work already undertaken between Primary Care, Public Health, Medicines Management and Dietetics colleagues in relation to smoking cessation and obesity with the view to having more assessment of contractors focussed on clinical domains. Achievement scores from QOF will be used to identify areas of underperformance, and can be used to inform the PCT's screening process, enabling targeting of support for action planning.

We can do more to make QOF an integral part of the work of the PCT as part of our work to secure changes to services and improvements in quality. New contract models are emerging which could offer further diversity in the way services are provided, and alternatives to patients visiting their doctor. Such contracts would offer opportunity to embed QOF standards into core contracts whereas they are voluntary or aspirational for GMS/PMS contractors.

We will reward efficient and cost effective providers with greater autonomy and the ability to compete where tendering for services takes place. Underperforming providers will be signposted to the support necessary to enable improvement.

As Practice Based Commissioning develops we will employ a process of tendering against a service specification and criteria that not only describes the service but also requires the contractor to meet access targets in relation to core

services, and achieve a range of quality indicators. We will aim to reinforce the obligation on the contractor to provide all services - not just those that receive enhanced payments - to a high standard, and in a manner that meets patient needs.

The information made available to consortia can be improved to make it more accessible and to help with planning and monitoring changes to services.

Neighbourhood differences and reducing inequalities

There are no differences to contracts across neighbourhoods or consortia as to date these are national contracts and PMS local contracts in Sheffield have mirrored GMS. QOF equally is not affected by neighbourhoods. Practices with high ethnicity and/or turnover do find it difficult to achieve in some clinical areas however this has not proved a uniform problem as some do achieve higher scores than practices with low turnover. Language barriers and the requirement for interpreters can impact on appointment availability, with the need to tie in to availability of interpreters.

We will address health inequalities in part through encouraging diversity of providers and contracting routes, in strengthening our response to underperformance or under-responsiveness to statutory and mandatory requirements and reinforcing contract requirements to work toward National Service Frameworks as part of growth objectives.

We will develop and use access indicators and QOF outcomes as prompts to review primary care provision, linking with PBC consortia plans as means of providing contractors with incentives to improve quality and improve outcomes. We will review practice performance including where there variances from national benchmarks. We are reviewing the information on the level of patients excluded from some clinical standards and the reasons why. This will enable appropriate targeting of practices to ensure that all registered patients are being provided with the appropriate and equitable level of care.

The formulation of a single performance monitoring framework that begins to plot areas of underperformance or under delivery (both soft and hard information) against what the PCT, national benchmarks or prevailing good practice consider unacceptable will provide foundation on which to develop systems and processes that strengthen our response in this area.

We will work with PBC consortia to actively promote improvements in access and quality to all services provided by individual practices as an element of the commissioning of enhanced services.

Engagement with users and improving the patient experience

Funding for a significant element of Primary care contracts is now predicated on positive patient experience and the ability for patients to access services in a timely manner. Our aim is to ensure that patient views are not merely collected and then subjected to a reasoned argument as to why contractors are unable to meet patient expectations. Patient & Public Involvement/Patient Advice & Liaison colleagues, and Patient Forum representatives, will be invited to participate in the PCT's review of Practice Action Plans in response to local and national patient surveys. Their views will influence the PCT's response and recommendations. In addition to these groups we will work to involve individual service users more in advising us on these services.

Robust scrutiny of GP action plans produced in response to local and national patient experience survey, and indeed some additional independent surveys undertaken by GP providers themselves. Ensuring that clear actions with expected outcomes are then followed through (via ongoing liaison between practice and PCT) which address the specific areas of concern identified by these surveys.

Service level agreements for enhanced services require providers to undertake audit or evaluation of service and outcomes. Through scrutiny of outcomes the patient experience will be reflected in future commissioning decisions.

Priorities for next five years

- Access to General medical services in a primary care setting across full core hours period where this meets patient need.
- Extended availability of core and enhanced general medical services through GP practices and other non traditional points of access, moving to Alternative Personal Medical Services contracts to secure services in areas of under-delivery.
- Primary care provision in areas of high ethnicity front ended by staff able to communicate in predominant languages. Improvements in overall standard of information and availability in appropriate languages.
- Quality assurance of core and enhanced services obtained through various quality improvement schemes and monitoring arrangements to be embedded into a single PCT performance framework - ensuring that our response to clinical or contractual underperformance is strengthened.

OPTOMETRY SERVICES

Aim of service

Sheffield PCT is working with optometrist practices and with their representative body the Local Optical Committee (LOC), to develop more services that can be accessed through Community Optometrists and to ensure good eye health for the wider population. City wide schemes are in operation to provide equitable access for patients suffering from three common eye conditions

Description of current service

Optometrists examine the eyes to detect defects in vision, signs of injury, ocular diseases or abnormality and problems with general health. Optometrists make a diagnosis, offer advice and when necessary prescribe, fit and supply contact lenses or glasses or make a referral for specialist advice when required. Principle areas of specialist intervention are for cataracts, glaucoma and diabetic retinopathy.

Description of current position

Cataracts are primarily a disease of the elderly, where a simple operation can radically improve a person's quality of life. A successful initiative developed by the NHS in Sheffield has been the introduction of direct referrals from optometrists to surgeons for patients who need cataract operations. This has worked well as a partnership between patients, optometrists, the PCT and the Sheffield Teaching Hospitals Foundation Trust (STHFT). All Community Optometrists participate in the scheme and provide both an initial assessment of the patient and post operative care. In the financial year 2006/07 4192 patients were assessed of whom 900 were referred for cataract surgery.

Community Optometrists offer the patient a choice of trusts for their surgery. A survey conducted over two years has shown that 98% of patients opt to go to Sheffield Teaching Hospitals Foundation Trust, 1% go to Chesterfield Royal Hospital and the remaining 1% go to Rotherham DGH or privately.

Community Optometrists can refer directly to the Glaucoma Unit at STHFT. A review of referrals indicated that the number of "false positives" was 60%. A Glaucoma Referral Refinement Scheme was piloted and then in February 2007 was extended throughout the city with 22 practices currently involved in the scheme. By August 2007 the numbers of referrals from the participating practices to the Glaucoma Unit had reduced to 34%.

The number of patients with diabetes is increasing and the current estimate in Sheffield is that there are 21,000 known diabetics but with many more yet to be diagnosed. Annual screening can prevent patients developing a sight threatening disease. Sheffield has run a community based diabetic eye

screening scheme for 10 years and it is the biggest in England. This is now supported by the use of 22 digital cameras allocated across the city. These have been used since November 2005 and the Community Optometrists use them to take a photograph of the patient's eyes. The discs are sent to the Diabetic Eye Screening Programme (DESP) where specially trained graders assess the images with access to a Consultant where necessary. The scheme has been 'live' since November 2005. In the last full year 13,408 patients were screened. The success of the scheme has enabled 3,000 patients to be discharged from hospital to community care.

Scope for improvement

The PCT is working with Community Optometrists and the School Nursing Service to assess the viability of a pilot scheme to screen children when they enter school. Children identified by the School Nurse as needing further investigation would be given a letter requesting the parents to take their child to a Community Optometrist for a further check. The Community Optometrist would then refer on to the Children's Hospital if necessary but otherwise treat the child at the practice.

A joint planning group for ophthalmology that brought together Optometrists and Ophthalmologists was established by the previous four PCTs. The new PCT will look to restart this group as a forum for bringing together community and hospital colleagues to help with service developments. Members of the LOC are currently working with the PBC consortia to discussing further options for handling referrals. Two PBC consortia are putting together business cases to pilot a new approach to referrals working with interested Community Optometrists.

Neighbourhood differences

There is variation in the take up of the Glaucoma Referral Scheme and the use of diabetic retinopathy and areas where coverage could be improved have been identified and the PCT will be working with practices in those areas.

Reducing health inequalities

Glaucoma has a higher prevalence amongst Afro-Caribbean residents of the city. Scope exists to improve links with those GP practices that have a high percentage of Afro-Caribbean patients and with community groups to raise awareness of the disease. The PCT is working with the Chinese community, for example by attending the community's twice yearly health days with open access to a Community Optometrist with a digital camera.

Engagement

The PCT is establishing links with services for people with learning disabilities and took part in the recent *Looking After Yourself* day. We hold awareness

events within the city on diabetic retinopathy. Scope for further engagement with the public is being explored as part of the PCT's wider approach.

Priorities for the next five years

For cataracts services future plans include: improving audit of the service, working with the LOC and STHFT to improve the direct referral scheme and working with neighbouring PCTs to improve access between areas. We will be working with Community Optometrists in areas where Glaucoma and Diabetic Retinopathy coverage could be improved to encourage more practices to raise awareness of our programmes and with GP practices in areas with a high referral to the Glaucoma Unit to examine the issues for this. In areas of poor take up for diabetic retinopathy screening we will work with GPs and community workers to increase take up.

COMMUNITY PHARMACY

Aim of service

The community pharmacy service, delivered via a network of 113 community pharmacies is responsible primarily for dispensing prescriptions generated by GPs, Dentists, Hospital Doctors and Non-Medical Prescribers. In Sheffield, as elsewhere the majority of these pharmacies belong to chains.

In addition to dispensing the service also has a key role in improving public health, promoting self-care and providing support for patients with long-term conditions. The clinical resource represented by community pharmacy is becoming increasingly recognized and this has led to an expansion of the role via advanced and enhanced services.

Description of current service

Sheffield PCT has placed an emphasis on commissioning high quality services from pharmacies, which are convenient for patients and represent good value for the NHS. We will build on this approach and seek to utilize fully pharmacies as an NHS resource. The service is regulated through the Community Pharmacy Contractual Framework (CPCF) which encompasses three categories of service:

Essential Services – which all pharmacies must deliver (includes dispensing, repeat dispensing, signposting, health promotion and clinical governance)

Advanced Services – which are optional and require accreditation (medicines use review)

Enhanced Services – This may be commissioned by PCTs in accordance with local needs.

Description of current position

Sheffield's Community Pharmacy Development Unit has developed services that have been taken up across the country; these include service for dealing with minor ailments, for the provision of emergency hormonal contraception, for smoking cessation and for dyspepsia management and monitored methadone and needle exchange services. Within Sheffield take-up of these services by pharmacies has facilitated patient access – currently services are available from Sheffield pharmacies as shown below:

SERVICE	PHARMACIES
Minor Ailments	101
Smoking Cessation	68
EHC	83
Dyspepsia	40

Scope for improvement

There is considerable scope for further work to maximise the benefits of the CPCF. These include extension of the range of services available from pharmacies and increasing the number of pharmacies offering enhanced services. These accords with the results of the Achieving Balanced Health consultation, which indicated that the public in Sheffield would like to access more services through pharmacies.

Neighbourhood differences

The 113 community pharmacies in the city are in almost all cases located either close to a GP practice, or within retail centres such as Meadowhall and Crystal Peaks. There are currently no neighbourhoods in Sheffield that do not have adequate pharmacy services.

Reducing health inequalities

By developing the clinical resource represented by community pharmacy we will be able to provide access to services for patients who are not well served by other primary health care services. Such groups include those who are not registered with GPs and those who require access to services in the evenings and at weekends.

Engagement with users and improving the patient experience

Community pharmacy engages closely with its service users as they are customers for the products and services it delivers, in addition the public at large are potential customers and so are kept informed of what is available. Community pharmacy in Sheffield engages with other parts of the health

economy via the Local Pharmaceutical Committee and Medicines Management Team of the PCT.

The ABH consultation has shown that patients are receptive to having more services provided in pharmacies. In addition service users of pharmacy services find that the lack of barriers and the informal settings, together with the extended opening hours, extremely useful. Patients also consider privacy to be very important when accessing services and since the introduction of the pharmacy contractual framework in 2005 the number of pharmacies that can offer a private consultation area has increased; currently 86 pharmacies now have one (76%).

Priorities for the next five years

The priority for the next five years is to maximise the benefits available from the pharmacy contractual framework. Currently the PCT is supporting pharmacies to deliver Essential Services to a high standard. In the immediate future and 2008/9 the focus will be on the delivery of Advanced Services – with all pharmacies able to offer Medicines Use Reviews for their patients. At the same time, and continuing over the remainder of the next five years we will look to pharmacies to commission, where appropriate, a wider range of Enhanced Services

IMPROVING ACCESS

Description of current service

Currently, GP contractors receive payments through two routes that support and reward the improvement of access to services for patients. Through the Quality and Outcomes Framework (QOF) an average £125 per QOF point depending on list size is available to practices that undertake a patient survey, analyse the results, and produce an action plan for improvements.

Furthermore GP contractors are able to secure additional funding via the Access Directed Enhanced Service (currently £1.1m - or 94p per patient registered - set aside), for meeting targets on clinical availability and telephone access. Up to two-thirds of the value of this DES is paid out based on the results of the national patient survey.

Description of current position

The Access DES pays practices for providing quarterly reports. Currently we set aside approximately £1.1m in Sheffield to pay for this 'enhanced service'. All GP practices report that they meet targets for patients seeing their GP or booking an appointment. All but one practice in the city undertook local patient surveys in 2006/07 as part of the Access DES.

Five indicators have been developed against which the PCT measures patient satisfaction with access:

- Access to surgery by phone (82% satisfaction in Sheffield)
- Access to an appointment within 48 hours (81% satisfaction)
- Ability to book an appointment in advance (75%)
- Able to see a specific GP (88%)
- Opening hours are accessible (84%)

This position puts Sheffield just below the national average on phone access by 4% and on 48 hour access by 5%. We match the national average on the other three indicators.

Scope for improvement

Although from the national patient survey 80% of respondents say they are content with access we know that from the results of the local QOF patient surveys, the *Achieving Balanced* Health consultation and also from complaints patients report that they remain unhappy with access, particularly in relation to pre-booking appointments

Messages in the consultation included concerns about surgery opening hours, getting appointments in the working day and at evenings and weekends. This

was contributing to people going to A&E departments when surgeries were closed or delays encountered. Possible barriers on the basis of language or culture were also seen as were concerns about services being sensitive to the needs of local communities.

In addition to the consultation, and reflecting the concerns raised, the PCT has carried out a review of *Improving access and responsiveness in primary care*. Issues identified including a need to review opening hours of GP contractors and incentivising them to extended opening hours and increase clinical availability within core hours.

The rules governing the payments made to GPs for improving access could also be published widely by the PCT so that patients understand them better. An innovation we are considering introducing is a 'Mystery shopper' type exercise to validate the measures we receive from practices, especially around access within 48 hours.

Following our recent access and responsiveness review the PCT has developed an action plan with that will inform our work with practices for the rest of 2006/07 and during the five year period of the strategy. We will be reviewing with each practice the results of the national survey results, and ensure that commissioning decisions made by the PCT take the access arrangements of individual practices into account.

We will provide further training for Practice Managers in the development of contingency plans that help manage variations in demand for appointments and the availability of clinical staff.

PCT employed GPs are an option to provide more services outside of core hours and staff walk-in facilities. We would need to develop this model further either as a complementary service or a replacement for the current out-of-hours arrangements. This could provide a mix of appointments, minor injury and minor ailment clinics. Consideration would need to be given to the potential contribution of community pharmacists to these arrangements.

Neighbourhood differences

The national patient survey gives results at an individual practice level. Phone access results range from 40% to 98% and a third of our practices were below the city average of 82%. For 48 hour access performance ranges from 42% to 100% with four in ten practices below the city average of 81% and two below 50%. For advanced booking the range is from 20% to 99% with seven practices below 50%. Access to a specific GP is less variable with all results above 55% in a range to 99%. The satisfaction on opening hours ranged from 66% to 99%. There was lower than the city satisfaction on opening hours for people aged less than 35 years and for people from Asian or British Asian, Pakistani and Bangladeshi communities.

Reducing health inequalities

Recognising the information needs of patients with poor reading and language skills is an important factor in securing improvements in, and access to, primary care services. The quality of information provided by contractors is generally poor and we will look to ensure that the information available reflects requirements of Disability Discrimination Act and local population needs. Including information/communication as a heading in actions plans may help in areas of deprivation and/or high levels of ethnic minority patients. Language barriers and the requirement for interpreters impacts on appointment availability, with the need to tie in to availability of interpreters.

Engagement with users and improving the patient experience

Knowing the rules around access will empower patients to demand better access. There is scope for greater patient education here that could be facilitated by the PCT. We will take account of access arrangements in its commissioning approach with the aim of getting providers to improve the patient focus of service delivery.

Priorities for next five years

Delivery of the action plan on *Improving access and responsiveness in primary care* including:

- Achieving maximum sign up to the Access DES
- Agreeing scope for practice level plans to improve access
- Review surgery opening hours
- Prepare information and support to practices to help draw up local improvement plans
- Develop specific interventions with practice achieving below 50% on the national practice survey
- Use PCT Medical Services to expand access
- Identify barriers on the basis of language or culture and ensure action plans address issues for these
- Include access issues in service level agreements with practices

We will also look at where improvements in telephone capacity in practices could improve access.

We will continue to improve our validation of the information received from contractors in relation to access measures.

PRESCRIBING

Aim of service

The core business of the medicines management team within Sheffield PCT is to ensure that patients' benefit from clinically effective and cost efficient medicines at all times. Our specific task is to save £2.199M from the prescribing budget in 2007/08. This will be achieved through the implementation of a series of targeted interventions, which will improve prescribing efficiency, and pro-actively focus limited resources to patient need.

Description of current service

Medicines represent the most common healthcare intervention, and expenditure on medicines by prescribers is the second largest spend (after purchase of healthcare) of all expenditure by Sheffield PCT. In 2006/07 prescribing expenditure amounted to £78.9M and the budget is set at £82.5M in 2007/08 (an increase of 4.6%). Clinically effective and cost efficient medicines management is the key to making the most of this increased level of investment. This is delivered through effective relationships and clinical engagement and support between pharmacy and medicines management teams and front line prescribers, who are largely independent contractors.

Description of current position

The current position is extremely challenging. Cost pressures on NHS drugs budgets are rising as newer; more expensive treatments come on stream. This pressure has been acknowledged at the national level with the Governments announcement that it wishes to renegotiate with the pharmaceutical industry the price the NHS pays for drugs.

These pressures are being felt acutely in Sheffield, which has an excellent record in the management of the prescribing budget with the lowest per capita prescribing costs in South Yorkshire.

Scope for improvement

The medicines management team provides support for the 94 practices across the city. Given the relatively small size of the team there is therefore an ongoing need to ensure that the service is provided in the most efficient manner possible. To this end the team are improving the use made of Information Technology and of data, both national and local, in order to target their interventions appropriately. The allocation of prescribing budgets to PBC consortia enables prescribing costs to be matched against hospital and other related costs.

Neighbourhood differences

Prescribing patterns across the city reflect the demographics, the level of deprivation and the relationship between the expectations of patients and the views held by prescribers. This knowledge of the local populations is essential in interpreting practice prescribing data in a meaningful fashion.

Reducing health inequalities

Through ensuring that patients are treated effectively with medicines in accordance with the evidence base, and treatment guidelines from NICE the PCT will contribute to work to reduce inequalities in the take up of treatments. The medicines management team works closely with public health to share knowledge to ensure that interventions are targeted appropriately.

Engagement with users and improving the patient experience

The medicines management team engages directly with patients that they review and see in practice, with the public via participation in initiatives such as Ask about Medicines and with other PCT staff via working with a variety of groups dealing with disease management.

The patient experience is being improved through the development of pharmacist led services. Examples of this include medication review clinics, hypertension clinics and home visits by pharmacists for the housebound. As more pharmacists become prescribers the service they will be able to offer to patients will improve as they will be able to issue a prescription at the same time as they see the patient, rather than wait for the doctor to agree any changes.

The development of pharmacists with special interests (PhWSI's) will ensure that patients are seen by the pharmacist with the greatest understanding of their condition so is in the best position to treat that patient.

Priorities for the next five years

To effectively manage the PCT prescribing budget, each year the PCT will develop an action plan including for example drug switches and more cost effective ways of prescribing and deliver on that plan throughout the year. We will continue to support practices and consortia with expert advice on evidence based prescribing. We will develop proposals to extend the range of services provided to practices and patients. Work will continue to reduce waste and encourage repeat dispensing and electronic prescribing.

URGENT AND UNSCHEDULED CARE

Aim of service

The aim is to provide a range of health care services across the city to meet the urgent and unscheduled care needs of the population. Our aim is to develop an effective and integrated approach to the care and management of patients who need to be seen urgently by a health care professional and to encourage self-care where that is appropriate. Care will be provided 'closer to home' both in and 'out of hours' and we will reduce avoidable admissions to hospital and attendances at Accident and Emergency.

Description of current service

A wide range of services are provided currently within Sheffield to meet the needs of urgent and unscheduled care: these include services based at GP surgeries, an A&E service at the Northern General Hospital, a children's A&E service at Sheffield Children's Hospital and 'Walk in' and minor injuries centres at the Hallamshire hospital. In addition, we also contract with the Yorkshire Ambulance Service for a 999 call handling and an ambulance transport service and, in addition, an Emergency Care Practitioner Service which enables patients with injuries to be seen and treated without having to go to hospital. The PCT also provides an Out of Hours GP service, an 'extended hours' pharmacy service from two locations in the city, rapid intervention nursing services and provides emergency dental services as well as the NHS Direct service. The PCT provides a single call access number (SCAN) to take calls from GPs and other staff that need support to obtain services that can prevent an admission.

Description of current position

Across Sheffield the position is generally very good. Almost no one has to wait longer than 4hrs in A&E. The Yorkshire Ambulance Service meets its response targets and other service providers are also delivering services to a high standard. The PCT has also invested additional resources in community based services over the past two years as part of its Turnaround programme in reducing avoidable admissions to hospital. However, we recognise that current primary care access fails to meet the needs of the patient population, hence heavy demand for primary care services at the Walk in Centre and from other providers.

Scope for improvement

Services have been developed in an uncoordinated manner and the PCT is committed to implementing an unscheduled care strategy that builds upon the best elements of services whilst at the same time ensuring that they offer value for money and meet the needs of the population. There is a lack of clear signposting right across the system which means that service users are not clear who provides what services, when it is appropriate to use them and when they

are available to be used. Here are a couple of examples highlighting where improvements could be made:

If in the early evening, a parent realises that their child is ill and needs to see a healthcare professional, it's not clear whether the most appropriate thing to do is to call an ambulance, take the child to A&E, the walk in centre, a pharmacist or call the Out of Hours doctor. Any of these could be the correct decision but we need to make it easier for people to make an informed choice.

If their child is ill, parents and carers often want to be able to see a GP quickly for reassurance as well as treatment and lack of daytime hours GP access and knowledge about alternatives eg Out of Hours GP services and Walk in Centre are often reasons why parents use the Children A&E service. As part of the unscheduled care and primary care strategies, services provided for Children will be reassessed

The PCT is currently spending over £1m per year on providing an ambulance response to all Cat C (low priority) 999 calls. Even if a patient's problem is best dealt with by a doctor, nurse specialist, and social care professional or even by advice over the phone the ambulance service doesn't have any option at the moment but to send an ambulance. We need to move to a situation where we can offer a 'different' response if appropriate.

Doctors tell us that they have had, on occasion, to get someone admitted to hospital because they have been unable to get the person supported in their own home. Similarly, people are being kept in hospital because it has not been possible to get the person supported in their own home post discharge. We continue to work to reduce avoidable non-elective admissions and to ensure timely discharge (excess bed days). This is absolutely necessary if we are to improve patient experience as well as deliver value for money from our service contracts.

Neighbourhood differences

Service use is, to a large extent, determined by where services are physically located. About 19% of people using the Walk in Centre are not registered at a GP practice within the city and the majority of all users live or works nearby. The top 20 highest users (based on practice population size) of A&E services at Northern General are people registered at practices less than 3 miles distant to the hospital. The biggest users of the GP collaborative services come from the Sheffield 5, Hackenthorpe/Beighton and Lowedges areas. Those living on the outskirts of Sheffield e.g. in Totley and Stocksbridge are up to 20% less likely to receive an emergency ambulance in 8 minutes than someone living in the centre of town.

Reducing health inequalities

We will ensure that Public Health and the PBC Consortiums work together to better map health needs with the aim of reducing the variation between localities and ensure that services better match the needs of the increasing city centre, ethnic and elderly population.

Engagement with users and improving the patient experience

We will work with the PBC consortiums, NHS and social care partners and the Patient and Public Involvement Forums and the new Local Involvement Networks to further develop our approach.

We intend to develop additional services closer to where people live and work. This may mean longer opening hours at primary care facilities or the delivery of services away from hospital. We know that people often make the trip to hospital A&E services because it's thought that that's the only place where 'expert' care can be provided. But we also know that people don't want to be taken to hospital if it can be avoided and don't want hold ups preventing their timely discharge from hospital when they are medically fit to go home. Our task is to ensure, through all the measures at our disposal that service users receive high quality, accessible and responsive services.

Priorities for the next five years

We have undertaken a rapid SWOT review to identify our key priorities. We will work closely with the Healthcare Commission on their current review of urgent and emergency care and consider carefully any recommendations. Over the next five years we will:

- Improve public awareness of the services we provide so service users are better able to access the 'right services' at any time of the day or night.
- Work with service providers including GPs, pharmacists, Sheffield City Council, our hospitals and PBC consortiums to reduce avoidable admissions, improve timely discharge from hospital and to offer around the clock access to primary care services. This will include service provision for the increasing city centre population, people with mental health problems, the homeless and other 'hard to reach' groups.
- Increase accessibility to the existing PCT GP Out of Hours facility and the Walk in Centre; initially be moving the facilities from the Hallamshire hospital to a more accessible location. We will seek, as resources allow, to develop multiple 'walk in' type services in different locations across the city including options for use of LIFT facilities.
- Work with Yorkshire Ambulance Service to triage Cat C 999 (non life threatening) calls and ensure that, where safe to do so, alternatives are provided to the current system of automatically sending an ambulance to every request. This could mean that a GP, Emergency Care Practitioner or

nurse visits a patient and the patient is treated in their own home rather than being taken by ambulance to A&E.

- Improve the sharing of information between service providers, for example, information on frequent A&E attenders and those with social care needs.
- Work with providers to better deliver out of hours dental services.
- Renew our efforts to ensure timely discharge from hospital and in turn reduce our spend on excess bed days.
- Continue to work with PBC consortiums to reduce the level of avoidable admissions and to assess the need for additional in and out of hours 'Walk in' capacity
- Develop service specifications for our OOH services and Walk in Centre services
- Begin to scope and plan the work with the Yorkshire Ambulance Service for the successful triage of Cat C (non life threatening) calls.

INTERMEDIATE CARE

Aim of service

Intermediate Care is the term used to describe a range of services with the following aims:

To provide short term rehabilitation and therapy to enable people to fully recover following hospital treatment, so that they can regain their independence and prevent premature need for ongoing social and health care, including placement in care homes. No-one should be placed in long term residential care without having the opportunity for rehabilitation

To facilitate early discharge from hospital or residential care settings, as part of the pathway home

To provide care in or near people's homes such that admission to hospital can be avoided

Description of current service

There is a wide range of services within Sheffield that are described as intermediate care. These include:

- Assessment services including the early discharge team, Assessment and Intermediate Care Service (AICS), and the Community Assessment and Rehabilitation Team (CART).
- Services provided in people's homes, including the rapid response nursing service and the Short Term Intervention Team (STIT)
- Short-term residential care in Sheffield City Council (SCC) Resource Centres
- Short-term nursed care in PCT run intermediate care beds
- Short-term interim care in SCC run centres

Services are funded by Sheffield PCT or by Sheffield City Council, and in some instances are jointly funded.

Description of current position

Two thirds of hospital admissions are for people over 65, and the proportion of people in hospital requiring intermediate care who are over 65 is greater still. Although the population of people over 65 has fallen over the last decade, numbers are expected to increase by around 10% over the next ten years. The number of people over 75 is expected to grow by around the same proportion.

There are several indicators of a greater need for intermediate care currently, including an audit of people in hospital beds that showed a large number who could be cared for outside of hospital, the number of discharges from hospital that are currently delayed and the number of Excess Bed days, and the number of admissions to hospital considered to be avoidable.

Some intermediate care services, perhaps particularly those delivered in patients own homes, are well received and considered to be effective. However, services across Sheffield are not currently consistent, as services developed differently in the four predecessor PCTs. The recent intermediate care bed audit showed that both admission and discharge from intermediate care beds could be quicker.

Scope for improvement

By adopting a joint commissioning approach to intermediate care and taking a fresh look at the services we wish to be provided for our patients, and the outcomes we wish to achieve for them, we can improve access to intermediate care and the effectiveness of the service. We will work to better align the commissioning of NHS continuing care within our overall approach to the commissioning of intermediate care and rehabilitation services.

There are a number of issues to be addressed in doing this, including:

- Being clear about what we mean by intermediate care –adopting jointly understood terms for the different components of care
- Understanding the respective health and social care elements, which determine whether individuals are charged for care
- Establishing the right clinical pathways and protocols for each service
- Ensuring premises are appropriate and fit for purpose
- Getting the right balance between support in people’s own homes and residential care
- Ensuring the patient’s stay in intermediate care is managed so that outcomes are achieved within the target of 6 to 8 weeks for most patients
- Ensuring the right mix of skills is available, including medical cover
- Commissioning the right capacity in the service
- Establishing robust information systems that will enable the commissioners to manage the performance of the service against stated requirements.

Neighbourhood differences

There are differences in provision between neighbourhoods, partly as a result of the separate approach to intermediate care taken by the predecessor PCTs. There is not currently evidence to suggest that this has resulted in inequity of provision. However, the PCT and Sheffield City Council will wish to ensure equitable access to services.

Reducing health inequalities

Following the above actions, the service will be based on protocols governing access, which will ensure the access is based on people’s needs rather than where they live.

Engagement with users and improving the patient experience

We will use the Patient and Public Involvement Forums and the new Local Involvement Networks to further develop our approach.

By setting service standards and ensuring case management of patient care, each individual should receive the maximum benefit from intermediate care with clear standards of patient care.

Priorities for the next five years

In the next six months we will review the protocols and rules that govern the use of intermediate care currently, including referral and discharge criteria, with a view to either amending the rules or improving compliance with current rules to improve access to intermediate care.

We will determine information needs and work with providers to ensure that information is provided to enable the PCT and SCC to better measure access to the service and compliance with service standards.

In the next twelve months we will develop a joint service specification for intermediate care that will set out the commissioners' requirements for the services, addressing the issues described above. We will then review current services and consider options for securing delivery of the specified service, including discussion with the current service providers.

The service specification will include separate statements of service aims, protocols and criteria for each of the constituent parts of intermediate care, and will set out parameters for the delivery of service, including location of services, service standards, case management, information requirements and required capacity.

PLANNED ELECTIVE ACTIVITY

Aim of service

We seek to commission services for patients needing hospital assessment, diagnosis treatment that are appropriate and evidence based, are of high quality and delivered efficiently with the fewest possible delays. The NHS has a target of delivering all planned care within 18 weeks of a patient seeing their GP to be achieved by 2008. We have a plan with interim milestones to achieve this supported service redesign schemes which result in financial savings and improve efficiency, effectiveness and patient experience. We are also working to minimise any clinically inappropriate referrals into secondary care and to put in place clear patient pathways and clinical protocols, owned and adopted by primary and secondary care clinicians. This will involve the decommissioning of clinically ineffective services against a clear evidence base.

Description of current service

We commission services from a range of providers but most elective activity is provided by Sheffield Teaching Hospitals NHS Foundation Trust and by Sheffield Children's NHS Foundation Trust. We have developed plans to implement specific service redesign schemes to deliver more services in a primary care setting, to reduce clinically inappropriate referrals; and to minimise inappropriate outpatient follow-up attendances. These have started to result in changes in referrals by GPs.

Description of current position

The elective Turnaround Plan focused on developing nine schemes in primary care within the 18 week pressure areas (procedure level analysis within specialty pressure areas at the Teaching Hospitals Trust, and to reduce inappropriate clinical practice (referrals, Outpatient follow ups, clinical protocols to reduce referrals in areas of limited clinical value). We plan to focus on four key areas from now on - orthopaedics, dermatology, pain management, oral surgery - where scope for biggest financial benefit, (and capacity/ability of leads to drive the change, and most ability to quantify impact. Performance management systems are now in place to quantify impact of schemes, with limitations such as outpatient data only being available at specialty, and not sub-specialty level. We will seek to use our systems to signpost GP referrals to the most appropriate service.

Scope for improvement

We are starting from a relatively low base – history and culture of such change management in Sheffield compared to other parts of the country where started earlier with community services as alternatives to traditionally hospital based care. More can be done on looking at the clinically appropriate referral levels by

PBC consortia. We currently benchmark below national best practice levels. GP referral levels are currently well above equivalent rates elsewhere.

We need to develop effective arrangements with PBC consortia in managing elective activity. Lead PBC consortia city-wide service redesign areas are more developed in orthopaedics and dermatology than other areas of focus: diabetes, diagnostics, chest medicine, rheumatology and urology. We will look to increase the pace of PBC-led service redesign. The PBC consortia are planning to develop proposals for a wide range of services. Detailed plans are currently being developed for:

- Insulin initiation in primary care (SONIC Consortium)
- Management of chest medicine in the community (Parson Cross Consortium)
- Rheumatology (West Consortium)
- Urology (Health Alliance Consortium)
- GPwSI in dermatology (Hallam Consortium)
- Orthopaedics – foot and ankle pathway (Primary Health South Sheffield)
- Direct access to diagnostics (Central Consortium)

Neighbourhood differences

Key demographic differences between the consortia are in the west of the city (Health Alliance, Hallam, West) large elderly populations therefore relatively high numbers of complex conditions associated with old age and cancers. In the east of the city (Parson Cross, SONIC, Central, South Sheffield) there is more deprivation, lower life expectancy and poor lifestyles, therefore higher levels of obesity and chronic disease.

Reducing health inequalities

We need to further develop PBC consortia health needs assessment profiles and consequent plans to address inequalities. A key issue will be moving towards fair share budgets without adversely affecting outcomes.

Engagement with users and improving the patient experience

As more and more patients get treated in the most appropriate setting – services by primary care professionals in the community, GPwSIs doing minor procedures once only done by hospital clinicians, NwSIs doing roles once only performed by GPs - providing services that are more accessible, that will make better use of capacity to meet need and help reduce waiting times for hospital care.

Clearly links with the 18 week target which focuses on measuring patient journey from start to finish, so will fully reflect patient experience (up 'til now targets

focused on individual stages of treatment). Patient pathways being developed in key areas jointly with STHFT, the lead PBC consortium and the PCT.

Priorities for the next five years

Orthopaedics, which continues to be a key pressure area, and we have developed an overall orthopaedics programme with sub-specialty plans. This area along with dermatology, pain management and oral surgery will be the focus of our early efforts.

We will work with PBC consortia to better understand the reasons for variance from national best practice levels for referrals to secondary care and to develop plans as a result.

Currently proposals are being developed for discussion by the PCT Board with a view to develop primary care minor surgery plans starting in 2008/9, supported by increased diagnostics activity as well as rationalising dermatology services and developing alternatives to current pain management services.

We will work with consortia to establish and implement detailed plans for cardiology, including one-stop clinics and rheumatology services.

Examine the factors driving hospital to hospital referrals and identify the scope for the development of alternative pathways.

SPECIALIST SERVICES

Aim of service

Specialised services are those with low patient numbers but which need a critical mass of patients to make treatment centres cost effective. Particular challenges for these services include training specialist staff, supporting high quality research programmes, and making the best use of scarce resources like expertise, high tech equipment and donated organs. Specialised services are subject to different commissioning arrangements than other NHS services, often referred to as Specialised Commissioning.

Specialised Commissioning should safeguard access for patients to the full range of services and manage demand for scarce resources and expertise, stimulate supply and control the entry and exit of providers to maintain safe and high quality services and promote contestability and value for money

Description of current service

There are 36 Specialised Services classed as Specialised⁶. These are commissioned either on behalf of the PCT by a local Specialised Commissioning Group (SCG) called NORCOM, or on a more regional basis by a Forum called YATH (Yorkshire & the Humber) Specialised Commissioning Group, or on a national basis by NCG (National Commissioning Group (formerly NSCAG)). SCGs are relatively new bodies and, as such, are just emerging as commissioning bodies in their own right.

Each PCT in the SHA area is required to be a member of the SCG, Sheffield PCT is a member of NORCOM which forms part of the larger regional SCG.

There are also 4 Networks that are facilitated by NORCOM, Cancer, Cardiac, Neonatology and Critical Care. The Networks have developed strategies and work programmes which the PCT has helped to shape. There is also a Renal Strategy and a work programme for Specialised Children's Services.

NORCOM has over the years, working with clinicians, public health specialists and PCT Commissioners, developed clinical guidelines to help facilitate quicker and clearer clinical decisions about treatment, for example Bone Marrow transplants for Lymphoma in adults and the implementation of NICE Guidelines. Much of the work has helped to inform individual PCTs when considering requests from Hospitals to perform procedures or offer treatments which are either new or the supporting clinical evidence is incomplete or weak.

⁶ www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Specialisedservicesdefinition/index.htm

Description of Current position

In the main for Sheffield residents most Specialised Services are contracted from Sheffield Teaching Hospitals NHS Foundation Trust, such as Cardiac and Renal Services or Sheffield Children's NHS Foundation Trust, such as Paediatric Intensive Care and Child and Adolescent Mental Health in-patient services. Services, such as Low and Medium Secure Health Services are provided outside the region and are commissioned by another SCG through NORCOM on behalf of the PCT.

In order to minimise the financial risk to the PCT a number of risk sharing agreements are in place that help smooth the costs to the PCT over a number of years or ensure that the PCT only pays its fair share based on its population.

Work is on-going to agree what services will be commissioned at specialised level and where the best source of expertise lies ensure effective and efficient commissioning. Existing clinical guidelines and service specifications across YATH or even across Regions are being reviewed with a view to merging or agreeing one standard approach.

Scope for improvement

How the PCT influences the emerging SCGs and how decisions are implemented locally needs to be improved through better communication and stronger commissioning links within the PCT. Better analysis and forecasting on how resources are spent within this area also needs to be improved to help in financial forecasting and accountability.

Neighbourhood differences and reducing health inequalities

Given the low volumes of most specialist services then there is not significant variation between communities in Sheffield. Specific issues for cancers, cardiac and neo-natal care are addressed in the relevant sections of this document. Within the specific networks inequality in terms of access and mortality are considered and their strategies have been developed to address these issues.

Engagement with users and improving the patient experience

The SCG is looking to develop a Patient and Public Involvement (PPI) strategy and to report progress against the strategy in its annual report. The SCG acknowledges that it needs to ensure more patient and public input to the designation process and routinely involve patient representatives in the annual prioritization process and annual commissioning plans. The position with patient representation on the SCG is being reviewed with a view to involve representatives of the public.

The development of Specialised Services in local centres such as cardiac services has been possible and new services are being considered within Sheffield. However, some services will still need to be provided in very specialised units, such as Paediatric Cardiology at Leeds, but local outpatient clinics have been set up to minimise travel.

Priorities for next five years

The main priorities for specialist commissioning are:

- The PCT has strong communication links into the SCG and representation on groups to ensure Sheffield PCT is actively represented and able to influence the priority setting
- Resources invested in specialised services are used to meet the health needs of Sheffield residents
- Decision making process is clear and transparent and communicated widely within the PCT
- Local groups are engaged in the decision making process, including Practice Based Consortia
- That, where appropriate, specialised services are kept as local as possible without compromising quality standards or safety
- To work with the SCG on agreeing how they can represent the PCT within Commissioning forums within a clear accountability and governance framework

The SCG also will also have an annual process for debating priorities and explicit mechanisms for eliciting and documenting the views of providers (clinical and managerial), PCT members, practice based commissioning leads, Public and Patient Involvement (PPI) representatives and commissioning teams. The agreed priorities will be set out in the SCG's annual commissioning plan.

LONG TERM CONDITIONS

OVERVIEW

Aim of service

As the population of the city ages a larger proportion of people will be living with long term conditions such as respiratory disease and asthma, cardio vascular disease, dementia and diabetes. Our aim is to develop an effective and systematic approach to the care and management of people with long term conditions, so that they can better manage their own health and receive care that meets their individual needs. More systematic and appropriate care received closer to home will result in better health for individuals and fewer unplanned admissions to hospital.

Description of current service

A Care Pathway is being developed for each specific condition which is consistent with national and local standards and aims to make best use of resources by preventing unnecessary admissions and targeting resources to areas of greatest need. Each pathway is supported in a staged approach to care:

- Prevention, Health Promotion, Health Protection
- Case Finding and registration.
- Level 1 care which includes patients at low to medium risk who can self manage with routine systematic review and information.
- Level 2 care which includes intensive interventions when needed for higher risk patients with more complex conditions, the management of acute exacerbation and access to intermediate care facilities.
- Level 3 care which includes case management.
- Self managed care is a theme throughout with the provision of a range of generic (expert patient) and disease specific rehabilitation and education programmes.
- The management of Crisis and Acute Exacerbation is also a theme with early alert systems in place and the use of assistive technology to support case managers.

Scope for improvement

The pattern of care for LTC is still often reactive rather than proactive as is demonstrated in the pattern of unplanned multiple admissions. Lengths of stay are often longer than necessary for a variety of reasons. Case managers are already identifying patient with multiple admissions, enabling them to return home more quickly and putting care in place to reduce further admissions this work needs to continue and expand. Our work with GPs to assist them in validating their registers for people with chronic disease will enable more patients to receive systematic review.

We will work with patients to give them the necessary knowledge and choices to enable them to better manage their own health and to extend these programmes to reach more of the people who need them. The 'Achieving Balanced Health' consultation has told us that people feel that they are unclear about how to access services in the community and would like more help to care for themselves. Services can still appear fragmented to service users. We will continue to work on the integration of the patient pathway between secondary care, primary care, social care and services provided by the voluntary sector. We will make better use of the information available and share information better between agencies.

Neighbourhood differences and reducing health inequalities

Through increasing the accuracy of disease registers and our ability to case find we will increase the numbers of people who are actively reviewed and receiving appropriate care. Our case managers will target work in communities with the highest rates of hospital admissions.

Engagement with users and improving the patient experience

In addition to specific events we will use the Patient and Public Involvement Forums and the new Local Involvement Networks to further develop our approach. By developing more self care support for people- particularly those in disadvantaged groups and areas – we will make it easier to make healthier choices about their condition and make best use of services available.

Priorities for the next five years

We will increase the amount of information available for people to care for themselves and to make this available in ways that are more readily understood and accessible than now. A more systematic approach will be taken to assisting GPs to validate their disease registers and provide active follow up and monitoring. We will work to achieve further alignment between the case management work of NHS and local authority staff to help achieve more consistent and seamless services for people who need both health and social care services.

- The scope for a joint service with Sheffield care trust to better manage the needs of people with dementia and long term mental health problems will be explored.
- Identify how data on GP registers can be reviewed and shared with practices.
- A systematic approach will be taken to review our patient education and support programmes for all the major long term conditions and provide programmes for all patients who might benefit and in a format that best suits their needs.

- We will provide care to patients when needed in an acute phase where possible close to home or in the patients own home.
- We will extend the use of telecare and telehealth to enable patients to stay in their own homes for longer.

SELF CARE

Aim of service

Self care includes the actions individuals and carers take for themselves, their children, their families and others to stay fit and maintain good physical and mental health; meet social, emotional and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital.

Our aim is to enable people to feel more empowered to manage their situation on a day-to-day basis, and more able to apply self-management techniques in their own lives.

This would help individuals accessing appropriate services at an appropriate time for example by noticing symptoms of deterioration early and therefore access primary rather than secondary care services.

Description of current service

The PCT delivers the:

- Expert Patients Programme – a course delivered by and for people who live with long-term health conditions
- Supporting Parents Programme – course delivered by and for parents whose children live with long-term conditions and life-limiting illness
- Looking After Me – course delivered by and for adult carers

Courses are delivered by lay-people who have been specially trained and work under a national quality assurance framework.

We are also piloting courses for people who live with learning disabilities in conjunction with Sheffield Care Trust and work closely with SHIELD – a third sector partner that supports people living with HIV and AIDS.

Health and social services support for self care includes:

- Appropriate and accessible advice, information and campaigns on lifestyle issues to change behaviours such as physical activity and healthy eating.
- Health education such as adult health skills and health literacy programmes.
- Self care support networks.
- Multi-media and multi-lingual self care facilities and information materials.
- Individualized care plans.
- Education of practitioners to change their attitudes towards supporting self care.
- Use of self-diagnostic tools, self monitoring devices, assistive technology, telecare and self care equipment.

The Sheffield City Wide Alarms service currently has 17,000 users. The telecare service is supported by City Wide Alarms which acts as the reception centre for the alerts raised by the equipment. A pilot scheme using telecare products has been conducted over the last two years.

Description of current position

We currently have 24 people, 21 of who are volunteers, able to deliver lay-led self-management courses with 250 places offered in 2006/07.

Assistive technology (any item, piece of equipment, product or system that is issued to increase, maintain or improve the functional capabilities and independence of people with cognitive, physical or communication difficulties). can play a vital role in supporting the ways in which older people or people with long term conditions can maintain or regain their independence. It also has the potential to modernise the way in which many aspects of health and social care are delivered to the benefit of users, carers and service providers.

Telecare is in use in people's own homes of new technology like alarms, detectors or monitors such as motion or falls detectors usually attached to community alarms systems in order to trigger a warning at a control centre so that problems can receive a fast response.

The exchange of data between a patient at home and care professional can assist in the diagnosis and monitoring of a patient's physical condition. These include a home unit to measure and monitor vital signs such as temperature and blood pressure and to ask the patient to respond to a series of health related questions. The health professional can receive and assess this information at a remote location using phone lines or wireless technology.

Apart from demography and the increasing number of people with more complex needs, there are a number of drivers towards the use of assistive technology in Sheffield :

- The importance of enabling people to remain in their own homes for longer.
- The need to reduce delayed transfers of care from hospital and emergency admissions.
- The cost and availability of care placements.
- Budget pressure on both social services and health and the need to make best use of resources.

Sheffield has conducted a six month trial to examine how telehealth monitoring could assist community case managers to manage their caseloads efficiently and keep patients out of hospital. This enabled nurses to identify which features of the technology enabled both case managers and their patients to respond positively to its use.

Results from the trial included a 50 to 80% reduction in home visits and a 50% reduction in potential readmissions to hospital. As a result 15 remote monitoring machines have been purchased for use with COPD patients.

In order to fully integrate this technology into the service and to support plans for extended use a randomised control trial is being conducted to examine the impact of telehealth in preventing admission and allowing early discharge in COPD patients. This study is being conducted through the School of Health and Related Research at Sheffield University.

Scope for improvement

We need to ensure that lay-led self- management courses are available across the whole City and can be delivered by people who represent local communities. This would be allied with more lay-led self-management into care pathways for all chronic diseases in primary care. We can do more to work with third sector partners and local hospital providers to develop opportunities for lay-led self-management development outside the traditional primary care setting. We can look to work with GPs to offer courses targeted to local populations based on local need.

Neighbourhood differences

Lay-facilitators do not currently fully represent the diversity of the Sheffield community and not all courses are delivered in community languages in community settings. There is less information available in the north and south east areas of the city about what self-management courses are available.

Reducing health inequalities

Lay-led self-management courses for seldom heard groups by using interpreters and BSL signers would help improve coverage. We need to encourage specific communities such as refugees, people that are homeless and travelers to access lay-led self-management support and to continue work with targeted populations e.g. people living with HIV/AIDS and people living with learning disabilities.

Engagement of users and improving patient experience

Our programmes are led by lay-people but we need to increase involvement and that we listen to ideas for development from local communities. This would help ensure that the courses we offer are accessible, local and appropriate. We will continue to use the national quality assurance framework to assess how we are doing.

Priorities for next 5 years

The national target is that by 2012 there will be 100,000 course places per year for lay-led self-management. The target for Sheffield will be to offer around 1,000 course places per year by 2012.

We will seek to:

- support the development of a lay-led training package so facilitators can offer each other structured and informal peer support. This could help with retention of current facilitators.
- continue to offer lay facilitators a personal and effective level of support that will maintain quality assurance standards.
- explore options for offering tutor training to other commissioners locally as to create revenue for the PCT.
- develop a joint approach with Social Services to developing the use of assistive technology and a sustainable process to support this development will be established.
- work jointly with PCTs in Rotherham, Doncaster and Barnsley to ensure that the South Yorkshire programme to develop a 'Digital Region' is consistent with and supports the strategy for developing assistive technology in health and social care across the region.
- use telehealth further for COPD patients in line with research outcomes.
- use telehealth with other long term conditions such as heart failure and diabetes.
- Provide Case managers with access to both telecare and telehealth to assist them in managing their caseloads.

ENABLEMENT

Aim of service

The concept of enablement emerges from the recognition that people who live with impairments as a result of congenital conditions or acquired injury or illness are disabled as much by attitudinal and environmental factors as by the impairments themselves. This is a founding principle of the Social Model of Disability. This work stream, therefore, comprises work to identify and manage barriers to participation as well as the delivery of practical solutions, rehabilitation and support. Evidence of success in achieving the work stream objectives will be derived from the behaviour of the organisation as an employer and city partner as well as from success in the provision of effective disability aware services.

Description of current services

There is a range of enabling services available, in different measure, across the city including aids and adaptations, wheelchairs, environmental controls, communication aids and telecare. It is recognised that these services lack a cohesive link and that effective person-centred service delivery is hindered by the lack of an overall strategic plan and associated clarity in service contracts. Knowledge of what is available and methods of access are not always clear. Service users engaging with primary and secondary health care still too often encounter problems of attitude and approach as well as challenging physical environments and inadequate support to maintain dignity and independence throughout the episode of care. Information about and communication with wider enablement services, for example, job retention and return initiatives, is improving but still patchy. Health professionals are not always sufficiently aware of these wider services to empower services users by the provision of timely information.

Description of current position

The PCT published in December 2006 its 3 year Disability Equality Duty Action Plan in compliance with the duty described in the 2005 Act. This includes a commitment to reflect the demands of the Act in contract specifications and to conduct Impact Assessments as part of any change to service delivery. A partnership group – Partners for Inclusion – has been established and key priorities for action across the city have been identified (see below). This city-wide approach is essential to continue and develop both to address previous inconsistencies across the former Sheffield PCTs and to develop the necessary wider partnerships and engagement to tackle all the factors identified using the construct of the Social Model of Disability.

Scope for improvement

The lack of a clear strategic plan to link legal duties, educational needs, organisational and structural change and practical and empowering service delivery has limited progressive development in this area. There is a lack of clear data to inform detailed contract specifications. This must be a key focus in the development of Strategic Needs Assessment. In the interim broad areas of need have been identified via partnership working and priorities for action described as follows:

- The development of a specialist advocacy and information service
- Mainstreamed involvement of disabled people in service planning in statutory sector
- The need to influence the Local Area Agreements to ensure the needs of disabled people are accounted for
- Ending postcode inequity of community disability service provision
- Improved access to all health services - removing estates and attitudinal barriers in primary and secondary care
- The development of a Sheffield Blueprint for “Improving the Life Chances of Disabled People” and “Our Health Our Care, Our Say” across the city council, and health partners
- Holding to account public sectors in Sheffield to deliver their Disability Equality Duty published action plans

Neighbourhood Differences

There has been no specific work on linking people living with all of the broad range of impairments that can lead to disability to certain neighbourhoods, but we can make assumptions about neighbourhoods where there are large numbers of people living on benefits, particularly Incapacity Benefit, as being likely to house disabled people. There is additionally some neighbourhood information on specific conditions such as stroke.

Reducing health inequalities

Health Needs Assessment will enable us to identify more accurately the health inequalities that exist around disability. Services to disabled people have developed in an ad hoc manner over many years, leading to inequitable provision across the city based on either geography or diagnosis. People with long-term neurological conditions particularly of working age; have not always been taken into account when mainstream services have been developed. We need to work across commissioning boundaries more effectively to address this. We will continue to work on the disability and employment agenda through the Sheffield Health and Work Strategy group to aim to reduce the numbers of disabled people experiencing worklessness and living on benefit. Additionally, health inequalities for this population can be based on environmental and attitudinal barriers to

accessing mainstream health services. There are actions in the Disability Equality Duty Action plan to address this.

Engagement with users and improving the patient experience

The Disability Equality Duty (DED) gives us a requirement as a public authority to engage with disabled people, and we have therefore published actions within our DED action plan to ensure that disabled people are included in our planning mechanisms. “Partners for Inclusion” the partnership board for physical, sensory and cognitive impairment, remains a key partnership with disabled people as service users, and as members of the public, as a way to engage around the specialist and broad health agenda. We need to review the method of identifying and engaging with disabled staff following role restructuring within the organisation. PALS officers will need to ensure that there is appropriate attention paid to engaging with disabled people, particularly the seldom heard voices of certain groups.

Priorities for the next five years

The key immediate objective is to develop a Sheffield strategy to deliver on our legal requirements, address attitudinal and environmental barriers to full participation and allow the development of a cohesive commissioning plan to establish appropriate linked provision for service users. In order to achieve this we will need to continue to develop the appropriate partnership structures to ensure proper engagement with disabled people and systems for targeted strategic needs assessment to establish clarity of detail. In the interim we will be guided by the priorities and scope for improvement identified by the partnerships structures, and on national policy drivers as identified above, and will focus on achieving stability and clarity in service provision

NEUROLOGICAL CONDITIONS

Aim of service

The Long Term Neurological Conditions (LTNC) work stream encompasses services for those with neurological injury or disease that can lead to long term, sometimes lifelong, impairments. The aims of service provision in this area are to ensure high quality emergency services for neurological injury, prompt attention and diagnosis for neurological disease and systematic progression to rehabilitation, support and adjustment services that enable individuals to maximise their autonomy and participation in everyday life. Provision must also address the needs of those people with advanced progressive disease or very severe outcomes from injury who have palliative and end of life care needs. The identification of this area as a specific focus of attention is a new departure in Sheffield and a recognition of the scope for improvement in the commissioning and delivery of services.

Description of current service

Sheffield already has high quality emergency and acute services for those with neurological injury and a highly skilled department of neurology enabling diagnosis and management of disease, based at the Royal Hallamshire Hospital. There are neuro rehabilitation beds, including specialist spinal injury provision, on the Northern General site. There is also a range of neurologically skilled and focused care in the community that is highly valued by service users. Much of this provision, though not all, is linked formally via care pathways and includes joint working arrangements with social care. Access to rehabilitation and support services is, however, not always straight forward and current planned provision does not yet meet all predictable needs.

Description of current position

One of the key limitations in moving service design and development forward is a lack of systematic information detailing the prevalence of need in this area. Based on the best available national figures we estimate that the Sheffield population will include approximately 11 000 adults of working age with a significant neuro-disability. Around 40% of these (4 400) will result from congenital or progressive conditions and 60% (6 600) from acquired brain injuries. Not all of these people will require continuous access to specialist neurological health care but a proportion would benefit from direct periods of service contact and some from active case management or planned review. A recent survey assessing Sheffield's baseline position with respect to the Quality Requirements outlined in the National Service Framework (NSF) for LTNC produced a consensus view that the quality of service provision was high but that services were not as visible as they should be and, particularly in terms of rehabilitation and long term support, often did not have the capacity to respond in an equitable and timely manner.

Scope for improvement

Service commissioning in this area has been complex and incomplete. This is recognised as a national problem and so there is increasing attention to the work stream in policy development. There is lack of clarity in service provision and limitations of the systematic data that should underpin service planning. Sheffield is contributing to national work to develop a minimum data set and has taken local action to make progress on the implementation of the NSF for LTNC, and in particular to address a key barrier to progress by including a specific post to lead this work within the new PCT structure. Clarity and cohesiveness in service commissioning will be essential in ensuring the development of accessible, person-centred services with transparent processes. Effective joint commissioning of wider enabling services and other provision, such as supported living options, will also help to ensure that people are enabled to live full lives irrespective of impairments.

Reducing inequalities

As a consequence of the lack of a prior cohesive commissioning plan, services have developed in a piecemeal way inadvertently limiting access to equitable provision. In Sheffield this affects access to some services by place of residence and some by virtue of the underlying diagnosis. The needs particularly of people of working age have not always been taken into account in developing city-wide solutions for common service limitations.

Priorities for the next five years

- We will work towards full implementation of the NSF for LTNC by 2015
- We will develop processes and systems to appropriately identify the size and type of need of people with LTNCs living in Sheffield
- We will develop a cohesive commissioning plan that facilitates the delivery of appropriate pathways of care and removes systematic inequities in service provision.
- We will focus on ensuring that pathways of care are balanced in terms of acute, medium term and long term provision and that the venue of service delivery is appropriate in terms of access, efficient use of resource and in line with outcome goals.
- We will ensure that service delivery is person-centred and is clearly focused on enabling people with LTNCs, their families and carers to have maximum autonomy and skills of self-management, while recognising the needs of some to be more actively supported to achieve optimal participation and a sense of well-being
- We will explore the development of monitoring systems and service review that is appropriately inclusive of service users and their advocates
- We will ensure that the needs of people with LTNCs are included systematically in the delivery of generic city-wide initiatives and given the same level of emphasis as other service groups

END OF LIFE CARE

Aim of service

To help all those with advanced, progressive, incurable illness to live as well as possible until they die.

To enable the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. This includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

Description of current service

Current supportive and palliative care provision includes Hospital Specialist Palliative Care Support teams and outpatient clinics at Northern General, Royal Hallamshire and Weston Park Hospitals. The provision of 25 acute specialist palliative care beds and 8 respite beds at St Luke's Hospice, together with another 18 acute beds at the Sheffield Macmillan Unit for Palliative Care.

In addition, 24 hour nursing care at the end of life is provided by the District Nursing service and the Intensive Home Nursing service. The Variable Intensity Palliative Care service provides home nursing support to people with palliative care needs. The Hospice at Home Team offers specialist community palliative care in people's own homes and nursing homes and there is a community based Lymphoedema Service.

A nurse led 24 hour helpline is also available with access to medical back up from St Luke's Hospice. Bereavement services are provided by St Luke's Hospice, Cavendish Centre and MacMillan Unit.

Description of current position

Sheffield PCT is currently undertaking a baseline review of services across the city for end of life care as set out in the Operating Framework 2007/08. This local end of life care service baseline review is in preparation for the End of Life Care Strategy due to be published in late 2007.

This review is to provide the PCT and Local Authority with information that will enable them to:

- Assess the population need for End of Life Care Services.
- Map current provision including its quality.
- Compare current provision with population need.
- Identify where service improvements are needed.
- Be prepared to respond to the End of Life Care Strategy when published.

Scope for improvement

Equal access to supportive and palliative care services remains a challenge. Choice over the type and place of care wherever possible with particular emphasis on community care needs to be addressed in the context of the 'Preferred Place of Care'. Despite 20% of all deaths occurring in care homes, many challenges remain to ensure widespread delivery of high quality End of Life Care.

There is a need for providers of services to have the appropriate training to deal proactively with end of life care issues in relation to advance care planning and use of the End of Life Care Pathway. A standardized form for recording DNAR (do not attempt to resuscitate) orders in the community also needs to be recognised by all relevant health providers.

Better partnership working is required to provide comprehensive services in the community hospital and hospice settings. The *Achieving Balanced Health* consultation has told us that people want better partnership working across agencies to reduce service fragmentation.

Neighbourhood differences

Work is underway as part of the baseline review to understand neighbourhood differences both in terms of geography and ethnicity.

Reducing inequalities

Following the baseline review of services we will have a clearer picture of how and where health inequalities exist. Variations between localities will be actively followed up. Currently the strategy is promoting prompt and equitable access.

Engagement with users and improving the patient experience

The strategy aims to ensure comprehensive user involvement in the planning of services, including patients and carers, regular evaluation of all services and the promotion of self-help and support groups with better representation of the views of black and ethnic minority communities. Sheffield Cancer Services Advisory Group (SCSAG) co-ordinates active user involvement in the design and development of palliative care services. The Sheffield Supportive and Palliative Care Committee (SPCC) meets quarterly with representation from service users and providers of supportive and palliative care services to feed into the commissioning process. By developing advance care planning and End of Life Care Pathway with a view that it becomes established practice across all services.

Priorities for the next five years

The Sheffield Supportive and Palliative Care Committee (SPCC) as the Joint Planning Group for supportive and palliative care services across the city have developed a strategy for 2005 – 2010. This will be reviewed following publication of the End of Life Care Strategy later in 2007 in the context of the baseline review.

The Sheffield Supportive and Palliative Care Strategy 2005 – 2010 sets out the following key areas for action:

- Improving access and co-ordination of services
- User involvement
- Communication and information
- Psychological and spiritual support services
- Social, family and carer supportive services, including bereavement care
- General palliative care services
- Specialist palliative care services
- Rehabilitation services
- Complementary therapy services
- Education and research

9. HOW WE WILL DEVELOP OURSELVES TO DELIVER THE STRATEGY

This section sets out how we are going to develop the PCT to become a more effective organisation, that engages better with the public, service users and carers and where our goals of reducing health inequalities and securing improved health services for the residents of Sheffield are reflected throughout our organisations.

OUR WORKFORCE

Sheffield Primary Care Trust is committed to the development of its workforce to ensure it is fit for purpose to deliver the new roles and functions of Primary Care Trusts. We will develop a specific focus on shaping a workforce that can contribute even more effectively to work to reduce health inequalities and improve health outcomes.

In demonstrating this commitment the PCT will undertake the following: -

Workforce Development

The PCT aims to have a Workforce Plan by the end December 2007 and a new structure for workforce development in the PCT will be developed. The workforce plan will enable the Commissioning Arm of the PCT to identify trends in its workforce as well as predict the impact on the workforce of future developments and service redesigns, in both Commissioning and Provider Arms of the PCT.

One of the key anticipated impacts on the workforce will be the increase in integrated working with health and social care partners, which will lead to new roles and career paths being identified.

Workforce development is central to ensuring that the PCT has a workforce that is fit for purpose, and developing and strengthening the links between Workforce Planning, Education Training and Development. The PCT Strategy will enable this to be achieved.

Specifically within primary care we need to ensure there is sufficient capacity and, to this end, we have over 50% of our GP contractors providing services through PMS contracts, which include growth funding for additional GPs, Nurses, and Allied Health Professionals tied to delivery of specific quality objectives. We will look at the scope to extend the numbers of PCT employed GPs providing services outside of core hours, and staffing 'walk-in' centres across the city. This model could either complement or replace elements of the current out-of-hours arrangements, providing a mix of planned appointments, minor injury clinics, and minor ailment clinics. We will look at the scope for pharmacists to be involved in such developments.

Recruitment and Retention

Our recruitment processes will be reviewed to ensure that optimum use is made of NHS Jobs (national recruitment mechanism) and the interface with the new Electronic Staff Record. The aim is to ensure a wide circulation of vacancies, mainly using NHS Jobs with the minimum use of expensive traditional advertising methods.

The PCT will continue to strengthen and develop a comprehensive and robust set of pre and post –employment health checks. There will also be new processes developed to accommodate the requirements of the Registration Authority and the issuing of Registration Authority Smartcards

The PCT will improve retention of staff by continuing to build on Improving Working Lives Practice Plus and working towards achieving Investors in People. The annual Staff Survey will provide invaluable feedback on the PCT's performance in these areas.

Leadership and Management Development Strategy

We will develop a strategy that sets out how Sheffield Primary Care Trust has a workforce with leadership capacity, capability and vision to take forward the modernisation agenda.

Leadership in the NHS is a key element of the modernisation process. Leaders are people with the vision and initiative to bring about substantial change through others - leaders enable others to achieve more through meaningful modernisation.

Leaders and managers will increasingly be required to think systematically and to work across traditional organisational boundaries, creating a coordinated and cohesive approach to developing leadership skills, competencies and opportunities for staff across health and social care. Partnership working will become the norm rather than the exception, requiring a range of new approaches to leadership, and a need for systems skills and understanding.

The increased emphasis on Clinical Governance places clinician/leaders at the forefront of organisational change and, over time will drive a change in the way those leaders operate. A comprehensive range of leadership development opportunities for leaders within the organization at all levels will be available to facilitate the above.

We will engage with staff as we develop our overall strategy as part of our wider engagement and organisational development strategies.

OUR PROVIDER SERVICES

Sheffield PCT is fortunate in having a wide range of directly provided universal and specialist services, including community nursing, intermediate care, primary care, sexual health services and a range of therapy services.

We will work in close partnership with the communities we serve and with other key agencies. We will develop, and where appropriate enhance, the range of services we provide. We will do this in the context of the developing NHS agenda around choice and contestability.

By:

- Developing into a nationally recognised organisation of excellence
- Being responsive to patients and their carers and to treat them with dignity at all times.
- Becoming a provider of choice for local commissioners
- Continually developing, supporting and listening to our staff to empower them to deliver high quality services
- Being responsive to patients and staff
- Developing processes which are open and transparent
- Working in partnerships to develop a vision for provider services with staff and stakeholders in partner organisations and the local community
- Having a robust organisational development programme

Partnership working has already helped us to create a new direction for children's health services in collaboration with the Children and Young People's Directorate of the City Council. Other services such as Physiotherapy and Podiatry have recently developed care pathways, which help to provide patient centred, one-stop services closer to home.

Over the next 12 months we will develop a plan to ensure these services continue to be available through appropriate arrangements. The PCT has not yet decided whether it will continue to be a direct provider of services or whether it will develop alternative arrangements. This issue will be addressed as part of the plan being developed for provider services.

ORGANISATIONAL DEVELOPMENT

We will work to improve our ability as an organisation to address our objectives and priorities. Work to contribute to a reduction in health inequalities and to improve health outcomes will be central to what all of our staff do. The PCT has agreed a strategy for Organisational Development (OD). The model uses the headings of Strategy, Structure, Skills, Systems, Staff, Style and Shared Values and actions have been agreed for each of these areas. The OD strategy will be used alongside other work to develop leadership - both clinical and non-clinical – within the organisation, developing a set of shared values and workforce development. Taken together this work will help us achieve our objectives and to turn the aspirations of the strategy into operational reality.

There will be a staff launch of the PCT five year strategy in October 2007 alongside the feeding back of the outcomes of the consultation on the aims and values of the PCT that have been reflected in the overall PCT strategy.

BETTER FACILITIES

Modern premises that are fit for the delivery of health services are critical to the achievement of the PCT's strategy for three key reasons:

- GPs need adequate premises to be able to provide high quality primary care services that are accessible for all their patients
- GPs and other providers need access to appropriate premises to deliver the range of services the strategy seeks to see provided in community settings
- The development of high quality premises in the more deprived areas of Sheffield supports the reduction of health inequalities not only by enabling improvements in health services but by enabling partnerships to develop through co-location of services and, importantly, by acting as a clear symbol of the importance placed on the health of the populations served

The PCT is developing a formal SSDP strategy for premises following on from the publication of this strategy, which will set out priorities and actions for the next five to ten years. The strategy is expected to include the following elements.

The PCT is responsible for funding GP premises, through the contractual arrangements in place with GPs nationally, as well as for maintaining its own estate. The PCT is not, however, directly responsible for funding premises for other primary care or secondary care providers.

The 94 practices in Sheffield operate from over 130 premises. PCT provided services work from a number of PCT owned premises, although most District Nurses, and some other services, are based in GP premises.

Premises might be either owned by the PCT (and rented to GP practices), owned by the practices, or, in a few instances, owned by another organisation or a developer and rented by the practice or PCT.

The standard of premises ranges from poor to excellent. The premises strategy will include an assessment of the state of all premises for which the PCT is responsible, so that improvements to premises can be prioritised. The first priority for the PCT will be to ensure that all premises are compliant with statutory requirements, for example access requirements (including the Disabilities Discrimination Act), fire and safety and infection control.

Beyond that, the PCT will be seeking to develop or extend premises to enable a wider range of services to be delivered in community settings.

The PCT is able to develop premises, or support GPs in developing their premises, in three main ways.

Local Improvement Finance Trusts (LIFT) are a national initiative for the procurement of health buildings, designed as a vehicle to improve and develop primary care facilities. LIFT companies are joint ventures between the Department of Health, the local healthcare community and the private sector.

The Sheffield LIFT project was part of the third wave of the national initiative. The stakeholders involved in the project are the PCT, Sheffield City Council, other local NHS Trusts, and Partnerships for Health (a company jointly owned by the Department of Health and Partnerships UK) and the private sector company First Health Solutions Ltd. In October 2005 Community 1st Sheffield Ltd (C1SL) was formed. The PCTs were 20% shareholders; Partnerships for Health 20% shareholders and First Health Solutions Ltd took the remaining 60%.

Under the agreement for the project, C1SL will build premises of at least 22,000 square metres, which the PCT and/or GPs will then rent. This arrangement provides capital and expertise in building development to the PCT. The first group of developments built through LIFT is in Deepcar, Wincobank and Jordanthorpe. The next group of developments being considered includes sites in Darnall, Norfolk Park, Parson Cross, Foxhill and the City Centre. Business cases for these proposed sites are being developed. The PCT's SSDP will prioritise further developments.

Whilst the PCT has an exclusivity arrangement with LIFT, GP practices can choose to develop premises with other developers or to manage a development themselves. In these circumstances the PCT's role is to ensure compliance with standards, ensure the proposed building is appropriate to the practice and patients' needs, and to consider reimbursement of the rental costs.

The PCT has a small allocation of capital funds made to it each year, which can be used to fund improvements to its own premises or to provide improvement grants to practices (in addition to the purchase of capital equipment).

Allocation of capital funds, and of future revenue funds, has to be subject to a prioritization process as the requests for funding will inevitably exceed that available. Cases for the use of capital, or for developments with revenue costs, will be considered against criteria to be set out in the premises strategy. The revenue costs of the developments built through the LIFT arrangements will be a first call on the funding.

USE OF INFORMATION MANAGEMENT AND TECHNOLOGY

Improving our use of Information Technology will be essential to delivering better services to patients. The aim is to provide all clinicians and support staff employed by both Sheffield PCT and the associated General Practices with access to a National Programme for Information Technology solution, which supports their operational needs and the reporting needs of the PCT.

In addition to recording interventions undertaken in primary and community care, information flows between primary and community and other parts of the NHS and partner organisations will be electronic, reducing delays and inefficiencies in pathways.

The increased reliance of all staff, clinical, managerial and administrative on IT systems, requires an underlying infrastructure with adequate capacity, resilience and business continuity/disaster recovery facilities.

Sheffield PCT has deployed the NPfIT Community solution, SystemOne from The Phoenix Partnership, to approximately 15% of the clinical workforce of the PCT, with plans in place for that to increase to approximately 30% by the end of March 2008.

The GP practices in Sheffield currently have 7 different types of clinical system from 4 different suppliers, of these approximately 20% use the NPfIT Community solution, SystemOne from The Phoenix Partnership, enabling records to be shared between General Practice and community services.

The underlying infrastructure, although adequate for normal usage, has multiple single points of failure and limited disaster recovery facilities.

During the five years of this strategy we will work to:

- Embed shared records in all services provided by the PCT, including General Practice, including links with the National Summary Care Record. Within the PCT provided services this will involve substantial business change, including the use of lean production thinking to streamline processes.
- Enable efficient electronic flows between all providers of Healthcare, including NHS and non-NHS providers, to allow tracking and auditing of patient journeys. These electronic flows must support choice, patient booking, waiting time targets and effective discharge processes.
- Improve data quality; in particular all General Practices to achieve the data accreditation standards defined in the IM&T DES.
- Increase staff skills to ensure all staff have the IT skills for them to make effective use of the systems and increased skills for managers to analyse, interpret and act on summary and aggregate data.
- upgrade and expand the infrastructure, based on the estates strategy, to ensure there is an adequate level of resilience in the network infrastructure

and business continuity/disaster recovery facilities in place to ensure continued working of core services.

Our early priorities during the strategy period will be to:

- Deploy TPP/SystemOne to 30% of GP practices and 30% of community clinicians.
- Define electronic recording and sharing protocols for PCT employed nurses in particular for the cardiac, respiratory and diabetes pathways.
- Develop reporting solutions to support both service management and the supply of information to meet commissioning and performance requirements
- Provide access to images for community services as part of the implementation of PACS in the Acute Trusts, in particular musculoskeletal and orthopaedic pathways.
- Implement electronic transfer of information for:
 - Electronic transfer of prescriptions between GP practices and community pharmacies.
 - Electronic transfer of records between GP practices.
- Provide support to practices to improve data quality, in particular to achieve data accreditation as part of the IM&T DES.
- Ensure all PCs met the minimum technical specification.
- Provide every consulting room within PCT premises with access to SystemOne and work with GP practices where PCT clinicians deliver clinics, to ensure they have access to SystemOne.
- As part of the move into new premises for the PCT Commissioning arm, establish the basis of a robust infrastructure, which can be expanded to cover sites where the organisation operates, as required.

GOVERNANCE AND RISK MANAGEMENT

The PCT has since its inception in October 2006 developed a system of Standing Orders, Standing Financial Instructions and Scheme of Delegation which form the legal framework for the PCT to function effectively and within the law.

All NHS organisations are required to have a Board Assurance Framework (BAF). The BAF details the key strategic objectives for the organisation, the highest level risks which may prevent these being achieved, what the organisation currently does to overcome these risks, how it monitors this and what more might need to be done. In addition the documents highlights how the Board is kept informed of progress and any gaps which may need to be addressed to ensure the Board is receiving the right level of assurance.

The current BAF is based around the Healthcare Standards, the highest level risks faced by the organisation and comments from Board members and senior managers. The BAF is updated in light of progress or changes to these risks.

The BAF is considered at all meetings of the Risk Management Group, Governance Group and Audit and Integrated Governance Committee. A quarterly report on the BAF is presented to the PCT Board and key indicators relating to the BAF will be included in the quarterly performance report.

The BAF will underpin the delivery of the PCT's Strategy and will be updated to reflect the principle objectives, risks, controls and assurances to delivery of the Strategy and the Business Plan.

Linked to the BAF is the Risk Register. The PCT maintains a comprehensive register of all identified risks faced by the organisation. This identifies what the risks are, the controls already in place to address the risk and future actions required to further reduce the level of risk.

All risks included on the Register are ranked using the standard scoring system of impact (range 1-5) multiplied by the likelihood (range 1-5) to give a risk score (the higher the number the greater the risk).

Risks are identified through a variety of means including risk assessments, incident reports, audit reports and external assessments. All identified risks are reported to the Risk and Health and Safety Advisor for inclusion on the register.

All new risks are reported to the Governance Group to confirm and challenge the allocated ranking, agree actions and decide if it is significant enough to be included on the BAF. In addition all high level risks (those ranked 12 or over) are reported to every meeting of the Governance Group. The Group will agree an acceptable level to which the risks should be reduced, the actions required to achieve this, the timescale and subsequently monitor progress.

10. TAKING THE STRATEGY FORWARD

DEVELOPING AND DELIVERING THE STRATEGY

This strategy is about building on what we have but with the intention of making changes of a greater impact than previously. The purpose of the strategy is not the production of a document, despite the size and complexity of this particular one. This strategy is about drawing together the plans we already have and the plans we need to develop, in such a way that we ensure they focus on and contribute to reducing inequalities in health and health care experience whilst at the same time contributing to making health services in Sheffield sustainable – including financially. This means that the core elements of the overall strategy become integral to the delivery of individual service plans where the PCT has a leadership role. We will also be revisiting and revising this strategy over the next five years. The ways and means in which this will be carried forward are set out below.

Process for LDP and commissioning plan

Although this strategy covers a five year period the PCT, in common with other organisations, has an annual plan, usually referred to as the Local Delivery Plan (LDP). There are two important elements that inform the LDP. These are the Government's Comprehensive Spending Review (CSR) which determines the level of financial resource available to the NHS and the NHS Operating Framework which provides planning priorities. The LDP therefore sets out the local plan for achieving national and local targets for the year ahead, consistent with the available resources. It is an important financial and activity planning document as it forms the basis for legally-binding contracts and other service level agreements, as well as providing the basis on which the PCT is scrutinized by auditors and regulators such as the Healthcare Commission, the Strategic Health Authority and the Department of Health.

The LDP is also central to the PCT's annual corporate objectives determined by the PCT Board.

The LDP is no longer, however, the sole preserve of the one organisation. For 2008/08 and beyond it will increasingly be the product of agreement between the PCT and the local Practice-based Commissioning Consortia, drawing on and informing their plans. Over time it will also become increasingly congruent with the plans of other partners – in particular partners to the Local Area Agreement through the Local Strategic Partnership (LSP) Sheffield First that public bodies in Sheffield have with central Government.

The PCT will share the process it will be developing in readiness for and in response to the CSR and the Operating Framework, with Consortia and with partners in the LSP.

Process for further iterations of the strategy

Reporting progress in delivering this strategy will be central to the PCT's accountability to the people of Sheffield, in broad terms through formal annual reports as well as in more specific forums, whether locality-based, patient-based or for example, City Council Scrutiny Committees.

As described in our five year financial plan we need to do some work to fully cost proposed service developments in order to confirm our priority actions.

It is envisaged that the strategy will also require updating to accommodate national policy changes, local progress and changing local needs. To avoid unnecessary bureaucracy it is proposed that it will be formally reviewed each autumn with any proposals for updating or revision being presented to the Board for approval. This will explicitly take account of Practice-based Commissioning Consortia plans and the information and intelligence flowing through the PCT's public and patient engagement activities.

MEASURING HOW WE ARE DOING

The PCT is committed to implementing a **Performance Management Framework** that provides regular updates across a wide range of Performance indicators that relate directly to the PCT's objectives. These indicators will be benchmarked wherever possible against National data and across Sheffield.

National comparator data sources will be utilised to provide benchmarking data for example from the Secondary Uses Service (SUS) PBC Comparators.

The PCT has developed its own web based **Practice Based Commissioning** reporting system for 2007/08. This aims to deliver monthly reporting to practices and consortia which provides aggregate summaries with plans to allow drill down to individual patient level if required. We will work with consultants to identify how the data available to them can be improved.

A key activity for the PCT is to make the data / information as **accessible** to staff as possible whilst ensuring that appropriate security and confidentiality controls are in place.

We are **continually re-assessing** our reporting systems, tools and processes so that we are using the resources we have most effectively. We will be moving to increased use of web-based access for staff and will be reviewing our presentation tools.

The Pact's Information Services works directly with managers and front line staff to develop reporting that has an identifiable impact on their day to day work. Our overall aim is to **make the information work for the organisation**.

Data set processing & quality assurance will be managed to ensure that all data sets are fit for purpose. This will cover all the traditional hospital activity data sets and be expanded to cover Performance Indicators, Provider Services, Primary Care and other data sets as they become available. Our intention is the pro-active development of data sets and their conversion into useful information to support PCT business.

COMMUNICATING THE STRATEGY

Arrangements are in place to communicate this strategy to all PCT staff (commissioning and provider arms).

Effective communication will raise awareness of the PCT so that people, groups and stakeholders know of its existence, function, how to access its services, make their views known and influence service development. To facilitate this, the PCT's communications and patient public involvement teams will continue to work closely together. In addition the PCT is committed to; establishing and developing good communication networks with local health communities, voluntary, community and faith organisations, working together with other agencies to provide integrated services. The PCT will also build on the work of existing groups and networks.

Communicating what we do needs to be matched by listening to the public and our staff. As well as the wider public engagement work described in this strategy we will seek to develop better internal communications with our staff.

Sheffield PCT has recognised the need to involve the public through consultation to develop and improve communication links with the people of Sheffield and has therefore, developed a strategy for patient and public involvement which will include consultation, involvement and effective communications. We will encourage the involvement of patient representatives, the Patient Advice and Liaison Service (PALS), expert patients and partnership with voluntary, community and faith groups through workshops/events and existing projects in the community. We are currently exploring the most appropriate and effective methods of communication with primary care contractors and will inform, consult and engage with other partner organisations regarding the assessment, planning, commissioning and provision of services. The PCT will make every effort to ensure public involvement in its activities thus increasing the number of 'ambassadors' for its work.

It is important that evaluation of all communications activity is monitored through methods such as; qualitative and quantitative media evaluation, feedback forms, email / web-based audit, reviews and feedback on performance, focus groups, surveys of patients and service users, opportunities to comment at public meetings e.g. Board and AGM, PALS enquiries, compliments and complaints, thereby achieving targets and objectives and meeting legal deadlines. The PCT will also liaise with staff in Standards and Engagement to assess the impact of

specific communications or campaigns on individual sections of the community and / or user groups. The PCT is dedicated to working with others and with the individual to improve the health and well-being of its population.

11. GLOSSARY OF TERMS

A&E – Accident and Emergency
ABH – Achieving Balanced Health
ACE – Angiotensin-Converting Enzyme
AICS – Assessment and Intermediate Care Services
APMS – Alternative Personal Medical Services
BHF – British Heart Foundation
BME – Black and Minority Ethnic
C&YP – Children and Young People
CAMH – Children and Adolescent Mental Health Service
CART - Community Assessment and Rehabilitation Team
CAS – Census Area Statistics
CGC – Child Guidance Clinic
CHD – Coronary Heart Disease
CIRC – Community Information Resource Centre
CMHT – Community Mental Health Teams
COPD – Chronic Obstructive Pulmonary Disease
CPCF – Community Pharmacy Contractual Framework
CVD – Cardiovascular Disease
CYPD – Children’s and Young People’s Directorate
CYPP – Children and Young People’s Plan
DAAT – Drug & Alcohol Action Team
DES – Direct Enhanced Service
DNA – Deoxyribonucleic Acid
ECM – Every Child Matters
EHC – Emergency Hormonal Contraception
EPHP – Enhanced Public Health Programmes
EPP – Expert Patient Programme
ETP – Elective Turnaround Plan
FESC – Framework for External Support to Commissioners
FHS – Future Health Systems
GMS – General Medical Services
GP – General Practitioner
GPwSI’s – General Practitioners with Special Interests
GUM – Genitourinary Medicine
HAZ – Health Action Zone
ICD – Implantable Cardioverter Dibrillator
ICDH – Introduction to Community Development & Health
ISTC – Independent Sector Treatment Centre
LAA – Local Area Agreement
LD – Learning Disability
LDC – Local Dental Committee
LDP – Local Delivery Plan
LIFT – Local Improvement Finance Trusts
LMC – Local Medical Committee
LOC – Local Optical Committee

LPC – Local Pharmaceutical Committee
LPSA – Local Public Service Agreement
LTNC – Long Term Neurological Conditions
MI – Myocardial Infarct
MRSA – Methicillin Resistant Staphylococcus Aureus
NCG – National Commissioning Group
NHS – National Health Service
NHSLA – NHS Litigation Authority
NICE – National Institute for Health and Clinical Excellence
NORCOM - North Derbyshire, South Yorkshire and Bassetlaw Commissioning Consortium
NRF – Neighbourhood Renewal Fund
NSF – National Service Framework
NTA – The National Treatment Agency
NwSI's – Nurses with Special Interests
ONS – Office of National Statistics
OPFU – Outpatient Follow-Ups
PALS – Patient Advice and Liaison Service
PBC – Practice Based Commissioning
PBC IS LES – PBC Incentive Scheme Local Enhanced Service
PCT – Primary Care Trust
PCTMS – Primary Care Trust Medical Services
PDU – Problem Drug Users
PEC – Professional Executive Committees
PhWSI's – Pharmacists with Special Interests
PIPE – Patient Involvement and Public Engagement
POPP – Partnerships for Older Peoples Project
PMS – Personal Medical Services
PSA – Public Service Agreement
QOF – Quality and Outcomes Framework
SCAN – Single Contact Access Number
SCH – Sheffield Children's Hospital
SCNHSFT – Sheffield Children's NHS Foundation Trust
SCT – Sheffield Care Trust
SD's – Service Districts
SHA – Strategic Health Authority
SHAIPS – Sheffield Health and Illness Prevalence Survey
SHIELD – South Yorkshire HIV Support group
SICG – Strategic Integrated Commissioning Group
SMT – Senior Management Team
SONIC – South of the North In Consortium
SSDP – Strategic Service Delivery Plan
STH – Sheffield Teaching Hospitals
STHFT – Sheffield Teaching Hospitals NHS Foundation Trust
STIT – Short Term Intervention Team
TIA – Transient Ischaemic Attack
YATH – Yorkshire and the Humber

12. REFERENCES AND ANNEXES

- Annex 1 Report on the outcome of the *Achieving Balanced Health* consultation
- Annex 2 List of meetings held as part of the consultation
- Annex 3 Twenty questions for Sheffield PCT to consider from the consultation
- Annex 4 Life expectancy in Sheffield and percentage of deaths by causes
- Annex 5 Five year finance plan

Annex 1

SHEFFIELD PRIMARY CARE TRUST

Report on the Achieving Balanced Health Consultation Board Meeting September 2007

1. Purpose

- 1.1 To inform the Board of the outcome of the Achieving Balanced Health Consultation. This report sets out the consultation process and the key feedback themes from the public.
- 1.2 Sheffield people have been keen to have their say during the consultation process and this will influence the shape of the PCT Strategy.

2. Main Consultation Themes

- 2.1 The consultation focused on four specific areas:
 - Improving the health of people in Sheffield and reducing inequalities.
 - Taking more services into the local areas where they are most needed.
 - Providing out of hospital alternatives for planned or unplanned inpatient or outpatient care.
 - Providing alternatives to Accident and Emergency for some health problems.

3. Consultation Process

- 3.1 The PCT Achieving Balanced Health (ABH) consultation was launched to the public on 2 March 2007 for a three month period, finishing on 8 June 2007.
- 3.2 The consultation was branded Achieving Balanced Health with a logo giving it a distinctive look. It has been suggested that this should continue as part of the future engagement process.

- 3.3 A Core Delivery Team was established to oversee and co-ordinate the consultation process and included a lay member who acted as an independent scrutineer.
- 3.4 A questionnaire was developed which also provided space for the public to make their own comments about health care.
- 3.5 The main vehicles for obtaining the views of the public included:
- 80 people/organisations representing a variety of voluntary and faith sector organisations attending the consultation launch.
 - Sending 100 information packs out to all those invited to the launch who were unable to attend.
 - 20,000 questionnaires containing the four main consultation themes.
 - A website specifically for the consultation, which included PCT papers and general information. Links were also developed between the PCT website and Local NHS Trust and Local Authority websites.
 - A mail out to 1000 organisations including GP Surgeries, Dental Practices, Pharmacies, Libraries, Nursing Homes, Surestarts and many Voluntary, Community and Faith sector organisations.
 - 8,000 letters to new patients registering with GPs in Sheffield, informing them of the consultation.
 - ABH media coverage including articles in the Sheffield Star, Yorkshire Post, local radio interviews with Jan Sobieraj and Dr Jeremy Wight, 5 Alive (North Sheffield), Look Local, 0-19 Children's Partnership newsletter and the Health Service Journal.
 - Presentations by senior PCT managers at public meetings and Stakeholder events (a template of the meetings held can be seen in Appendix 1).

4. Summary of Public Involvement

- 4.1 The consultation aimed to involve a wide range of Sheffield people with particular emphasis on seldom-heard groups. This included:
- A telephone opinion poll of 1000 randomly selected demographically representative Sheffield people conducted by an independent organisation.
 - 76 ABH public meetings including 4 large public meetings.

- A 'Deliberative Event' involving 78 members of the public chosen by an independent organisation as a cross section of the community (recruited from the telephone poll participants).
 - An Expert Patient Programme event involving 70 people.
 - A meeting of the Health Partnerships Network encompassing the voluntary and community sectors, involving 55 people.
 - An expert Elders event involving 42 people.
 - 4 PCT staff roadshows.
 - 1200 responses to the questionnaire, including many who added their own comments about healthcare.
 - 910 individual responses to the consultation website.
- 4.2 Seldom-heard groups were reached by adopting a flexible and adaptable approach using a variety of methods. These included:
- The telephone poll and deliberative event as described above.
 - Sessions at Howden House effectively targeting a cross section of the public (Howden House is the city centre Local Authority facility for the public to centrally access information and advice across a range of local authority services).
 - Events which targeted key groups in Darnall, Tinsley, Arbourthorne and Park.
 - Focused events for Children and Young People including under fives in Early Years Centres, Youth Parliament members and a Children's Hospital Focus Group.
 - BME events including the Chinese, Afro Caribbean, Asian and Somalian communities.
 - 1:1 sessions with homeless clients at Archer Road and the Victoria Court Project.
 - A consultation event with women refugees involving six interpreters.

- A consultation event with 16 substance misuse service users.

5. Consultation Responses

5.1 Whilst there were a wide range of views expressed by respondents pertinent to their lifestyle, local environment, age, disability, gender and ethnicity, several common themes emerged from the consultation's four main questions:

- More information on self-care.
- Mobile health facilities.
- Local advice and health support workers.
- Alternatives to their GP, such as pharmacists and a local helpline.
- More services within GP surgeries.
- Alternatives to A&E, eg primary care satellite services out of hours.

6. Key Feedback Themes

6.1 The consultation responses have been analysed fully, mainly using the skills of a volunteer data analyst from a local voluntary organisation, who is also a volunteer member of the PCT's Clinical Audit Panel. An executive summary (Appendix 2) contains the major issues from the consultation.

6.2 From this analysis a number of key feedback themes emerged from the meetings with the public:

- Prevention
- Self care
- Inequalities
- Access
- Quality of Care
- Resources

6.2.1 Prevention

Key points included:

- More practical information is required on how to look after yourself eg healthy eating, stopping smoking, taking more exercise. Help and encouragement is needed for people to take action.
- Targeted local advice centres, support workers and local experts working with the community to improve people's confidence and knowledge and in offering support to improve their health.
- More focus on equitable access to screening.

6.2.2 Self Care

Key points included:

- Need for change in individual behaviour including taking more responsibility for one's own health.
- Need for better and more focused NHS service information as there is current confusion about the choices on offer. Leaflets were felt to be largely ineffective unless they were imaginative and eye-catching.
- Individuals want more control over care provided.
- Public wants more engagement in service design and delivery.
- Recognition of the need to get health problems dealt with early to avoid more intensive treatments later, but people require more information to help them manage their health better.
- Suggestion that tools be developed that help people navigate the care system with different approaches developed for different communities and groups.

6.2.3 Inequalities

Key points included:

- Support for addressing differences in health outcomes.
- Support for increasing resource in places of greatest need but levelling up, not down.
- Equity of care for people with:

- Physical disabilities
- Learning disabilities
- Mental health problems

recognising that these client groups can often be particularly disadvantaged through multiple chronic health problems and are often unable to proactively seek help.

6.2.4 Access

Key points included:

- Better signposting through health and social care systems.
- Promoting access and providing health information in non-traditional settings, including mobile facilities, community centres, pubs and at community events. More locally based services ensure people seek help earlier.
- Very unhappy about delays in getting GP appointments; the public stated they will use A&E when surgery is closed to cut through the confusion of understanding the alternatives.
- Develop concept of walk in centres in different locations.
- Openness to alternatives to current services, non-traditional settings and models of delivery of care.
- Possible barriers on the basis of language, culture, mental health problems or marginalised health needs when services not sensitive to the needs of different communities.
- Access to dentists varies.
- Knowledge, motivation, key contacts and trust in health workers are important factors for people to act early when they have a health problem.

6.2.5 Quality of Care

Key points included:

- General satisfaction about quality of care, but want it maintained.
- Sexual Health Services well received by young people.

- More consistency between GP services needed.
- Some concerns re respect by health care professionals to service users, particularly elderly, BME communities and marginalised groups.
- Better partnership working – concerns expressed about the fragmented nature of what should be seamless delivery of care.
- Concerns were expressed about a dilution of quality arising from a possible relocation of specialist services to local settings.
- Some concerns were raised about NHS Direct.
- Equity of care including concern about access to health care by those who are housebound or disabled.

6.2.6 Resources

- Concerns were expressed over the levels of funding available in the city to fund NHS services.
- Concerns about the possible waste of resources including whether some current services could be provided more efficiently/differently. Some out patient appointment can be unnecessary. GP appointment systems could be more imaginatively planned.

7. Demographic Information

7.1 Analysis of the questionnaire showed the age profile of respondents as 16-25 years (5%). 26 – 35 years (14%). 36 – 55 years (46%). and over 56 years (34%). 87% of respondents were White British. 3.8% of respondents were Asian or Asian British, 2.4% Black, 1.5% from other ethnic groups, 1.4% of Mixed Ethnic Origin and 1.3% Irish. 2% did not wish to disclose their ethnic origins. People with a disability represented 28% of respondents.

The telephone poll and deliberative event showed the age profile of participants as under 20 years (6%), 20 – 44 years (14%), 45 – 64 years (35%), 65-75 years (31%), 75+ years (14%). 57% were female, 5% from BME groups and 19% people with a disability.

Particular emphasis on an age group, geographical area or BME community can be viewed from the meeting template (Appendix 1).

All Sheffield postcodes participated in some form or another.

8. Equality Impact Assessment

- 8.1 An equality impact assessment was conducted by the PCT. It was recognised that the consultation process had worked hard at ensuring an inclusive approach through selecting a range of methods for engagement and consultation, taking into account the needs of diverse groups. However, there had been limitations and key learning points would be incorporated into any further engagement or consultation. The main comments can be viewed in Appendix 3.

9. Evaluation

- 9.1 The ABH Core Delivery Team conducted an evaluation of the process. Generally it was felt that the consultation events have been very well attended, received and appreciated by the public. The public viewed the high visibility of the PCT during this period very positively.

10. Conclusion

- 10.1 The PCT has adopted an open and transparent process of consulting with the people of Sheffield. The public have responded by providing a wealth of views about current health care and proposals for the shape of health services in the future. This rich source of data is now feeding into the production of the PCT strategy document scheduled to come to the PCT Board in October. There will also be a public launch of the Strategy at the Town Hall on 12 October 2007 including many organisations who have participated in the Consultation. Some groups and organisations have also requested a return visit from the PCT from October to discuss the PCT strategy in the context of the consultation comments. The consultation process will also inform the PCT's ongoing public and stakeholder engagement.

11. Recommendation

- 11.1 Board members are asked to:
- Receive the consultation report.

This paper was prepared by:

Sara Bradley, Achieving Balanced Health Consultation Lead

On behalf of
Simon Kirk, Director of Strategy

Meetings held during the consultation period			ANNEX 2
Date	Group	Venue	No. of attendees
31.1.07	Stakeholder Event	Town Hall	25
21.2.07	Carers Reference Group	Quaker Meeting Hs	18
2.3.07	PCT Achieving Balanced Health Launch	Town Hall	79
6.3.07	Sheffield Racial Equality Council	SYAC Wicker	6
14.3.07	Roadshow for Nurses	Firth Park Clinic	60 HV & Nurses
16.3.07	Children & Young People 0-19 Partnership Board	Town Hall	15
17.3.07	Deliberative Event	Ponds forge	78
19.3.07	SCC Roadshow	Chapelton	N/A
20.3.07	Sheffield First Health and Well-being Partnership Board meeting	Town Hall	11
26.3.07	Overview & Scrutiny Committee	Town Hall	9
27.3.07	Enhanced Public Health Meeting facilitation	Orgreave	6 Staff
29.3.07	Enhanced Public Health Programme Meeting	Town Hall	14 Staff
29.3.07	Compact	Centre in the Park	74 VCF sector representatives
29.3.07	Mental Health Partnership Board	Middlewood	17
4.4.07	Older Peoples Partnership Board	Fulwood	16
5.4.07	Winn Gardens Older People's Event	West Court	residents and specialist nurses
13.4.07	Clinical Audit Patient Panel	Fulwood	8
13.4.07	Stocksbridge Community Health Forum	Library	10
16.4.07	Cardiac Rehabilitation Group		12
18.4.07	0-19 Overview & Scrutiny Cttee	Town Hall	19
18.4.07	Sheffield Care Trust Council Meeting	Quaker Meeting Hs	34
19.4.07	Enhanced Public Health Leads	Don Valley Hs	10 Staff Leads covering deprived communities
19.4.07	STHT Governors Meeting	XX	Decided to do individually
20.4.07	Staff Roadshow	Fulwood	8 staff
20.4.07	Staff Roadshow	Orgreave	15 staff
25.4.07	Asian community meeting re EPHP	Darnall	6 Asian men from community
30.4.07	Healthier Darnall Meeting		8
30.4.07	Community Health Advisory Group (CHAG)	Firth Park Clinic	9
1.5.07	Sheffield PCT Board (private section)	Fulwood	
2.5.07	Sheffield Community Access and Interpreting Service	Fulwood	15 Interpretation staff
2.5.07	Staff Roadshow	West Court	8 staff
2.5.07	Staff Roadshow	Firth Park Clinic	6 Staff
4.5.07	50+ Stocksbridge Event	Stocksbridge Library	N/A

Date	Group	Venue	No. of attendees
8.5.07	Shiregreen Forum		N/A
9.5.07 6.30 pm	Childrens Hospital PPI Forum	St Mary's	7
10.5.07	Parkinson Disease Stakeholders Group	Fulwood	15
10.5.07	Norfolk Park & Arbourthorne Community Grp	Mega Centre	14
10.5.07 1.00 pm	PCT PPI Forum	Quaker Meeting Hs	15
14.5.07	Firth Park Forum	Old Library	N/A
14.5.07 10.15	Women's Health & Discussion Group Parson Pa	Parson Cross Park Pavillion	11
15.5.07	EPP Event	Shel Wed FC	70
15.5.07	Shiregreen Neighbourhood Panel		N/A
15.5.07	Manor, Woodthorpe & Park Hill EPHP Grp	Norfolk House	N/A
16.5.07	Healthier Tinsley Meeting		15
17.5.07 2.00 pm	Community Support Services, Grange Crescent Service Users	Grange Cres, 105 Grange Cres,	11 people with physical disability
17.5.07 9.30	Sheffield Care Trust Non Exec & Exec	Fulwood	14
19.5.07	Burngreave Celebrates Learning Event	funival Burngreave	N/A
21.5.07	Community Involvement Strategy Group	Orgreave	0
21-25.5.07	12 Area Panels	Various	N/A
23.5.07	Health Partnership Network	Quaker Meeting House	47 VCF sector
26.5.07	Mosborough/Handsworth Forum		6 Children & Youndg People
29.5.07	Sheffield Children's Hospital Focus Group	Abbeydale Room Univerity House	9 children
29.5.07	UK Youth Parliament Members		6 Young people
30.5.07	50+ Event at Darnall	Darnall Community Resources C	N/A
31.5.07	Nursery Group	Manor Nurser	6 under 5 years
5.6.07	Healthier Darnall - meeting for BME women	Subud Centre	8 Somali women
7.6.07	CAST/Care Leavers and LAC		8 young people
6.6.07 pm	Victoria Court Project	73a Victoria St S3	3 Homeless individuals
	Cathedral Breakfast Project		5 Homeless individuals
5.6.07	Nursery Group	Manor Nurser	6 under 5 years
5.6.07 9.30	Roshnie Management Committee	London Rd	10
4-8.6.07	First Point Service (SCC)	Howden House	N/A
05/06/2007	Sheffield PCT Board Meeting		
5.6.07	Early Years Centre	Palgrave Rd	4 young children
5.6.07 2.00 pm	Expert Elders	Ponds Forge	44 older people
6.6.07	Early Years Centre	Palgrave Rd	4 small grp
6.6.07	Chinese Community Centre Management	London Rd	7 Chinese community

Date	Group	Venue	No. of attendees
7.6.07	Refugee Support Women's Activity Group	Station Foyer	19 from 6 different ethnicities
7.6.07 12 noon	Physical Disability Therapy Team	Pub, Handsworth	8 physically disabled
8.6.07	Wybourn Health Trailblaxer	Wybourn Wellbeing	8
	DAT User Volunteer Project		16 ex-drug users
12.6.07	NSF Long Term Conditions Group		8
13.6.07 6.30	Carribean Health & Wellbeing Group (blackcard)	SADACCA	21 Caribbean & African community
13.6.07	Chinese Community Centre Event	London Rd	27 Chinese community
Feedback meetings			
30.7.07	Strategic Review Meeting	Town Hall	
16.11.07 10.30 am	Stocksbridge Community Health Forum	Stocks Library	
12.10.07	Feedback Event	Town Hall	

Annex 3

Achieving Balanced Health – Public Consultation: Executive Summary of Major Concerns

The 2400 plus individual comments that have been submitted to the PCT during its consultation on Achieving Balanced Health have been transcribed, examined and categorised.

These comments are encapsulated by the following 20 questions that need to be addressed by the PCT in both framing its strategy for the next 5 years and perhaps as importantly in responding to those who participated over the 3 month consultation period.

Some of the questions cannot be resolved by the PCT alone or in part but perhaps need to be acknowledged as real concerns expressed by those who responded to the invitation. However some of the questions can and should be addressed by the PCT.

It is hoped that these questions will form the framework for a continuing dialogue with the people of Sheffield. They can be useful reference points when the PCT reports back on their initial strategy and when, hopefully soon afterwards, it embarks on a longer and more open consultation process to inform its first review.

The 20 Questions:

1. To achieve the better equalisation of life expectancy and access to hospital care across the city that you aspire to, to what extent will you level down or level up resources?
2. In achieving a balance in the allocation of resources across Sheffield, to what extent will you also be able to equalise access to family practitioner services for those who are disabled, housebound or isolated, wherever they might live in the city?
3. To what extent will you be able to ensure that people with mental illness, learning disabilities and physical impairment have an equal access to quality and fairly resourced services, wherever they might live in the city?
4. To what extent can you reinstate an effective and local family doctor service 7 days a week -instead of just 9 to 5 for 5 days a week (and in some practices just 4 1/2 days a week
5. To what extent can you remove barriers to working people being able to make an appointment to see their GP?
6. Are you able to withdraw funding from NHS Direct - which has demonstrably failed to deliver quick, personal or helpful advice - and stop wasting our money on this alternative to an adequate out of hour's family doctor service?
7. What, if anything, will you do to restore access to regular NHS dental examinations and treatment across the city?

8. What, if anything, will you do to provide more regular sight, hearing and general health screening services to avoid the wasteful use of our money on emergency and acute management of illnesses that could be treated less expensively if detected earlier?
9. What can you do to prevent or reduce long term health damage caused by tobacco, drug and alcohol abuse? If the continuing provision of information and support does not reduce demand what other action can you take to minimise the unequal burden that some believe is placed on our health services for these avoidable reasons?
10. To what extent can you recognise that many of us prefer good local services to having a choice of different service providers because we value continuity of care?
11. Do you recognise that many are bewildered, confused and increasingly frustrated by the maze of services now available as an alternative to an effective, accessible local family doctor service and need clear guidance how to negotiate their way through it all?
12. To what extent will you negotiate with local hospitals to ensure they share information more effectively with other hospitals in the city, with our GPs and with us? Can you provide those of us, with many and complex health problems, or our prime carers, with our health record so we can manage and share it with those who treat us?
13. To what extent and in what ways can you respond to the willingness by many to have more control over their own healthcare and by some to be more engaged in service design and delivery through involvement in patient panels and continuing dialogue with the local NHS and its officers?
14. To what extent and in what ways can you do anything to improve the respect shown by health service staff to patients, particularly those who are elderly?
15. To what extent and in what ways can you ensure local hospitals do more to protect the dignity of patients, irrespective of their cultural needs, and ensure we not only receive adequate nutrition and hydration but avoid hospital acquired infections?
16. To what extent and in what ways can you ensure that accelerated discharge from our local hospitals does not leave vulnerable patients isolated and without adequate home support?
17. What if anything can you do to ensure that the more local provision of hospital services, that you aspire to, will maintain the same (if not higher) levels of quality of clinical care, when you are both diluting the skill mix and diminishing the levels of practical experience of those who will provide the service to us?
18. To what extent will you be able to you reintroduce and expand the use of mobile clinics and Health buses in Sheffield that have been well received in the past?

19. To what extent, if any, can you provide continuing as well as respite care for those of us who care for others at home?

20. To what extent are you able and prepared to provide segregated services for and staffed by individual ethnic and/or gender groups within Sheffield?

These 20 questions encapsulate much of what has been submitted.

Although some individual observations will not be covered - it is hoped that there will nonetheless be a high degree of acceptance by the individuals and organisations involved in the consultation process that these 20 questions represent fairly what has emerged as the “voice of the people of Sheffield”.

Anyone who reads the selected quotes used as evidence to support the 20 individual questions will soon realise that the PCT cannot possibly satisfy all opinions that have been expressed. Indeed some of the concerns cannot be addressed other than by changes in policy at National or Regional level.

However it is hoped that, even if the resulting Strategic Plan of the new PCT can not respond to all of the concerns expressed in the 20 questions, the PCT will still endeavour to represent these concerns, and report back from time to time, to those who commented during the consultation period, on any progress that can be perceived.

The 41 Transcribed reports of meetings and correspondence related to the consultation process will therefore be checked against progress in responding to the 20 questions before reporting back to groups and individuals. Any outstanding comments not encapsulated by the 20 Questions will also then be addressed during these feedback meetings.

It is hoped that the feedback meetings will not mark the “beginning of the end” of consultation with the people of Sheffield by the PCT. Rather it is hoped that the feedback meetings will mark the “end of the beginning” of a process of continuing dialogue.

A continuing dialogue between the PCT and the people who both pay for and receive the services it is charged with purchasing (and - for some time to come – providing) on their behalf, must represent the best way of informing the future planning of local health services in Sheffield.

If after the feedback meeting anyone feels that their specific comment has still not been responded to then they will be able to draw this to attention of the Public and Patient Involvement Forum of Sheffield PCT and through them to the Health and Well being Oversight Scrutiny Board of Sheffield City Council.

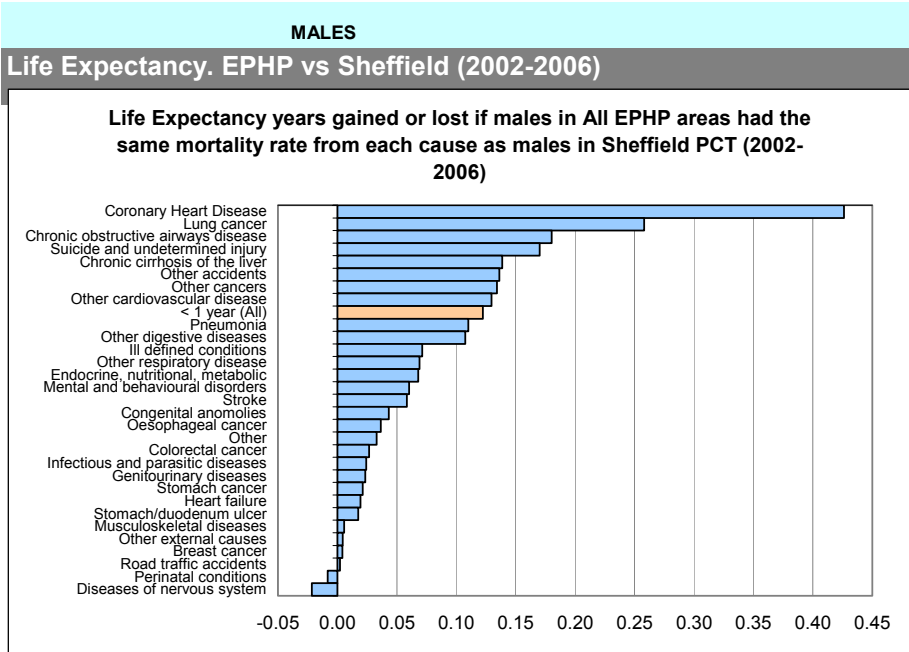
Prepared by David Symes

September 2007

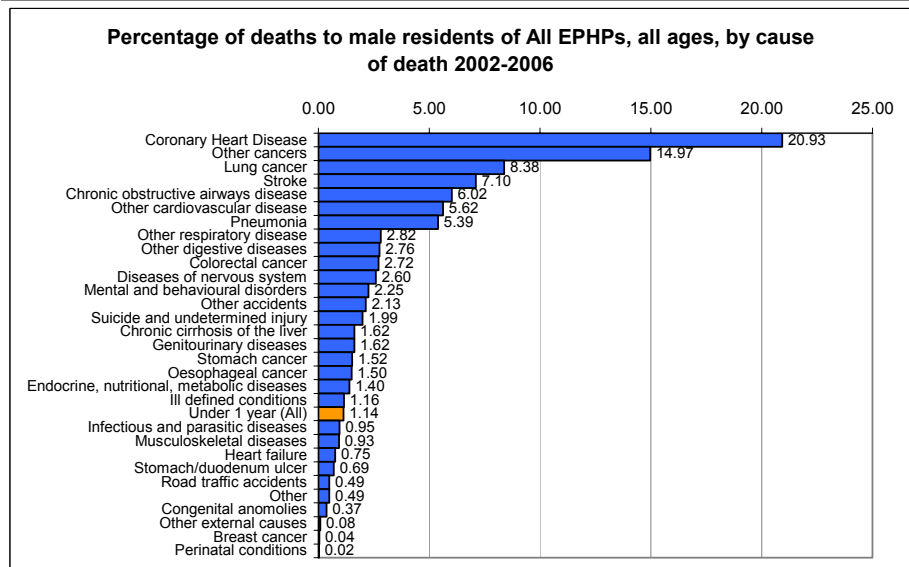
These questions are drawn from a summary of all of the consultation responses received during the thirteen weeks of the consultation period. This 50 page summary is available from Caroline Langley at Sheffield PCT on 0114 226 4035.

Annex 4

**All Enhanced Public Health Programme Areas
Life Expectancy and Percentage of Deaths by Cause (2002-2006)**



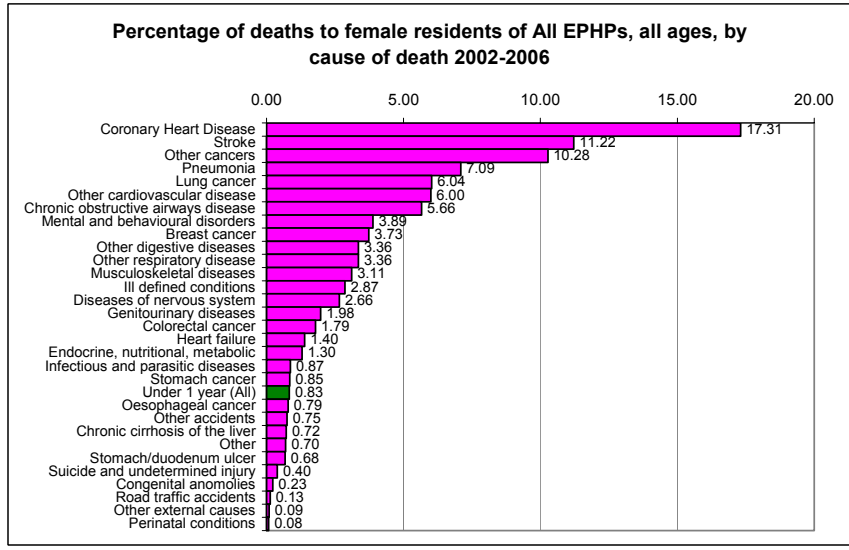
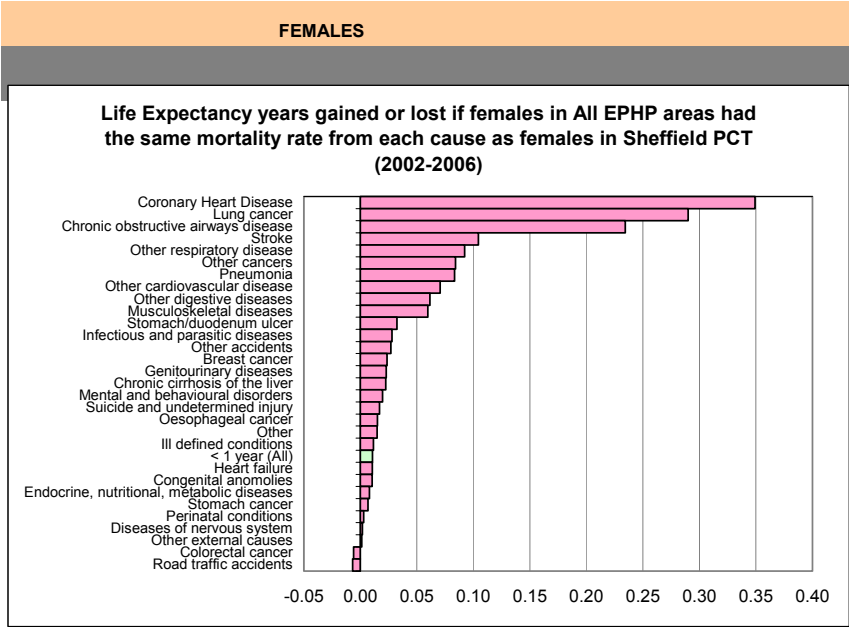
All Cause, All Age Mortality. (2002-2006)



NB: Where the graph or count shows Under 1 year (All), this includes all deaths aged under 1 year. Where cause of death falls under a specific category, the death is also included in that category. Deaths under 4 weeks tend not to be included under a spec

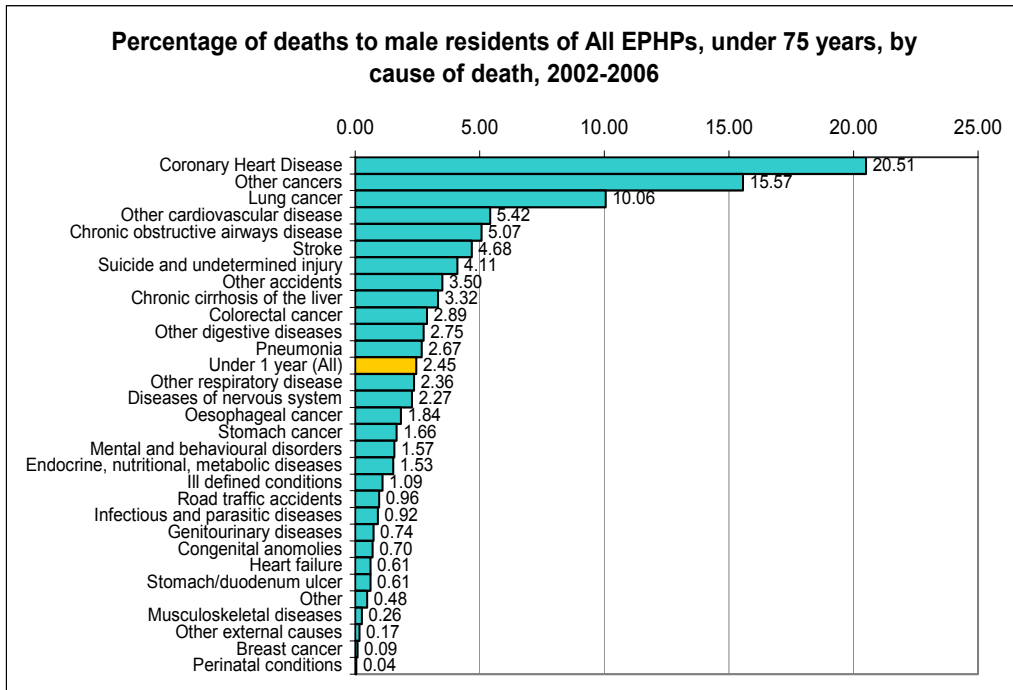
All Enhanced Public Health Programme Areas

Life Expectancy and Percentage of Deaths by Cause (2002-2006)



NB: Where the graph or count shows Under 1 year (All), this includes all deaths aged under 1 year. Where cause of death falls under a specific category, the death is also included in that category. Deaths under 4 weeks tend not to be included under a spec

Premature Mortality aged Under 75 years. (2002-2006)



Top Ten Main Causes of Death (2002-2006)

MALES

All Ages

Cause	Total
Coronary Heart Disease	1032
Other cancers	738
Lung cancer	413
Stroke	350
Chronic obstructive airways disease	297
Other cardiovascular disease	277
Pneumonia	266
Other respiratory disease	139
Other digestive diseases	136
Colorectal cancer	134

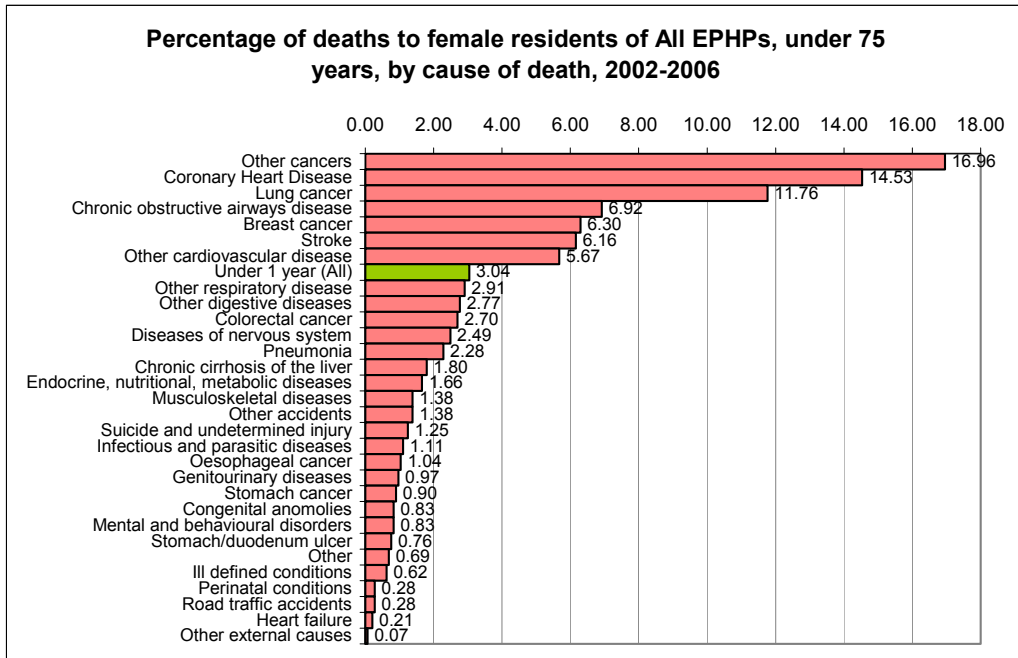
Aged under 75 years

Cause	Total
Coronary Heart Disease	469
Other cancers	356
Lung cancer	230
Other cardiovascular disease	124
Chronic obstructive airways disease	116
Stroke	107
Suicide and undetermined injury	94
Other accidents	80
Chronic cirrhosis of the liver	76
Colorectal cancer	66

Public Health Analysis Team, (TJ,AR), August 2007

NB: Where the graph or count shows Under 1 year (All), this includes all deaths aged under 1 year. Where cause of death falls under a specific category, the death is also included in that category.

Premature Mortality aged Under 75 years. (2002-2006)



Top Ten Main Causes of Death (2002-2006)

FEMALES

All Ages

Cause	Total
Coronary Heart Disease	918
Stroke	595
Other cancers	545
Pneumonia	376
Lung cancer	320
Other cardiovascular disease	318
Chronic obstructive airways disease	300
Mental and behavioural disorders	206
Breast cancer	198
Other digestive diseases	178

Aged under 75 years

Cause	Total
Other cancers	245
Coronary Heart Disease	210
Lung cancer	170
Chronic obstructive airways disease	100
Breast cancer	91
Stroke	89
Other cardiovascular disease	82
Under 1 year (All)	44
Other respiratory disease	42
Other digestive diseases	40

Public Health Analysis Team, (TJ,AR), August 2007

NB: Where the graph or count shows Under 1 year (All), this includes all deaths aged under 1 year. Where cause of death falls under a specific category, the death is also included in that category.

Annex 5

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
	£'000	£'000	£'000	£'000	£'000	£'000
REVENUE RESOURCE LIMIT						
Revenue Resource Limit (Recurrent)	823,680	852,509	882,347	913,229	945,192	978,273
Revenue Resource Limit (Non Recurrent)	(26,303)	(19,056)	(11,095)	3,317	5,264	(604)
Deficit/Surplus b/f from previous year (Non Recurrent)	1,286	0	(3,980)	(11,185)	(12,159)	(9,224)
TOTAL REVENUE RESOURCE LIMIT	798,663	833,453	867,272	905,360	938,297	968,446
EXPENDITURE						
Commissioning/Other Contracts						
Acute	415,086	434,497	448,383	470,929	493,935	517,400
Mental Health	70,598	72,276	73,721	75,196	76,700	78,234
Community Services	90,525	99,183	102,959	106,398	110,354	114,430
	576,209	605,956	625,064	652,523	680,988	710,064
Primary Care						
Dental	24,277	24,547	25,038	25,539	26,050	26,571
GMS/PMS	69,539	70,793	73,212	77,143	78,685	80,259
Pharmacy	4,263	4,418	4,507	4,597	4,689	4,782
Prescribing	84,881	91,564	98,889	106,800	115,344	124,571
	182,960	191,322	201,646	214,078	224,768	236,184
Other						
Provider Services (Full Cost Recovery)	(398)	(110)	(110)	(110)	(110)	(110)
Public Health	10,379	10,431	10,639	10,852	11,069	11,291
Corporate Infrastructure	17,121	17,933	18,291	18,657	19,030	19,411
Reserves - Committed	11,108	(226)	(3,781)	(7,327)	(11,363)	(15,485)
Reserves - Uncommitted	1,284	4,167	4,336	4,527	4,691	4,842
	39,494	32,195	29,377	26,600	23,318	19,949
TOTAL EXPENDITURE	798,663	829,473	856,086	893,201	929,073	966,197
(UNDER)/OVERSPEND	0	(3,980)	(11,185)	(12,159)	(9,224)	(2,249)
(Under)/Overspend assumes NEW recurrent service redesign and benchmarking savings of:	£12m turnaround savings	4,000	4,000	4,000	4,500	4,594
Hence cumulative savings required are:		4,000	8,000	12,000	16,500	21,094
IN ORDER TO CREATE AN INVESTMENT FUND OF £4M PA, FURTHER SAVINGS AT AN EQUIVALENT LEVEL WILL NEED TO BE GENERATED, POTENTIALLY BY MOVING TO NATIONAL BENCHMARK BEST PRACTICE PERFORMANCE						
Memo						
Recurrent (under)/overspend	(32,303)	(15,024)	(14,618)	(8,175)	(4,430)	(540)
Non Recurrent (under)/overspend	32,303	11,044	3,432	(3,984)	(4,795)	(1,710)
TOTAL (UNDER)/OVERSPEND	(0)	(3,980)	(11,185)	(12,159)	(9,224)	(2,249)

Annex 6

PATIENT INVOLVEMENT & PUBLIC ENGAGEMENT STRATEGY

1. Introduction

This Strategy has been developed to take forward Sheffield Primary Care Trust's (PCT) commitment to putting patients, carers and the public at the centre of its everyday business. It supports the PCT's overarching five year strategic plan which is our route map of how we develop and deliver health services for the population of Sheffield.

2. Why do we need an engagement strategy?

Sheffield PCT welcomes the fact that the Government has made service user involvement and engagement a high priority by including it in all recent guidance and policies. It highlights that in order to improve patient experience of their health services, we should empower patients to have a say in the way the health service works and enable people to have a greater role in their own health.

As a PCT we have responsibilities regarding patient involvement and public engagement which include:

- Foster and represent patients/ public interest
- Create structures for the public to have a tangible input into decision making
- Support and implement patient choice.

Section 11 of the Health and Social Care Act 2001, which places a duty on PCTs to make arrangements to involve and consult the public on:

- Planning services they are responsible for;
- Developing and considering proposals for changes in the way those services are provided;
- Decisions to be made that affect how those services operate.

The overall aim of Section 11 is to make sure patients and public are involved and consulted from the very beginning of any process to develop health services or change how they operate. It brought about legislation that created:

- Overview and Scrutiny Committees (OSC)
- Patient Advice and Liaison Service (PALS)
- Patient and Public Involvement Forum (PPIF)
- Independent Complaints and Advocacy Services (ICAS).

The Local Government and Public involvement Health Bill 2006-2007 is expected to gain Royal Assent later this year. This will abolish Patient Forums and introduce Local Involvement Networks (LINKs) from April 2008. It will also place a duty on PCTs to respond to feedback from patients and the public. It may also expect more patient experience information to be included in the PCT prospectus and give the right to service users, Overview and Scrutiny Committees and Local Authorities to raise concerns in a petition, which the PCT will have responsibility to respond to.

One of the key roles for Sheffield PCT is as a commissioner of services. This includes the services we commission directly and working with Family doctors (General Practitioners (GPs)) who are forming into Practice-based commissioning (PBC) groups

where they are using budgets delegated by the PCT to help design better ways of meeting the needs of patients, carers and the public. We also have a key role to provide services directly and to undertake both the provider and commissioner roles effectively we need to engage with patients and local communities.

In order for the PCT to achieve effectively all the responsibilities outlined above, its important that we have structures and mechanisms in place to ensure that we can and importantly that patients and the public know what the PCT is doing and how they can be involved. This Engagement Strategy sets out how the PCT will do this.

3. What is our previous experience?

Across the 4 previous Sheffield PCTs there was a wealth of expertise regarding effective involvement and engagement. However, in bringing together the current Patient Involvement and Public Engagement Team it was realised that it would be useful to clarify where we had good systems and where we needed to develop new ways of working. The PCT therefore worked in partnership with Sheffield Hallam University as part of a Knowledge Exchange Project. The report from the Project involved many staff and stakeholders whose views have helped to develop this strategy and this has helped us be clear about how to achieve effective involvement and engagement.

4. How was the strategy developed?

It is important to the PCT to be able to demonstrate that we have developed this Strategy on the experience, knowledge and views of all our stakeholders and being clear about what we are going to do. It takes into account the PCTs vision for the future, which includes:

- Ensuring active engagement with patients, the public and staff
- Building on what is already good
- Working through partnership.

The strategy builds on previous work undertaken in partnership with Sheffield NHS Trusts, Sheffield City Council and Voluntary Community and Faith sector groups. This work culminated in a strategic vision for Patient and Public Involvement paper, which was presented to the Sheffield First for Health Partnership Board in 2006.

The Achieving Balanced Health consultation was undertaken earlier this year. Key themes arising from this were shifting services and resources from secondary care to community and primary care and tackling the high level of health inequalities within Sheffield. This strategy builds on learning from the consultation and partnership working undertaken. The PCT staff were actively involved within this process both for their views on what we needed to do and how we should do it.

5 What are our Key Priorities?

The PCT has also agreed that three key priorities are central to achieving effective engagement. These underpin the Strategy and give clarity and direction to both our staff and service users:

Focus resources on creative engagement of the seldom heard - Focusing fixed resources on engaging the population that are seldom heard will help us to develop and shape the services required to improve the health inequalities across Sheffield. The strategy aims to improve communication with local communities and service users so that they are engaged in the commissioning process for the PCT and Practice Based Consortia Groups. This is especially important in gaining the views of those groups that are seldom heard, where services may be inappropriate and therefore not accessed. This strategy includes feedback from a special event which was held to ensure input from these groups and the staff working with them

Maintain effective engagement through agreed approaches - Excellent work has been carried out across Sheffield to involve service users in health and wellbeing structures. The Patient Involvement and Public Engagement Team have collated this, and along with the work undertaken in partnership with Sheffield Hallam University (the Knowledge Exchange Project), will form the basis for understanding what gaps we have and what methods give the best outcomes for service user satisfaction and service improvement.

Have patient involvement in the development, purchase of appropriate services, and monitor of their effectiveness – Lay involvement is crucial to the development of services and therefore the PCT will ensure that service users are part of the strategic procurement cycle.

6. Principles of Involvement for Sheffield PCT

7.

During the last year the new Patient Involvement and Public Engagement Team have worked with service users to develop our principles for involvement.

Ten Steps to Involvement

1. **Why** - Patient and Public Involvement (PPI) will contribute towards improving the overall health and well-being of the people of Sheffield.
2. **What** – Sheffield PCT will engage with users and the public in planning, redesigning, delivering, monitoring and evaluating health services. To Listen, Act, and then Communication
3. **Who** - People who have contracts with the PCT such as GPs, dentists, pharmacists and opticians will show the same commitment to involvement.
4. **How** - There will be clear processes and structures established for engaging service users and the public that will be easily understood and used by local people and PCT staff.
5. **How** - The PCT will use many different ways to involve as many users and members of the public as possible.
6. **Where** - Sheffield PCT will involve people in the places and at the times that are convenient for them.
7. **Support** - The PCT will provide adequate and appropriate information, resources, training and support so that public engagement is genuine and effective for both NHS staff and patients/public.
8. **Standards** - Sheffield PCT will make sure that its processes are open, honest and transparent so that everyone can see how it uses public money
9. **Completing the Cycle** - Feedback to the public following involvement and consultation will be timely and made available in a range of formats as requested and appropriate.
10. **Evaluation** – The PCT will ask users and the public to regularly evaluate PPI work to ensure that it is appropriate and effective.

7. What will we achieve?

By using the ten steps to involvement within the work required for the priorities of the PCT, will enable us to deliver several key outputs:

Key outputs

- We will introduce and implement innovative patient and public mechanisms that meet the needs identified.(e.g. via internet,)
- There will be active encouragement for patients and the public to proactively engage with the PCT and Practice Based Consortia and provide feedback and views on existing services and future services.
- Patients and the public will be able to access our strategic plans, proposals for reform, and performance data
- Provision of effective PALs service

An Engagement implementation plan will be developed which will set out the key outputs, how we will work to achieve them, who will be responsible, when will they be delivered, and how will we know that we have undertaken it effectively.

This work is in progress awaiting the final agreement from the PCTs Trust Board regarding the Five year strategic plan.

8. How will we engage?

The feedback we received when undertaking many of the consultation events is that one size doesn't fit all and that we need a variety of approaches of how we will engage and involve people. The framework below sets out the "**Patient involvement Continuum**" which can be viewed as a scale or continuum ranging from minimum to maximum. The level of involvement should be matched with the circumstances and context in which it is to take place. It is good practice to consider a variety of approaches to decide how they fit together to establish a pattern of ongoing involvement and dialogue. Generally, in moving along the continuum towards maximum involvement there will be more in-depth involvement in the PCT's decision-making processes.

Public Involvement Continuum

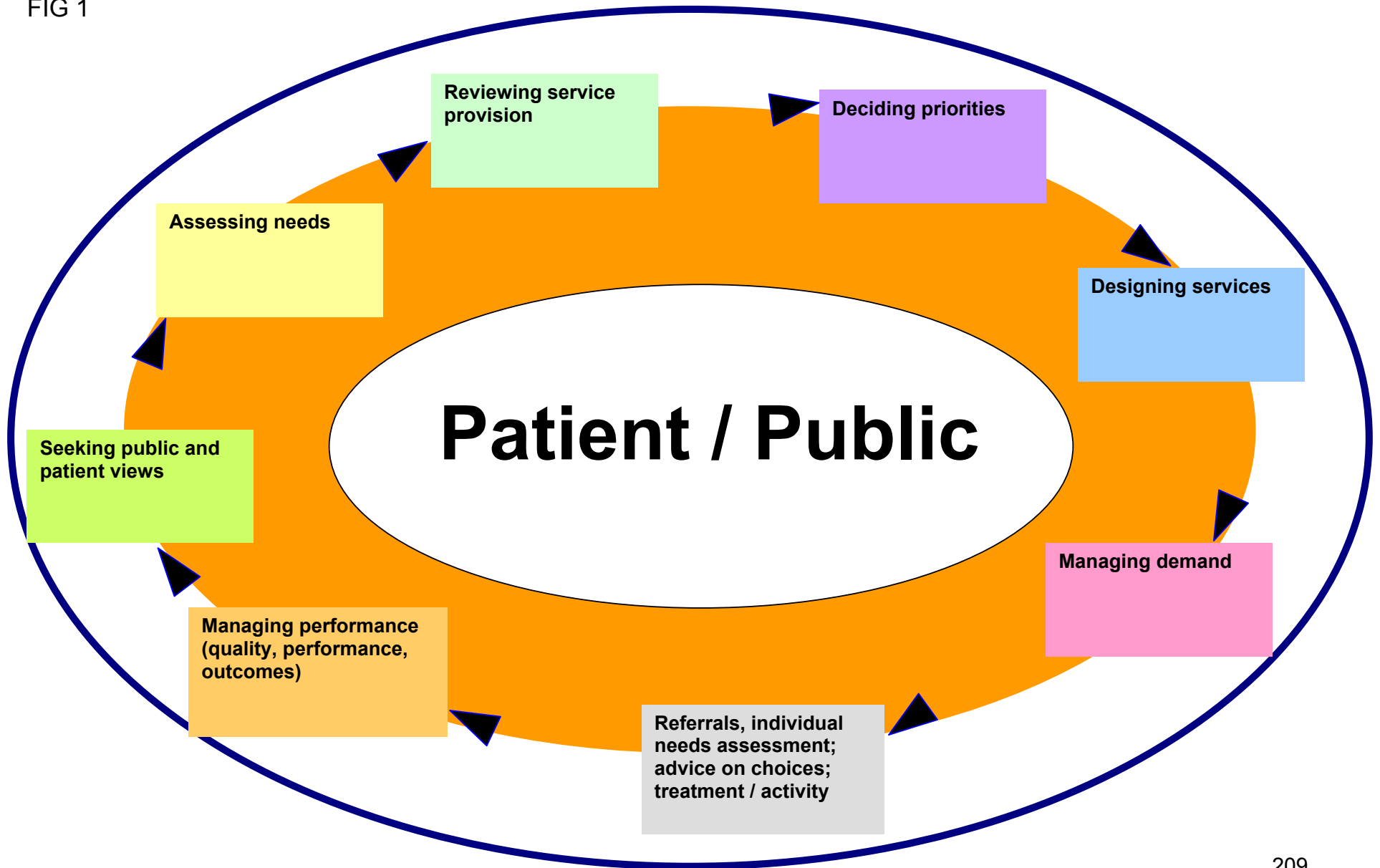


Minimum involvement
involvement

maximum

Giving Information (eg the PCT patient prospectus)	Getting Information (eg Patient Surveys)	Forums for Debate Deciding together (eg Patient Panels)	Participation - Acting Together (eg Expert Patient Tutors)	Partnership - Supporting Local Initiatives (eg Local Health Forums)
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FIG 1



9. Stages of involvement

Figure 1 sets out the opportunities for both the PCT to go out and engage and involve people but also for people to get proactively involved with the work of the PCT. It forms the Strategic procurement cycle which is the process that PCTs use when developing and delivering services for the population of Sheffield. It covers the whole cycle from assessing and identifying needs to the managing the performance of the services that are delivered. Examples of involvement are given below at the appropriate stages but are not exclusive.

Assessing Needs

The PCT undertakes Health Needs Assessments and this provides valuable information about the health needs of particular communities and populations. This will help the PCT to determine what and where services need to be provided to meet these needs.

Examples:

- As part of the Drug and Alcohol Team's Service User Involvement Volunteer Project a major consultation around the needs of carers has been completed.
- A comprehensive needs assessment of service users is in progress and will be available in the autumn of 2007 looking at teenage pregnancy, demand for abortion for older women and sexually transmitted infections. This will assist in better targeting of services.

Reviewing service provision

Service users will help the PCT and Practice Based Consortia groups to identify gaps in provision and potential for improvements.

Examples:

- This can be done by national patient surveys of the PCT as well as surveys of individual GP practices.
- The PCT has an audit programme which reviews clinical practice, and some Practices are actively involved. The Clinical Audit Patient Panel ensures that service users are involved in the process.
- The Community Health Advisory Group is a group of service users interested in health issues. Over the past five years they have helped to PCT managers to review various aspects of service provision that we provide or commission eg out of hours services, dermatology and medicines management.

Deciding priorities

The PCT's Strategy for provision of services during the next 5 years has been developed following extensive consultation with stakeholders, service users and staff. As Practice Based Consortia Groups develop plans these will need to be consulted upon.

Examples:

- The citywide Diabetes User Group recently viewed the national survey for people with diabetes to agree priorities for action to make improvements where necessary.

- As part of the Enhanced Public Health Programme and Local Area Agreement plans service users and staff trained together to help neighbourhoods to identify priorities.
- The Learning Disabilities Partnership Board has developed over the years and now has strong representation with service users. Service user representatives sit on project groups for all the key workstreams.

Designing services

Services will be designed around the needs of the local population. Health Needs Assessments will be conducted and service users will be involved at strategic and operational level in groups planning service development. Where appropriate the PCT or Practice Based Consortia Group will consult with the relevant groups.

Examples:

- Sheffield Cancer Services Advisory Group, which seeks to facilitate the engagement of patients using cancer services. It is important that the PCT should work with service users, to learn how we might improve services.
- Individual Practice Patient Panels or Practice Based Consortia Patient Panels can provide a rich source of input to designing services and be champions for change in a specific area.
- Via Partnerships for Older People Projects (POPPS) and Expert Elders the views of people with dementia and their carers have been obtained to form part of the Dementia Strategy, including membership of its reference group and the writing of its foreword.

PCT prospectus

This will be an annual publication delivered to every household in Sheffield. It will include future plans for local health services; choices open to them; inform service users about how PCT money has been spent and form the basis for communication with the PCT via contact details. Information received as part of the *Seeking public and patient views* process will also be included in the prospectus.

Managing demand and ensuring appropriate access to care

PALS and complaints contacts can help to inform the PCT and Practice Based Consortia Groups about satisfaction with demand and access to care. National surveys, the Quality and Outcomes Framework survey and the National GP Access and Choice survey will also give relevant information.

Examples:

- As part of commissioning the PCT is responsible for In-Patient activity within Sheffield. Clearly links with the 18 week target, which focuses on measuring patient journey from start to finish, so will fully reflect patient experience. Patient pathways are being developed in key areas jointly with Sheffield Teaching Hospital Foundation Trust, the lead Practice Based Consortia group and the PCT.
- By developing more self care support for people, particularly those in disadvantaged groups and areas (eg the Expert Patient Programme), service

users will find it easier to make healthier choices about their condition and make best use of services available.

Clinical decision making

On an individual basis service users and clinicians will always make health care decisions together with all relevant information being assessed.

Examples:

- Community pharmacy engages closely with its service users as they are customers for the products and services it delivers. Via the Achieving Balanced Health consultation the PCT learned that people valued the advice and information given by pharmacists to help them make health choices.
- The PCT has provided GP practices with Choice information booklets and access to the NHS Choice website.

Managing performance

The PCT's aim will be to comply with all necessary performance measures indicated in the Standards for Better Health, Fitness for Purpose and Auditor's Local Evaluation Programme. The Patient and Public Involvement Forum, the Local Involvement Network when developed and patient groups and advisory groups can all be involved in monitoring our performance against our plans.

Examples:

- Part of the Enhanced Public Health Programme's aim is to reduce the number of service users in Sheffield who smoke. As part of this work a focus group with staff and service users will be held to gain feedback on the user experience.
- Funding for a significant element of PCT contracts with family doctors is dependent on positive patient experience on the quality of and accessibility to service. The Primary Care Team's aim is to ensure that patient views are not merely collected but form part of a reasoned discussion as to why family doctors are unable to meet patient expectations. Service users will be trained and invited to participate in the PCT's review of Practice Action Plans in response to local and national patient surveys.

Seeking public and patient views

Sheffield PCT has a duty to report patient's views on their experience of local health and wellbeing services. This will be done in a variety of ways.

Examples:

- Quarterly reports within internal clinical governance procedures using information collated from various methods mentioned previously but also including incidents reported.
- Specific surveys eg the National Patient Survey of the PCT will be made public and a report and action plan developed to take forward necessary improvements.
- Meetings and groups attended, events organised and other methods of involvement will be collated on a database to ensure easy access to information about specific groups or community views. This will also help with our performance monitoring targets.

- Via the Achieving Balanced Health consultation the PCT visited many seldom heard groups eg Asylum Seekers, the Chinese Community. This engagement led to service user views from these groups informing the new PCT strategy for service provision and also underpins this strategy.

10. What do we need to ensure capacity and accountability?

Sheffield PCT is dedicated to the involvement and engagement of and with service users regarding health and well-being issues and understands the importance of embedding this within the structures of the organisation. This commitment has been evidenced by the appointment of an Executive Director with lead responsibility for this work and a dedicated team to steer the activity identified in the strategy.

Within the PCT a multi-disciplinary group will be developed to help to take the actions in the strategy from words to reality. Membership will include a Non-Executive director, senior PCT officers and service users. The Group will be accountable to the PCT Board, who will regularly receive activity reports. Sheffield PCT is represented on the City-wide PPI/PALS Group that is accountable to the Sheffield First for Health and Well-being Board.

In developing this strategy the PCT found that staff want to undertake involvement initiatives and improve ongoing dialogue with service users. However, they felt they needed support; a central information resource; and training, especially about how to evaluate work in terms of “distance travelled” for the participants. The PCT will therefore include developments to remedy this in the Implementation Plan. Examples are:

- The Introduction to Community Health Development Course (ICHHD) is used as a network of health and involvement champions.
- Develop a database of involvement and engagement activity.
- Build on the pool of volunteers committed to a relationship with Sheffield PCT
- Develop an interactive Patient Involvement and Public Engagement Website for public and staff.
- Training for staff, including exploring the opportunities opened up via Knowledge Exchange regarding e-learning interactive training packages for staff, including GPs and service users about involvement.

11. How will we be measured?

We will be measured on how well we implement this strategy in a variety of ways and we will be continually reassessing our performance based on the feedback that we receive to ensure that we are using the resources that we have in the most effective way.

External assurance will be via our compliance with Standards for Better Health, Fitness for Purpose, the Auditors Local Evaluation and annual patient surveys.

Internally indicators regarding our performance will be part of the Performance management framework. Key staff will have personal objectives to achieve and in addition there will be an annual programme of evaluation of public engagement activity against the implementation plan. The PCT Board also receive an annual report from the

Patient Advice and Liaison Service and will evaluate change deriving from the input of the service.

The National Patient Survey and the Quality and Outcomes Framework Patient Survey will provide information regarding the General Practitioners and the experience of patients using their services. We will also use information from patient satisfaction/ experience surveys that the services we commission and provide.

12. How will we communicate this strategy?

We will use many of the existing channels to communicate how we will take this work forward, but will also build on new links made through the recent consultation work. This includes the development of a web based facility to keep people involved and informed.

The Patient Involvement and Public Engagement Team, the Primary Care Team and the PCT Communication team will work in partnership to identify appropriate and effective methods of communication with partners such as Practice Based consortia and other independent contractors Dentists, Opticians and Community Pharmacists.

We will work with staff to ensure they feel fully informed and that the core elements of this engagement strategy become part of their everyday role.