FINAL DRAFT DOCUMENT

Sheffield Clinical Commissioning Group

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SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Ian Atkinson, Chief Officer, NHS Sheffield CCG
Date:	25 April 2013
Subject:	NHS Sheffield CCG Commissioning Intentions
Author of Report:	Tim Furness, Chief of Business Planning and Partnerships, NHS Sheffield CCG

Summary:
NHS Sheffield CCG's commissioning intentions were approved by its Governing Body on 4th April 2013, in the form of the attached document. They represent the CCG's plans for 2013/14, intended to make progress on the CCG's four priority aims, described in the document. The plans were developed by the clinical leaders in the CCG, with suggestions from around 30 practices. The plans were discussed by the shadow Health and Wellbeing Board in December 2012. The document describes, at page 6, how these plans contribute to the outcomes the Health and Wellbeing Board wishes to achieve.

Recommendations:
That the Health and Wellbeing Board notes the CCG's plans for 2013/14 and the contribution they will make to the outcomes described in the Joint Health and Wellbeing Strategy.

Sheffield Clinical Commissioning Group

Commissioning Intentions 2013/14

Contents

Executive Summary

1. Our prospectus sets out four aims:
   1. To improve patient experience and access to care
   2. To improve the quality and equality of healthcare in Sheffield
   3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield
   4. To ensure there is a sustainable, affordable healthcare system in Sheffield

2. To achieve these aims, we intend to achieve a major shift in care to a community setting, working with our current and potential providers to establish properly funded primary care and community based services to
   - Transform the way outpatient services are used
   - Reduce emergency admissions and the average length of stay for people who do need a hospital bed, and
   - Redesign mental health services.

   These changes will improve the quality of care and patient experience, and release resources to invest in quality improvements and actions to reduce health inequalities.

3 Actions include:
   - Increasing provision of intermediate care, to provide an alternative to hospital care and support timely discharge from hospital
   - Expanding community nursing, reviewing and revising the specification, to ensure services are fit for purpose
   - Integrating community services to provide better care to patients
   - Commissioning risk stratification and care planning in primary care
   - Resourcing primary care providers to provide enhanced care management, including shared care models of delivery, in agreed clinical areas
   - Supporting people to manage their health and long term conditions
   - Reducing unwarranted variation in the quality of care
   - Establishing simpler urgent care systems, reducing use of A&E for problems that could be managed elsewhere
   - Ensuring NHS111 is implemented and fully integrated into our urgent care systems
   - finalising plans to tackle inequalities in access to healthcare and to reduce inequalities in health

4 Despite the challenging financial context we intend to invest in mandatory requirements such as:
   - Responding to the requirements and recommendations of the Mid Staffordshire Hospital and Winterbourne View inquiries
   - Establishing an autism service
   - Implementing NHS 111

And we aim to release resources to invest in local priorities, including:

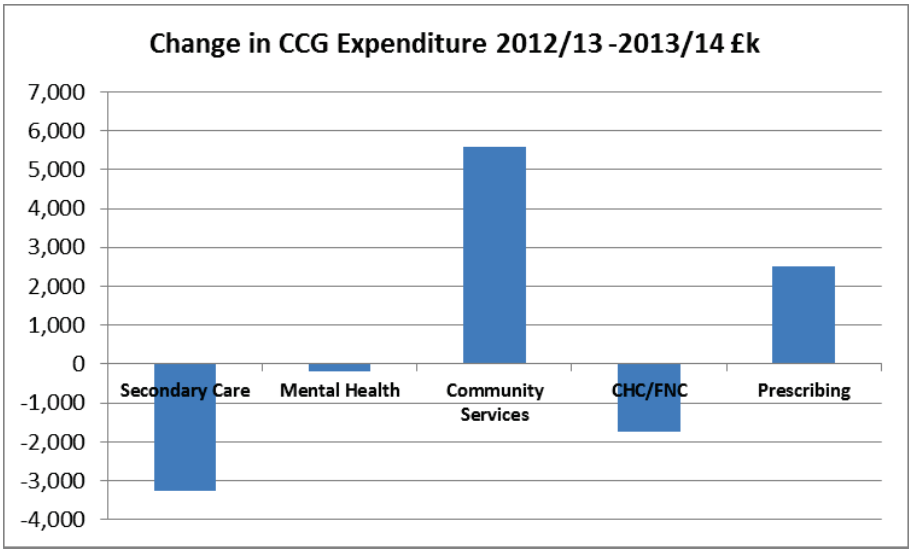
- Self-care programmes such as community Health Trainers
- Speech and language therapy services for children
- Improving services for managing the complications of cancer treatment
- Implementing planned improvements to end of life care
- Improving the physical health of people with LD
- Ensuring good transition from children's to adult mental health care
- Targeted screening for TB and Hepatitis B

5 In addition to these service specific areas of action, we will be finalising our plans to tackle inequalities in access to healthcare and to reduce inequalities in health, which will include seeking providers' commitment to actions through our *partnership with purpose* agreements and contractual routes.

6. We will use the CCG Outcome indicators and wider benchmarking information to help us focus our efforts and ensure that change improves patient outcomes. We have been asked by the NHS Commissioning Board to identify three local priorities on which we will make specified improvements and have chosen to submit the following as local priorities:

- Reduction in emergency admissions for ambulatory care sensitive conditions
- Alternative service provision to current hospital outpatient attendance
- Reduction in waiting times for children's Speech and Language Therapy

7. In implementing all these actions in 2013/14, we will see changes in the way we use our recurrent funding compared to 2012/13.



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Our Plan on a Page

Our Vision and Values	Authorisation principles	Strategic context and scale of challenge	Patient safety and quality	Performance improvement	Transformational change 13/14		2015-17 "End State" Ambition	Authorised Clinical Commissioning
Four priority aims: • To improve experience and access to care; • To improve the quality and equity of healthcare in Sheffield; • To work with Sheffield City Council to continue to reduce health inequalities in Sheffield • To ensure there is a sustainable, affordable health care system in Sheffield.	Effective Governance: Sound custodians of healthcare budget Patients at heart of all decisions Empowered clinical leaders creating an innovative improvement culture Best possible health; highest quality health care Evidence based care meeting individual need Delivery through effective partnerships	One CCG, with 4 strong Localities. Ageing population (75+) & unwarranted clinical variation. Higher comparative rate of emergency admissions, length of stay & CHC spend. Health inequalities between sexes & minority groups CCG will remain within its £14.1m RCA Deliver 1%(6.9m) surplus on £691m in line with national requirements representing a significant increase on PCT's £0.5 m surplus in 2012/13 2013-2014 QIPP programme to deliver £7m NET savings. Improve the life expectancy of the most deprived fifth of our population, to reduce current health inequalities.	Develop CCG strategy for Quality Improvement Improved quality of service to aid patient choice. Commission evidence based pathways & procedures Support implementation of NICE Standards Clearly defined pathway; aiding detection and management of patient's wit dementia. Support implementation of Family and Friends Test. Work with NHSCB to improve quality of primary care	Commission services to deliver key operational standards. Ensure delivery of required performance against each of the 5 domains of nationally assessed measures. Ensure delivery of our quality and efficiency commitments. With partners and providers ensure all standards, rights and pledges under the NHS Constitution are met.	**Acute Elective care**	Build capacity and capability in primary care to provide enhanced care management and service delivery. Transform Outpatient Services. Optimise efficiency of hospital based services for planned/elective interventions. Make best use digital technology to transform models of patient care delivery.	Services delivered through integrated service model with specialist expertise supporting primary care led patient care All patients receive appropriate clinical services on an equitable basis at the same point of their clinical condition / presentation. Optimise use of IT to support out of hospital structured clinical surveillance models	Strong clinical leadership, wide clinical engagement. Patients and the public are enabled to have a voice and to communicate with the CCG Development of membership organisation and establishment CCG of membership area. Creating financial headroom through QIPP to support system wide change. Aligned information systems which enable sharing of patient level information across health and social care Strengthened strategic partnerships, collaborative action and Co-Commissioning.
					Acute Urgent Care	ICTs delivering supported self management and community based care. Streamline assessment process and reduce delayed transfers from hospital; Improve care for people with dementia in hospital with acute medical needs. Establish single integrated intermediate care pathway	Reduced hospital based capacity. Integrated Community Teams and Intermediate Care service manage urgent care proactively to avoid ambulatory care sensitive conditions that do not require hospital admission. Streamlined 'front door' urgent care response manages primary urgent care away from A+E	
					Long Term Conditions	Progress population approach to develop tiered models of risk stratified LTC care including models of multi-morbidity. Commission generic self-care programmes of care. Implement planned improvements to end of life care.	Risk stratified multi morbid LTC population enabled to self care. Actively engaged in care through care planning and shared decision making; maximum use of assistive technology. Increased identification of those approaching end of life, advance care planning and an increase in deaths outside of hospital.	
					Children and Young People	Establish case for change to manage minor illness outside of A&E for children. Develop integrated practice in primary and community services. Develop high quality of transition of care from children's to adult mental health care Improve access to Speech and Language Therapy and to MH care for 16-17 year olds.	Developed pathways of care to enable common conditions to be managed out of hospital. Developed integrated practice in primary care and community multi-agency support teams. Seamless high quality transition of care for children through to adults. Equitable access to services.	
					Mental health and disabilities	Reconfiguration of community MH services completeAcute care redesign underway, minimal number of out of town placementsImproved care of people with LD, completing procurement of local services for people with complex needsCommission Autism service	Few out of town placements for people with MH problems and people with LD. Physical health of people with MH and LD improved. Improved access to MH care and psychological therapies; Integrated community based service delivery MH PbR effective in focussing on outcomes	
					Clinical Quality and Improvement	Implementation of recommendations - Mid Staffordshire Hospital public inquiry across the whole healthcare system. Implementation of DH recommendations into abuse at Winterbourne View. Reduce C Difficile cases and deliver new targets for MRSA/E coli. Medicines optimisation and safety. Ensure patient feedback informs service developments and FFT is embedded.	Sheffield providers and the CCG are compliant with recommendations from national inquiries and reviews and the quality of care is improved Hospitals will reduce cases of HCAI year on year. Systems to improve medicines safety are effective lessons are learned from incidents. Patient feedback is proactive in effecting demonstrable improvements to services.	

1. Introduction and Context

1.1 Our prospectus sets out four aims:

- To improve patient experience and access to care
- To improve the quality and equality of healthcare in Sheffield
- To work with Sheffield City Council to continue to reduce health inequalities in Sheffield
- To ensure there is a sustainable, affordable healthcare system in Sheffield

1.2 2013/14 is the first year of operation for the CCG. This document describes NHS Sheffield Clinical Commissioning Group's (CCG) priorities for action for 2013/14, as the first steps to achieving our strategic aims, as described in our prospectus, published in January 2012, and in our five year strategy (to be published in Spring 2013). They will contribute to achieving the aims of the Joint Health and Wellbeing Strategy, published in December 2012.

1.3 Its primary purpose is to share our intentions with providers of healthcare, with partner organisations in the city, and with the public we serve. These intentions will inform our contract negotiations and our detailed business planning for next year.

1.4 Our planning is based on the proposals put forward by the CCG member practices and by the clinical portfolio holders within the CCG management structure. Actions will be achieved through investment and decommissioning, through contract negotiation, and through the work of our staff either directly employed by us or through our SLA with the Commissioning Support Unit. Where investment and/or decommissioning is planned, specific plans and business cases will be developed to support decision making, to ensure that intended benefits can be realised and that the most cost effective solutions are adopted.

1.5 Our planning takes place in the context of significant national economic challenges, which of course influences the funding available to the NHS, and major change within the NHS, of which the establishment of CCGs in April 2013 is just one part.

1.6 Within the allocations for the NHS in 2013/14, CCGs receive a cash uplift of 2.3% (marginally above the current inflation rate). This increase must cover price rises outside of NHS contracts, growth in demand for services, funding of nationally mandated services, and local quality requirements. As set out in section 7 of this document, the cash uplift is not sufficient to meet all these requirements and, in addition to the general efficiency requirement upon providers, we will need to achieve £5.5m of savings. This document describes how these savings will be achieved, through changing the way some elements of care are delivered and ensuring our prescribing and referral to hospital are as clinically and cost effective as possible.

1.7 There is a nationally set price change for all providers – fixed in national tariffs and expected to be applied in local pricing – of minus 1.3%, which is based on a 4% efficiency improvement and 2.7% inflation. We will apply this to all our contracts, except where indicated in section 5.

2. How our Commissioning Intentions Contribute to the Joint Health and Wellbeing Strategy

Outcome 1 – Sheffield is a healthy and successful city
This outcome is largely about tackling the wider determinants of health and wellbeing. The commissioning actions of the CCG will not specifically contribute to these, as we focus on the immediate causes of ill-health, and on treatment and care for people with health problems. Our sustainability work will contribute to tackling some of the environmental factors that affect people's health.

Outcome 2 – Health and wellbeing is improving
This is focused on on-going, shorter term improvements in health and wellbeing. The actions described in this document are all intended to improve health, focussing on prevention of health crises, of improved quality of care and patient experience, and on improved clinical outcomes.

Outcome 3 – Health inequalities are reducing
This outcome focuses on those people and communities who experience the poorest health and wellbeing. We think these commissioning intentions will contribute by seeking to improve the physical health of people with Learning Disabilities and mental health problems, who on average have a much shorter life expectancy than the population as a whole, by establishing more self-care programmes, such as health trainers, focussing on areas and populations with the worst health outcomes, and by establishing locally based services that will be more accessible and responsive to the needs of the populations they serve.

Outcome 4 – People get the help and support they need and is right for them
The improvements in quality, patient experience and accessibility that we seek will all contribute to this outcome.

Outcome 5 – Services are innovative, affordable and deliver value for money
Our plans are intended to ensure better quality and reduced health inequality whilst at the same time delivering improvements in the efficiency and effectiveness of care, with a specific aim of releasing enough resource to allow new investment where it is needed, within the financial plan outlined in this document.

An earlier draft of these commissioning intentions was discussed by the shadow Health and Wellbeing Board on 20th December 2012. The contribution to the outcomes set out in the Joint Health and Wellbeing strategy was recognised. In addition, it was agreed that the two organisations need to do more detailed work to understand the scope for joint work and the impact on each other's services, that there should be more co-commissioner discussion in relation to Right First Time and Future Shape Children's Health, and that the current joint commissioning groups should be the means of having those discussions.

Fairness Commission

The CCG Governing Body has considered the report of the Fairness Commission. We fully support the recommendations in the plan and believe that our plans are in line with them. We shall work with partners, including at the Health and Wellbeing Board, to contribute to making Sheffield a fairer city.

3. How Our Commissioning Intentions have been developed

3.1 The CCG has established clinical leadership across a number of areas of healthcare, with GP members of the Governing Body and Commissioning Executive Team leading commissioning work in Acute Care (Elective and Unscheduled), Long Term Conditions and Cancer, Children and Young People and Mental Health and Learning Disabilities. These portfolios holders, with the support of senior managers, have each put forward proposals for action in 2013/14, which have been considered by the Governing Body and prioritised for action based on criteria including benefit to patients, contribution to the CCG objectives and practicality.

3.2 We have considered the health needs of our population through advice received by our Governing Body (attached at Appendix 1) and through our work with the Health and Wellbeing Board, which has commissioned a refresh of the Joint Strategic Needs Assessment to support the development of Sheffield's Joint Health and Wellbeing Strategy. The key issues from this analysis are:

- Sheffield's population has a lower life expectancy than the national average
- There are significant differentials in life expectancy between the most deprived and least deprived parts of the city
- Public health priorities to increase life expectancy and reduce health inequalities are
    - Child and maternal health
    - Long term conditions (cardiovascular disease, chronic obstructive pulmonary disease and diabetes)
    - Mental health and wellbeing and
    - Healthy lifestyles.

In addition to that analysis, we will continue to make cancer prevention and treatment a priority area of work, reflecting the fact that under 75 mortality rates from cancer are worse in Sheffield than in most of our comparator cities.

3.3 Around 30 practices submitted proposals to the CCG. In the main, these have been included within the proposals put forward in each of the clinical areas. A summary of practice responses and how they are being taken forward is shown at Appendix 2.

3.4 Recognising that clinical quality issues often cover some or all of the clinical areas identified above, we have identified priorities for quality improvement separately to the portfolios, and describe these separately below.

4. Commissioning Intentions by Portfolio

4.1 Acute Elective Care

We aim to change the way elective care, specialist advice, diagnosis and treatment is provided in Sheffield so that, wherever clinically appropriate, patients receive the majority of their planned care in general practices or locally based specialist services. We will, through our contracts, ensure there is sufficient resource to do this. Patients will continue to have rapid access to specialist services and expertise in hospital where they and their GP agree that is needed.

Our ambition, informed by clinical analysis of current patterns of outpatient attendance and supported by comparative benchmarking information, is to reduce the number of hospital based first outpatient attendances by 40% and the number of hospital based follow up attendances by 80% by 2016. As a first step to achieving that, in 2013/14 we will, in selected specialties, reduce hospital based first attendances by 5% and hospital based follow up attendances by 7%, releasing £1.7m gross savings in year, of which half will be reinvested in alternative provision.

We will do this by continuing to work with secondary care specialists to design the best care pathways, and supporting general practices to work together to utilise specialist skills and to enhance the skills practices have. Where it is both clinically and cost effective to do so we will provide more specialist services in a community setting, agreeing protocols to discharge patients back to their GPs for on-going care for follow up of many conditions, through modern technology, implementing alternative methods of remote monitoring of patients, and commissioning new services to meet patients' needs.

We will invest in primary care and community services to support this, funded by the release of resources achieved by reducing the use of hospital services. We will work with the FTs and with primary care providers to ensure that this transfer of resource is achievable and does not destabilise organisations.

These changes should result in a net saving, after the above investment, which will be used to pay for anticipated growth in demand for some services and the quality improvements described later on in this document.

Specific actions planned to support achievement of the above include:

- Implementing a range of Referral Education and Support initiatives
- Implementing a systematic review of care pathways, to make the best use of hospital services and specifying where primary care provision is required
- Resourcing primary care providers to provide enhanced care management, including shared care models of delivery, in agreed clinical areas
- Commissioning only clinically useful outpatient follow-up, establishing pathways with specified hospital attendances and agreed GP follow-up.
- Establishing Inter-Practice referrals for specific patient treatments
- Developing community alternatives to hospital attendance

- Making best use digital technology to transform how we provide care, including electronic transfer of referrals and the summary care record
- Exploring clinical areas where benchmarking suggests Sheffield is an outlier, to establish scope for improvement, e.g. cancer, upper GI, infectious diseases

4.2 Acute Unscheduled Care

Our ambition to transform urgent care, shared with our partners in the health and social care system in Sheffield, has been previously expressed through the Right First Time (RFT) programme. This seeks to ensure that patients are treated and supported as well as possible when they need urgent care, at home wherever possible, with hospital stays no longer than necessary. This will help people, especially older people, recover as quickly as possible and remain independent.

During 2012/13 we started to secure benefits from the RFT programme but these must be realised on a much more significant scale in 2013/14. We will work with partners through RFT to ensure that care is supported in the most appropriate setting with a move in resources to support that. This will increase resourcing of primary and community health and social care funded by reduced capacity and activity in the secondary care setting.

Based on detailed modelling of the needs of our population, the RFT programme has estimated that, over three to five years, provided the right alternative services are put in place and the appropriate clinical, managerial and patient behavioural and culture changes take place, the impact on hospital activity could be:

- The number of emergency admissions could reduce from around 54,000 per year to between 38,000 and 45,000
- The effect of reduced emergency admissions and shorter lengths of stay equates to a reduction in emergency beds from 996 to between 473 and 555
- Expenditure on urgent hospital care can be reduced, by avoiding emergency admissions, from a current figure of £116m to between £87m and £100m.
- Further resource could be freed up with reduced lengths of stay and reinvested in community services.

The opportunity for the programme is clear. We will work with our providers and partners, through the programme, to ensure that the above benefits are achieved. We expect that, in 2013/14, we will move at pace to implement alternative services and change service pathways, and achieve a significant reduction in the number of emergency admissions and a consequent cost reduction to the CCG, and reduce lengths of stay, reducing costs to the FTs.

We plan to invest significantly in the Right First Time programme in 13/14 both in terms of non recurrent pump priming and recurrent expansion of community services, adding to the substantial investment in 12/13. We expect that there will be net savings achieved by a shift in resource, i.e. not all of the reduced spend in hospital care will be directly invested in community emergency care, but an element will be available for quality improvements. For 2013/14 we aim to release a minimum of £900k NET QIPP savings to the CCG to invest in these improvements and/or contribute to other cost pressures.

To support these improvements we will invest in primary and community services, commissioning more care from practices, transferring more resource to

community services, including intermediate care and District Nursing, and commissioning new services in community settings. Specifically, we will:

- Increase provision of intermediate care, to provide an alternative to hospital care and support timely discharge from hospital
- Expand community nursing, reviewing and revising the specification, to ensure services are fit for purpose
- Integrate community services to provide better care to patients
- Commissioning risk stratification and care planning in primary care
- Ensure NHS111 is implemented and fully integrated into our urgent care systems
- Improve access to urgent care services at all times, establishing a single point of access to urgent care and providing GP expertise in A&E, so that A&E deals with genuine accidents and emergencies
- Supporting Primary Care providers to provide enhanced care management

4.3 Long Term Conditions including End of Life Care& Cancer

Many of the patients who most need healthcare have long term conditions. Improvement in the way our services are designed must be accompanied by changes in clinical practice, particularly for people with long term conditions, to help them manage their health and to reduce the number of health crises that might result in a need for urgent care. Proposed actions in 2013/14, which will help improve people's health and support the changes in elective and urgent care described in the above sections, include the following, subject to the level of additional resources which we can make available:

- Implement planned improvements to end of life care
- Commission generic self care programmes e.g. health trainers service, expert patients programme
- Finalise an agreed approach to shared decision making and care planning
- Consider options and determine a means of improving primary care quality and reducing unwarranted variation
- Commission new mental health services for people with long term physical conditions
- Review the Stroke pathway, to enable early discharge, 6 month review and longer intermediate care where needed
- Commission a specialist diagnosis & management service for Familial Hypercholesterolaemia
- Establish a latent TB community testing service
- Establish Hepatitis B screening for populations most at risk
- Implement city-wide cancer survivorship transformation programme and earlier awareness, earlier diagnosis of cancer
- Review the Care Home LES to establish a sustainable system of primary care for care home residents
- Develop a consistent approach to specifications and fees for all non-standard residential- care commissioned by the CCG
- Increase the number of personal health budgets
- Fully engage in the National Centre for Exercise and Sports Medicine which aims to improve the level of activity and fitness of Sheffield Residents

4.4 Children and Young People

We will continue to work with Sheffield City Council and Sheffield Children's NHS FT on the "Future Shape Children's Health" programme and, subject to the level of additional resources which we can make available, intend to take the following actions as part of the CCG's contribution to that programme:

- Reduce waiting times for Speech and Language Therapy
- Reduce A&E attendances and unscheduled admissions at SCH
- Develop integrated practice in primary care and community services
- Improve maternity care
- Increase cost effectiveness and child/family experience for children with complex needs
- Review respite care services and develop proposals to improve respite care for children with complex medical needs.
- Review community equipment and improve access
- Ensure good transition from children's to adult mental health care, including care of 16 and 17 year olds
- Ensure good transition from children's to adult LD & complex needs care
- Improve the effectiveness of investment in CAMHS, including implementing Children's IAPT
- Improve elective care pathways
- Stop commissioning procedures with limited clinical value, including religious circumcisions
- Work with partners to reduce the number of teenage pregnancies in Sheffield
- Support and influence the proposed site development at SCH

4.5 Mental Health and Learning Disabilities

We will continue the joint work with Sheffield Health and Social Care NHS FT on service redesign in community and acute mental health services, and will work with them to:

- Ensure the Acute care and Community team reconfigurations achieve the stated aims
- Implement a Personality Disorder pathway in Sheffield
- Review dementia intermediate care services to ensure we achieve best outcomes and best value
- Improve forensic care for people with LD
- Improve care for people with complex LD needs
- Manage the implementation of Payment by Results in MH services to ensure the intended quality improvements are achieved

In addition, we will work with all partners to achieve the following aims:

- Commission Autism(+) Diagnosis and Post Diagnosis Service
- Continue work to deliver on the priorities within the National Dementia Strategy (2009) and the Prime Minister's Challenge (2012)
- Improve physical health and wellbeing of people with MH problems
- Improve physical health of people with LD

4.6 Clinical Quality Improvement

Priorities for our work to ensure patient safety and improve the quality of care experienced by our patients will include:

- Review and ensure appropriate recommendations from Mid Staffordshire Hospital public inquiry (Francis 2) across Sheffield
- Implement DH recommendations following the investigations of abuse at Winterbourne View
- Medicines optimisation & medicines safety
- Ensure compliance with national standards and guidance for cancer care, and reduce unwarranted variation
- Work with the NHS Commissioning Board Area Team to ensure continual improvement in primary care quality and reduce unwarranted variation
- Working with the Local Authority, continue to improve the quality of care in Care Homes
- Continue to reduce C Difficile cases and have zero tolerance of MRSA, with a new process for investigation and accountability with contract penalties for each recorded case.
- Implement more stringent safeguarding standards for adults and children and focus on learning lessons and outcomes of initiatives.
- Establish more challenging Quality Improvement Schemes, including CQUINS, with all providers including AWP
- Ensure service developments systematically take into account quality considerations and patient views, including learning lessons from complaints
- Work with providers to deliver the 'duty of candour' requirement in the national contract, working towards a transparent delivery of clinical governance.
- Ensure feedback from patients and carers is reviewed and action is taken to deliver continual improvements – this includes the implementation of Family and Friends Test.
- Ensure that electronic discharge letters to GP's improves communication between primary and secondary care.
- Be a key player in the Yorkshire and Humber Academic Health Science Network (AHSN)
- Work with partners to ensure education and training supports achievement of our objectives, including the expansion of community based services.

We will support, promote and contribute to research, working with partners to ensure that research supports the achievement of our ambition and that our practices and providers have access to the latest evidence and innovations.

Ensuring patient safety and improving clinical quality is everyone's business in the CCG. Much of the work listed above will be led by the Chief Nurse and his team. However, the commitment and contribution of the clinical portfolio leads will be critical and some aspects of work will be led by the portfolios or by the contract management team.

4.7 Tackling Health Inequalities

The CCG has agreed an outline plan setting out how we can contribute to reducing health inequalities in Sheffield – recognising that many of the factors that lead to inequalities in health outcomes are outside the influence of the NHS. We will be discussing our plans with partners, including at the Health and Wellbeing Board, to ensure that we have identified the right actions. Our outline plan includes actions to:

- Provide high profile clinical support for national and local actions that reduce health inequalities, including public health interventions
- Support individuals to be aware of their own health and their health risks, and to take responsibility for their health
- Ensure equality of access to healthcare, targeting resources to areas and populations with the greatest need
- Commission disease specific interventions that are known to help reduce health inequalities
- Ensure compliance with the Equality Act, taking action to eliminate any discrimination in the provision of healthcare in Sheffield.

Many of the quality improvements identified in these intentions address the above, in supporting individuals and in commissioning specific interventions. The CCG Governing Body has approved an Equalities Action plan that sets out action to ensure equality of access to healthcare and compliance with the Equality Act. We will seek providers' commitment to actions through our *partnership with purpose* agreements and contractual routes.

4.8 CCG Outcomes

The NHS Commissioning Board published comparative data for all CCGs on a set of outcome indicators in December 2012. Sheffield benchmarks in line with or better than comparator areas for most indicators, but the data shows we have significantly worse outcomes in a number of areas, as set out below:

- Cardiovascular prevention in hypertension patients. This is a QOF indicator and as such an element of GP contracting. We are committed to working in partnership with NHS CB to support improvements in cardiovascular prevention.
- Cancer mortality. Sheffield CCG fully understands our position on cancer mortality and therefore has a programme of work covering the whole pathway to ensure that outcomes in cancer continue to improve year on year. This work is led by the Sheffield CCG GP clinical Lead for cancer through the Long Term Conditions and Cancer clinical portfolio. The CCG is particularly committed to focussed work on earlier awareness and earlier diagnosis of cancer with a clear aim of improving cancer detection. In addition, with successful funding support from Macmillan the CCG has also embarked on a transformational project supporting the needs of cancer survivors in the community. This work is based on the principles of risk stratification, care planning and supported self-care and is intended to ensure that both patients and primary care feel supported to manage the needs of cancer survivors out of hospital. The CCG is also committed to working both in partnership and as a co-commissioner, particularly with

the NHS CB on those aspects of cancer pathways where it does not have direct commissioning responsibility to ensure that pathways of care remain seamless.

- Hip replacement PROMS. Sheffield CCG is fully aware of, and monitoring, the provider position in relation to hip replacement scores generated via the PROMs programme. STH is currently undertaking a strategic internal review of orthopaedic services, with a particular focus on hip surgery. The Trust is also liaising with the Yorkshire and Humber Quality Observatory looking at a number of factors in detail, including the patient reported hip scores (mainly the EQ5D measure), peer performance, rates for revision and new surgical procedures, as well as consultant level data. We will continue to work with the trust to review progress and service quality.
- Child admissions for lower respiratory tract infection (LRTI) (second worst in England). A review of rates of admission for Children with LRTI was undertaken some time ago, at that point the admissions were seen to be clinically appropriate. Recent data suggests there is a huge variation on the admission rates for the Sheffield population, which appears to be a common theme in a city which hosts a Specialist Children's Hospital. Further work is planned to look at the rates and the current pathway with our provider and develop clear guidance for the management of respiratory conditions for children within the community and within the hospital environment.
- C Difficile. Significant reductions have been made in Sheffield this year, and Sheffield Teaching Hospitals Foundation Trust (STHFT) has recorded fewer cases than the annual target. Sheffield CCG has not achieved the end of year target, but the total numbers of cases is considerably lower than 2011-12. During 2013/14 the CCG will continue to undertake a full review of each community case with GP's, and manage antibiotic prescribing. We will also develop more integrated working with STHFT to deliver on the challenging targets for acute and community for 13/14. Sheffield Children's Hospital Foundation Trust did not achieve the end of year target and action plans are being delivered following each case review.

4.9 NHS Constitution Rights and Pledges

The CCG will work with partners and providers to ensure that all the standards, rights and pledges given to patients under the NHS constitution are adhered to, including ensuring that contractual requirements and remedies are in place. These include:

- Achieving the 18 week wait and diagnostic waiting time standards
- Achieving standards for maximum waiting times in cancer care
- Ensuring patients wait no more than four hours in A&E
- Achieving standards for ambulance response times
- Eliminating mixed sex accommodation
- Reducing cancellation of operations, and ensuring a new date is offered when operations have to be cancelled

- Ensuring all mental health inpatients on the Care Programme Approach are followed up within 7 days of discharge from hospital

Appendix 3 sets out in full the national standards that we will achieve, describing the current position and, where required, the commissioning action we will take in 2013/14 to ensure the care our patients receive meets these standards.

5. Achieving Our Intentions

5.1 Investing in Quality Improvement and Reducing Health Inequalities

These commissioning intentions include a number of actions that will require investment, either to support service change and associated disinvestment elsewhere, or to improve current services or establish new ones to improve health. (Investment proposals to support our elective and unscheduled care QIPP programme are discussed in section 5.2 below.)

In addition, the CCG will be funding a number of developments to meet national expectations and statutory requirements, including establishing an Autism diagnosis and support service, NHS11, and implementation of the recommendations of the inquiries into Mid-Staffordshire Hospitals and Winterbourne View.

The proposed discretionary investments can only be funded through the resources released through our elective care and urgent care work, as identified above. We will not commit to investment until we are confident that the necessary resources will be released, and we will work with FTs and other providers through our collaborative change programmes and our contract negotiations to ensure resources are released.

These proposals have been carefully considered and an order of priority agreed, as described in the table below. Approval of these proposals will be subject to availability of resources and approval of business cases. We intend to release sufficient resource to be able to progress all of these proposals, which we consider demonstrate significant health gain for our population.

Investment agreed to be made from 1/4/2013	**£k**
Generic self-care programmes, i.e. core health trainers service	200
Increase capacity of community Lymphodema services to manage the complications of cancer treatment	65

Proposals for urgent consideration of business cases and investment as soon as resource is available	**£k**
Implement planned improvements to end of life care	tbc
Additional health trainer activity	100
Darnall Wellbeing	25
Expert Patients Programme	30
Improve physical health of people with LD	120
Ensure good transition from children's to adult care, MH	100
Hepatitis B screening - Roma Slovak population*	77
Latent TB community testing service*	63

* Subject to clarification of where commissioning responsibility lies

Proposals for consideration of business cases and investment as soon as second level of resource is available	**£k**
Improve care for people with complex LD needs	223
Ensure good transition from children's to adult LD care	140
Ensure good transition from children's to adult care, complex needs	tbc

Improve forensic care for people with LD	150

Proposals for later consideration	**£k**
Commission 6 month review of people who have a stroke	90
Review effectiveness of community services	100
NHSI Quality programme for nursing homes	90
Commission new MH services for people with long term physical conditions	100

Statutory commitments and commitments already made	**£k**
Autism(+) Diagnosis and Post Diagnosis Service	500
Reduce waiting times for Speech and Language Therapy	200
Personal health budgets	tbc
Implementing NHS 111	1000
Implementing the recommendations of the Mid Staffordshire Hospital and Winterbourne View inquiries	tbc

5.2 Transfer of Care to Primary and Community Care Settings.

The sum of these contracting intentions represents a major shift of care, from hospital to community settings, in the next twelve months. In terms of patient activity, we plan to reduce outpatient attendances by 20% in selected specialties and commission alternative care in community settings, and to reduce emergency admissions, and commission preventative care and urgent primary and community care responses in their place.

The table below shows the specific changes that we have agreed to commission:

	£k	£k
Right First Time urgent care programme		
Dementia business case	100	
Single Point of Access (including bed bureau)	400	
Integrated Care Team - Care Planning Approach	600	
Community Nursing - 7 day extended availability of core services	300	
Increased and Responsive CICS Service	300	
Increased and Responsive STIT Service	1000	
Intermediate Care Beds - community support	400	
		3,100
Elective care programme		
Transfer services to primary care	25	
Advice and guidance via PPL pilot - 6 specialties	140	
Pathway advisors	160	
Education events	50	
Outpatient follow up incentive scheme	340	
Provider led efficiencies pilot in x no. of specialties	35	
Support to delivery of above	50	
		800
Learning Disabilities complex needs service	200	
		200
TOTAL		4,100

The funding released is needed to fund a range of cost pressures as the cash uplift for the CCG for 2013/14 at 2.3% is insufficient to cover all new pressures, together with the other financial planning requirements such as a 1% bottom line surplus and holding 2% of the CCG's allocations for spend only on NON – recurrent costs. The remaining resource released to the CCG will be used for investment in quality improvement, as detailed above.

To achieve this, we need to build upon these commissioning intentions to define and specify in more detail what services or patient activity will no longer be provided in hospital, and the services that will be commissioned to be provided outside of hospital. We will need to determine the most appropriate procurement approach to place contracts to secure these services, and agree the impact of the changes on current contracts with providers. Contractual models might include NHS standard contracts with new or existing providers for new community services, changes within current contracts to move resource to a community setting, and use of Local Enhanced Services to increase capacity in general practices.

The development of GP Associations (GPAs) is critical to our success. We will work with practices to support the development of GPAs as potential providers of care, and as a means of practices working together to share expertise and resources. We are mindful of the potential conflict of interest for members of the CCG in the development of GPAs and will ensure that decisions are taken in the best interests of patients, with any conflicts of interest declared, understood and managed, e.g. by excluding conflicted individuals from decision making processes.

5.3 Implications for current contracts

The financial plan section provides an overview including the impact of changes to national PbR arrangements and the tariff for 2013/14 which again this year imposes a challenging 4% efficiency requirement on all providers, unless exceptionally agreed otherwise by the CCG.

5.3.1 STH

In relation to the acute services provided by STH, these commissioning intentions are expected to result in lower levels of outpatient activity, A&E attendances and emergency admissions, with consequent expenditure reductions. However, we expect to see an increase in direct access diagnostic activity, cost per case activity and inpatient elective activity may still increase (subject to the conclusion of contract negotiations) due to the need to deliver the 18 week national pledge by specialty. This latter will partly depend on referral rates. The proposed changes under RFT in particular should support achievement of efficiency gains at STH, for example by working with STH and other partners to reduce lengths of stay in hospital. The RFT changes should also mean an increase in the funding for community services provided by STH.

We will work with STH to explore variations where appropriate from the standard NHS tariff arrangements, so that risk and benefit arising from planned changes is shared, transfer of resources enabled, and incentives are aligned with responsibility for delivery.

We will be rigorous in using contractual and partnership agreements to support and ensure achievement of NHS Constitution standards, and will take action where there is a risk of failure to meet those standards.

5.3.2 SCH

We expect these commissioning intentions to have some impact on our contract with SCH, resulting in lower levels of activity in A&E, emergency admissions and elective care. However, we may see an increase in direct access diagnostic activity, cost per case activity and elective activity may still increase (subject to the conclusion of contract negotiations) due to the need to deliver the 18 week pledge. This latter will partly depend on referral rates. We will set activity levels in our contracts accordingly.

We will work with SCH to explore variations where appropriate from the standard NHS tariff arrangements, so that risk and benefit arising from planned changes is shared, transfer of resources enabled, and incentives are aligned with responsibility for delivery.

We will be rigorous in using contractual and partnership agreements to support and ensure achievement of NHS Constitution standards, and will take action where there is a risk of failure to meet those standards.

5.3.3 SHSC

These commissioning intentions, with regard to mental health and LD care, largely represent continuity from 2012/13 plans. We will, subject to agreement of contractual terms, continue NHS Sheffield's collaboration with SHSC to achieve both commissioning QIPP requirements and provider efficiency improvements.

Where investment in mental health and LD care is proposed we will determine on a case by case basis whether health gain is best achieved through extension of existing contracts or by formal tendering processes.

We will be rigorous in using contractual and partnership agreements to support and ensure achievement of NHS Constitution standards, and will take action where there is a risk of failure to meet those standards.

5.3.4 VCF providers

We intend to renew all existing contracts with VCF providers, subject to assurance on ability to deliver and on quality. We will apply a nil uplift to the contract values, in effect waiving part of the NHS efficiency requirement. There may be opportunities for VCF providers to secure new contracts, where services are tendered, and to develop partnership working with the FTs or with GPAs to jointly deliver services.

5.3.5 Current Local Enhanced Services (LESs)

During 2013/14 we will review the current LESs to ensure they represent the best use of resources to support delivery of care in primary care, in the context of the intent expressed in this document to significantly invest in care in community settings. This review will consider the type of contractual arrangement that should be used going forward as well as the nature of the services commissioned.

5.3.6 Other acute service providers

We contract for acute care for Sheffield residents, from a range of both NHS and Independent sector providers mainly for elective care. The changes proposed under the elective QIPP programme may have an impact on these providers, as will patient choice.

5.3.7 YAS

For 13/14 the CCG will continue to have a contract for emergency ambulance services with YAS as part of a regional consortium arrangement in which Sheffield is taking the lead for South Yorkshire CCGs. The CCG will be looking to work with partners to reduce inappropriate rises in demand but expects some increase in demand to occur in 13/14 based on previous trends. The CCG will also continue to purchase most patient transfer services (PTS) from YAS in 13/14 but some services will be from other providers and currently there is a procurement exercise underway for certain elements of PTS.

In addition the CCG is part of regional contractual arrangements for the 111 service. The contract was awarded to after a competitive procurement process to YAS earlier in 2012 and this will see an increase in funding to YAS from the CCG in 2013/14 with the service commencing in March 2013. We will work with YAS to ensure that changes following establishment of the 111 service do not impact on emergency response times

5.3.8 Providers of Continuing Health Care

The CCG expects to spend over £50m on placements for patients eligible for CHC funding in 2013/14. This is expected to be through the standard NHS community contract arrangements and the CCG expects to use a similar range of providers to 2012/13. We will set fees for 2013/14 alongside Sheffield City Council, and will apply a nil uplift to the contract values, in effect waiving part of the NHS efficiency requirement.

5.3.9 Sheffield City Council

Generally the CCG will be working with SCC as a co-commissioner (as discussed in 5.4 below) and may as a result of this, transfer resources to SCC e.g. through S256 or S75 arrangements. There are certain areas where the CCG will be transferring resources to SCC as a provider and this may expand depending on conclusion of the RFT programme proposals for 2013/14.

5.4 Working with partners and co-commissioners

We will work with Sheffield City Council, as co-commissioners, in implementing the Right First time and Future Shape Children's Health programmes. We will explore with the Council whether there are opportunities to ensure benefits of the change programmes are realised through pooled budgets or other arrangements to share responsibility and manage risk. We will also work with the Council to share commissioning intentions and manage unintended consequences, e.g. where service change might increase demand for each other's services, or

otherwise create pressures. An important new aspect to this in 2013/14 is as the result of SCC taking over responsibility for a range of Public Health services from April 2013 following the transfer of £28.5m and a range of contracts from the PCT. The CCG is currently working through with SCC the impact of this change.

We will work with Healthwatch, when it is established, to develop a systematic approach to patient and public engagement, which will include the development of an improved web site, ensuring there is patient and public engagement in the work of each of our clinical portfolios, and establishing processes that ensure that patient and public views are considered in every significant decision taken by the CCG.

The NHS Commissioning Board Local Area Team will be a new co-commissioner for the CCG, as it will have responsibility for primary care contracts and for specialised services. We will work with the Team to develop our co-commissioning relationship and be clear about how we work together where we have shared interests, including the major stake we each will have in contracts with Sheffield Teaching Hospitals NHS FT and Sheffield Children's NHS FT, and the in understanding respective roles with regard to primary care quality.

We will work with neighbouring CCGs to collaborate on issues of joint interest, and have established a formal mechanism for this work with the CCGs in south Yorkshire and Bassetlaw.

5.5 The work of our staff

Many of our intentions are about planning, monitoring and partnership activities, which will be undertaken by CCG staff, most obviously in the work of service design and redesign, quality assurance, performance and contract management teams. The CCG retained direct employment of staff for this purpose.

We will also be reliant on the contribution of the Commissioning Support Unit, which will provide valuable support and will directly contribute to our intentions in continuing our excellent track record in Medicines Management and maintaining recent improvements in the cost effectiveness of Continuing Healthcare.

5.6 Our planning and delivery business processes

These commissioning intentions will form the basis of our business plan for 2013/14. Progress will be monitored by the Planning and Delivery Group, with regular monitoring of implementation and outcome of the projects put in place to deliver these intentions.

Investment and other service changes will require approval by the Commissioning Executive Team and/or by the CCG Governing body, and will normally need written business cases to support assessment of the case for change, confidence in achievement of the intended benefits, and understanding and management of any clinical or corporate risks.

We will develop a procurement plan for 2013/14, which will include competitive tendering for new services where that is appropriate, i.e. where it will help ensure that we achieve the best service for patients and the best value from investment.

6. Financial Overview

The 2013/14 financial plan has been constructed to support delivery of the CCG's commissioning intentions and at the same time to meet national financial planning requirements. There remain several important risks and uncertainties which have at this stage necessitated a number of assumptions to be made. Other risks, however, will remain to be managed during 2013/14 including those associated with splitting previous PCT resources and responsibilities between a range of new commissioners from April 2013. It is unlikely that there will be a perfect match of funding transfers and liabilities.

At this stage we have identified that the CCG will need to deliver £5.5m of recurrent NET QIPP savings to achieve a 0.5% surplus in 2013/14 and demonstrate that only 98% of its resources have been spent recurrently, which is a national requirement. Sheffield residents, patients and key local partners in the city will be interested to understand how we intend to utilise our total £690m commissioning resources and also how we have deployed the increase in funding in 2013/14.

The table below provides an overview of the additional resources available to the CCG in 2013/14 compared to the baseline funding and how these are likely to be deployed.

Sheffield CCG: Use of Additional Recurrent Resources in 2013/14

A	**Additional Resources available to the CCG in 2013/14**	£'m
		15.5
	Funding available by applying the national 4% efficiency target to most contracts. NB: this assumes CCG sees full benefit against PbR contracts which has yet to be confirmed.	22.4
		37.9
B	**Resources needed to meet underlying pressures/pre-commitments b/f from 2012/13 and national planning requirements**	
	The PCT will not end the year with the required underlying 2% surplus mainly due to acute secondary care activity pressures e.g. £6m of STH activity was funded from the 2% headroom reserves. In total the CCG needs to have £13.8m available for its 2013/14 headroom budget and only £8.8m has been carried forward representing a pressure of £5m against its new resources	-5.0
	CCGs must set aside 0.5% of baseline resources as a recurrent contingency reserve. As shown on summary plan - line 32 - Sheffield is unable to start the year with any such contingency b/f due to underlying hospital activity pressures and hence needs to create this contingency from its new resources	-3.5
	CCGs are required to invest in the implementation of 111- for Sheffield CCG the contract signed with YAS indicates a cost of just over £1m. NB risk of other pressures e.g. increase in ambulance journeys, use of A&E, GP OOHs etc	-1.0
	CCGs are also required to implement certain autism services and Sheffield CCG has agreed 2 local pre-commitments: Full year impact of LIFT developments and Paediatric SALT.	-1.7

		-11.2
C	**Impact of funding national inflation**	
	Inflation at 2.7% non PbR and at 2.9% on PbR	-15.6
	Thus it is important to note that contract inflation utilises ALL of the CCG cash uplift which means the CCG needs to use the 4% efficiency released by applying the tariff deflator to fund all cost pressures and national planning requirements	
		-15.6
D	**Demand led cost pressures**	
	Activity pressures including demographics, 18 weeks, cost per case, ambulance	-7.8
	Pricing pressures including ambulance, equipment, enhanced services and PbR risk	-1.5
	CHC - childrens and LD pressures and no tariff deflator applied	-1.8
	Prescribing - volume growth and price fluctuation	-3.4
		-14.5
E	**CCG Running Cost Allowance at c£25 per population**	
	Running Cost Allowance is £14,070k. The CCG is planning to underspend this by £1m to contribute to commissioning expenditure and reduce QIPP requirements	1.0
		1.0
F	**QIPP**	
	Target Savings	
	Planned Investment	
	MINIMUM NET QIPP is £5.5m - CCG is still looking to increase this by at least £1m to allow other local investments to proceed	**5.5**
G	**Delivery of 0.5% surplus**	
	Net of Items A to F above	3.1
	Utilise surplus c/f from PCT - expected CCG element	0.4
		3.5

CCG Allocation

CCG allocations for one year (2013-14) were announced on 18 December 2012 by the NHS Commissioning Board in parallel to the planning guidance, *Everyone Counts: Planning for Patients 2013-14*. ***Appendix 4*** provides a summary of the allocations announcement. It shows that nationally NHS CB decided to use the information provided by PCTs as part of the baseline exercise as the starting point for 2013-14 allocations. The opening figure of £734m is that submitted by Sheffield PCT for planned spend on CCG responsibilities in 2012-13. This is helpful as it means locally we have a full audit trail of the individual budgets which build up to this figure and NHS CB used our local information. However, the NHS CB has then made 3 deductions from this opening position. The specialised services deduction at £41m is by far the largest but was expected because the national definition set for specialised services has changed, increasing the scope of these services. Further work is on-going, in conjunction with the local Area Team, to understand how whether the resource adjustments actioned to date, accurately reflect the cost of specialised services transferring to the NHS Commissioning Board. The other two smaller adjustments (in total c£4m) represent a cost pressure compared to the local plan prepared in September.

Nationally the decision was taken to provide ALL CCGs with a standard cash uplift of 2.3% (£15.5m for Sheffield). This is primarily because national decisions on the methodology to calculate "fair share" budgets for CCGs have been deferred with further work required. This means that it was not possible to determine which CCGs were above or below their "fair share" budget and hence there was no rational for differential cash uplifts. This has probably benefited Sheffield CCG as traditionally the PCT has been an "over target" PCT and the formula for calculating fair shares for CCGs would probably have to be substantially different to change this position.

Key Assumptions used for Financial Plan

1. Delivery of 0.5% (£3.5m) reported surplus: The CCG has a statutory duty of financial breakeven but *Everyone Counts: Planning for Patients 2013-14* requires commissioners collectively to plan for a 1% surplus which will be carry forward to future years. Within the South Yorkshire and Bassetlaw area there has been sufficient flexibility for Sheffield CCG to plan on a surplus of 0.5% in 2013/14. The CCG made representations to the Area Team that to move to a 1% or £6.9m surplus represented too big a change from the PCT's plan for the last 2 years of only a £0.5m surplus. Having over £6m resources not being available for use in the local health economy in 2013/14 would substantially detract from the CCG being able to make progress on its strategic objectives and have an adverse impact on our financial resilience. The CCG does, however, need to plan on moving to delivery of a 1% surplus in 2014/15.

2. Retain 2% of baseline resources for NON recurrent expenditure (and hence deliver an underlying 2% surplus). This is a national planning requirement for all commissioners. For Sheffield this equates to £13.8m. For CCGs, approval to spend the resource has to be sought from their local LAT through business cases. We will hold back at least 0.5% as contingency reserves but plan on utilising a substantial element to support transition costs for our QIPP programme. There are already potential pre-commitments as part of the RFT programme.

3. Create a 0.5% general contingency reserve: This is the third national financial planning requirement. For Sheffield CCG this equates to £3.5m. It is financial "good practice" to start the year with a reserve for unexpected in year pressures such as those that can be created by exceptional winter conditions, flu pandemic, responding to national inquiries such Mid Staffs or Winterbourne View or of course as part of managing risk if planned QIPP savings are not fully delivered. This reserve is similar to the £4m which Sheffield PCT built up for 2012-13. Should such pressures not materialise the funding can be used for local priority investments in year.

4. Recurrent baseline opening budgets: For each contract or service area the best assessment of the recurrent baseline requirements has been made jointly by the budget holder and finance generally using M10 data. This is before taking into account any full year effect of existing QIPP

programmes as these will be built into the 2013/14 QIPP programme to allow for transparent monitoring of these savings and allow for stronger in year financial and risk management. Opening budgets are also before taking into account activity and price pressures/changes for the year ahead and the transformational change requirements.

5. Inflation, Tariff and PbR changes: The key assumptions are as follows:

The national planning guidance and allocations indicate that the tariff has been calculated as follows:

Inflation uplift to cover e.g. pay rises	+2.7%
Efficiency requirement	-4.0%
Hence net tariff	-1.3%

This means the standard position is that the CCG should seek to reduce prices on all contracts by -1.3%. There are however a few areas of community services spend where the CCG may wish or need to "waive" this requirement.

The Payment by Results (PbR) system will automatically implement the tariff changes for those elements of contract which fall under PbR. However, it is important to note that the -1.3% benefit to CCG commissioners which should result is a national average and may not be felt evenly by commissioners depending on the case mix of services purchased. CCGs have also been advised to reduce their estimate of the benefit by 0.2% (i.e. down to 1.1%) as a result of for example the treatment of CNST premiums in PbR tariffs.

Through the contracting process we are working through the impact of other elements of the PbR guidance such as the readmissions policy and the unbundling of tariffs for direct access diagnostics.

The national planning guidance has made NO change to the level of **CQUIN** (i.e. quality) funding which providers can earn as part of contractual arrangements. This remains at 2.5% of total contract value for 2013-14. The actual CQUIN measures for 2013-14 can be varied from prior years except for certain national requirements and will need to be worked through as part of the contracting arrangements.

GP prescribing is the one budget line where we have applied NO price reduction as prices are set nationally through national negotiations or by individual suppliers and the CCG has no control over price setting. 2012-13 saw some significant reductions in prices and the opening budget position builds this in as a recurrent benefit. This could well be a risk as 2013-14 could see increases in say some Cat M prices and of course new drugs coming on the market could prove expensive. Further work is needed with the medicines management team to horizon scan as far as possible what might be required in 13/14. A provision for growth in activity/price fluctuations is made within cost pressures.

6. Underlying/Specific Activity Demand: A critical element of the financial planning process is to consider possible changes to activity BEFORE the impact of any QIPP schemes. The plan incorporates cost pressures of c£14.5m to cover demand led activity increases covering acute hospital activity including cost per case, emergency ambulance, CHC, prescribing and certain community services. This funding is also intended to cover additional activity where this is required to deliver national pledges such as RTT in 18 weeks.

7. Mandatory and Local Quality Investments: Separate to the demand led cost pressures and pressures linked to delivery of national pledges highlighted in point 6, the CCG has identified 2 mandatory areas of investment to date for 2013/14 being 111 implementation and certain autism services at a total cost of c£1.5m. As discussed in section 5.1 "Investing in Quality Improvement and Reducing Health Inequalities", the CCG is also seeking to identify resources to support a range of local priorities.

8. QIPP: As discussed above to deliver our Commissioning Intentions a minimum £5.5m NET QIPP is required. The QIPP programme in 2013/14 is split across 4 areas as shown below:

Programme Area	Gross Savings £'m	Investment required £'m	NET Savings £'m
Elective care	1.7	0.8	0.9
Unscheduled care	4.0	3.1	0.9
CHC	3.0	0.2	2.8
Prescribing	0.9	NIL	0.9
TOTAL	**9.6**	**4.1**	**5.5**

9. Running Costs: The national planning guidance makes it clear that CCGs will receive a Running Cost Allowance (RCA) separately from their commissioning allocation. CCGs are not allowed to overspend against this allocation but can plan to underspend against the allocation and use any in year underspend on commissioned activities.

   Sheffield CCG's allocation at £14,070k is just slightly below £25 per head using our latest crude population. The work undertaken in autumn 2012 to confirm the staffing establishment of the CCG, committee structures, locality funding, premises costs and services to be procured from the CSU, suggested a spend around £12.5m. This does leave us headroom for cost pressures/changes. CCGs have in particular been warned that they may face an additional "levy" for costs from NHS Property Services Limited where these have not been fully resourced from the transfers from PCT allocations. At this stage the financial plan assumes £1m will be available for release to spend on commissioned services.

Appendix 1. Summary of Joint Strategic Needs Assessment for Sheffield

1. Population

The Sheffield population is increasing, with the latest 2011 census data indicating a total population of 552,700. This represents almost an 8% increase on the previous census (2001) and is broadly consistent with the national average increase. If this trend continues we can expect the population to rise to approximately 600,000 by 2020. Three factors are contributing to this rise: a continuing increase in the birth rate; more young adults (linked to economic migration and increasing university student numbers); and longer life expectancy.

The ONS census population estimates however under-counted the number of Sheffield residents registered with SCCG practices at April 2011 by 1.1% and the total number of persons registered with SCCG practices is 2.6% higher. The latest registered population figure for SCCG (April 2012) is 570,697, a 0.6% increase over the previous year. Of these, 2.2% (12,360) are aged 85 and over.

Of particular note is the expected rise in the over 65s by around 14% between 2009 and 2020, amounting to around 12,000 more older people in the city by the end of the decade. The over 85 year age group is expected to grow most rapidly, some ten times that of the 60-69 year age band. In absolute terms, women will remain the largest cohort over all older age groups with the gender gap increasing with rising age albeit narrowing over time.

We know that the ethnic population of Sheffield is changing but robust data on ethnicity is difficult to come by however we know that between 2004 and 2010 the number of non "White-British" school children aged between 5 to 16 years in local authority maintained schools increased by 29.8% to form 25% of the total school population in 2010.

2. Life Expectancy

As noted, one of the key drivers of population change, and a key headline indicator of overall health and wellbeing in a population, is life expectancy. Based on the latest available data (2009-2011), Sheffield's life expectancy at birth is 78.8 years for men and 82.3 years for women. Although this represents an increasing trend, Sheffield's figures remain statistically significantly lower than the national averages.

The inequalities gap in life expectancy (as measured by the Slope Index of Inequality) is a second key headline indicator of health. In Sheffield the gap between the most and least deprived men widened from 8.7 years in 2001-2003 to 10.2 years in 2005-2007 but has since narrowed, returning to 8.7 years in 2009-2011. For women, the gap initially narrowed from 7.1 years in 2001-2003 to 6.3 years in 2004-2006 and then widened again to 8.2 years in 2008-2010. In 2009-2011 it narrowed again to 7.4 years.

3. Deprivation

The Slope Index of Inequality has been adopted (locally and nationally) as the standard measure of inequality. It is a deprivation based measure and when applied (as appropriate) to public health indicators, demonstrates that health inequalities continue to blight our city. In particular, this indicates the role deprivation plays in the variation of

health and wellbeing across a population and serves to emphasise the importance of focussing on the wider determinants of health.

Based on data from the latest Index of Multiple Deprivation (2010), Sheffield is ranked overall as being slightly more deprived than in 2007. Most of the city's population live within a relatively deprived area and approximately 22% live in the 10th most deprived areas in the country (8% live in the 10th least deprived areas). Within South Yorkshire and Bassetlaw, Sheffield is of a similar deprivation rank to Barnsley, Doncaster and Rotherham and more deprived than Bassetlaw.

The Index of Multiple Deprivation takes into account the key wider determinants of health: income, employment, health and disability, education, skills and training, barriers to housing and related services, crime and living environment. Principal among these is income and employment.

4. Public Health Priorities

Given the above context for health and wellbeing in Sheffield, and notwithstanding the primary importance of the need to focus on the wider determinants of health (particularly employment and health, there are four broad areas of health that are considered to be priorities: child and maternal health, long term conditions (cardiovascular disease, chronic obstructive pulmonary disease and diabetes), mental health and wellbeing and healthy lifestyles.

4.1 Child and maternal health

A good start in life lays the foundations for future health and life chances. Despite continuing improvements generally across the range of child and maternal health indicators, marked inequalities in maternal and child health persist within the city. Between the 'best' and the 'worst' wards in the city we have:

- a 2 fold difference in achievement at Early Years Foundation Stage;
- a 4 fold difference in infant mortality rates; and
- a 7 fold difference in smoking in pregnancy.

There are 130,000 children aged 0-19 years in Sheffield and this is expected to rise by 2% over the next 5 years. The highest growth will be within the 0-4 age range which is projected to increase by 6% in the same time frame. 20% of 0-15s are of black and minority ethnic (BME) origin; the BME proportion in younger age groups is higher.

Around 11,000 young people currently have some form of learning difficulty or disability and this is projected to increase at a rate of 5.1% pa, 2% above the projected national rate of increase. The fastest growing special educational needs categories nationally and locally are speech, language and communication needs, and autistic spectrum disorder. 3,500 young people have continuing care and end of life care needs within the city.

Infant mortality rate (2009-11) is 4.5 deaths <1 yr per 1000 live births. Sudden infant death rates are higher in Sheffield than nationally and concentrated in more deprived areas. Analysis of mothers who lose children to sudden infant death shows that 90% of the mothers smoke and 83% have social or mental health risk factors.

Smoking during pregnancy is reducing but is still above the national rate and there is a seven fold difference at Community Assembly level in the proportion of women who are

smoking 'at delivery'. Smoking in pregnancy reduces birth weight and contributes significantly to stillbirth and deaths of children in the first year of life. The latest smoking in pregnancy figures show for 2011/12 show that 14.1% of mothers smoked around the time of delivery.

Breastfeeding rates are above the national average - currently 52.3% women are breastfeeding at 6-8 weeks compared to a national average of 45.2%, but again wide inequalities exist within the city.

2,000 pre-school children and 9,500 5-17 year olds are estimated to have a mental health difficulty of some kind. The most common disorders are conduct disorders, emotional disorders and ADHD. 3.4% of 11/12 year olds report they 'always feel sad or unhappy'; in 11/12 years olds with Special Educational Needs and in those eligible for free school meals the proportion rises to 6.8%. (ECM Survey 2009). Certain groups, including children of black and minority ethnic origin, young offenders and looked after children, are more likely to experience mental health difficulties and achieve lower educational attainment than their peers.

Sheffield benchmarks very poorly against the national average and core city average for A&E attendances and emergency admissions for the under-fives e.g. emergency admissions rate (09/10) for respiratory conditions in 0-4 year olds in Sheffield is highest in England at 239.41 per 10,000 compared with Bristol (98.05) and nationally (115.26) (ChiMat 2009/10). Local data show that the highest use of A&E attendance in Sheffield is from the most deprived areas where rates are up to 50% above the city wide average.

There has been some successful partnership working which has helped to slow the rise of childhood obesity but downstream the problem is still significant, which will impact health outcomes in later life and demand for hospital and primary healthcare services. Sheffield teenage pregnancy rates are lower than ever – although still above the national rate. Fewer children are in care overall and the number of children with a Child Protection Plan has fallen recently. The priorities are to improve outcomes through a reduction in inequalities in:

- Smoking during pregnancy
- Infant mortality
- Childhood obesity
- Children's emergency care
- Sexual health including teenage conceptions
- Emotional wellbeing and mental health

4.2 Long term conditions

People having at least one long term condition (LTC) account for approximately 31% of the population (rising to 60% of the over 60s) but use 69% of the primary and acute care budget in England[1]. People with LTCs are far higher users of health and social care services than average, accounting for approximately 55% of general practice consultations, 68% of A&E attendances and 77% of inpatient bed days[1]. It is estimated that 85% of deaths in the UK are from chronic diseases. Within this, 36% of all deaths are from cardiovascular disease and 7% from chronic respiratory disease. In the older age group, based on age alone and population projections, if 60% of the over 65s continue to have a long term condition[1], an estimated 52,000 people over age 65 in

[1] 10 things you need to know about LTC. DH website http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_084294

Sheffield would have had a LTC in 2009 rising to 59,000 in this age group by 2020. This would lead us to expect growth at an additional 650 cases per year.

The number of people with more than one LTC increases with age. Half of all individuals with chronic conditions have multiple chronic conditions[2], and similar chronic conditions tend to cluster (e.g. arthritis, hypertension, CVD, diabetes, mental health problems) with related and associated risk factors. Their differing health and social care needs should be recognised and addressed individually in order to avoid diagnostic overshadowing. These people are unlikely to fit on single disease management pathways and require additional support and non-disease specific approaches to manage their conditions. They are more likely to undergo rapid declines in health status and a greater likelihood of disability affecting daily functioning.

The impact on health and function is significant and can be lessened significantly by better control of the underlying condition(s). Better management of LTCs will also help to prevent a large proportion of health and social care contacts and these efficiency gains are supported by benefits to patients and their families. The biggest 'efficiency frontiers' are where the major costs in healthcare are[3]. These are:

- Management of people with long term medical conditions
- Care of older people
- Reducing avoidable emergency admissions
- Care for people at the end of their lives

4.3 Mental health and wellbeing

Mental wellbeing is increasingly recognised as a major factor in health and wellbeing and wider socio-economic outcomes. Definitions are important however and there is considerable debate and variation in meaning surrounding the different terms that are used in relation to this area (e.g. mental ill health, mental wellbeing and emotional resilience). From the perspective of what may make people vulnerable to problems with their mental wellbeing evidence suggests the need to focus on those experiencing: physical health problems, mental ill health, loneliness, being in debt, substance misuse and/or discrimination on the basis of their ethnicity, disability, gender etc.

Feeling good and functioning well influences physical health and affects people's behaviours in relation to smoking, exercise, healthy eating, sexual health, alcohol and drug use. People with mental ill health experience higher rates of physical illness and are more likely to die prematurely, largely from treatable conditions. There is a strong evidence base supporting the need to focus on children and young people given that over half of people with lifetime mental health problems first experience symptoms by the age of 14. Women are one-and-a-half times more likely to be affected by anxiety and depression and there is a higher rate of depression in people from non-white ethnic communities.

The Mental Health Needs Index indicates that Sheffield has a 15% higher than expected admission rate for severe mental health problems than England as a whole. Although the death rate from suicide and undetermined injury is lower in Sheffield than the national average, local audit data (2006-2010) reveal depression is a key factor in around 40% of such deaths. It is estimated that at least one third of all families

[2] Wolff JL et al. Prevalence, expenditures and complications of multiple chronic conditions in the elderly. Arch Intern med, Nov 11 2002

[3] Making progress on efficiency in the NHS in England: options for system reform. The Nuffield Trust 2010

(including parents and their children) include someone who is currently mentally ill. [4] If we focus on individuals, the figure is 17% for adults and 10% for children. Mental ill health represents up to 23% of the total burden of ill health in the UK – the largest single cause of disability. [5]Overall, the economic cost of mental health problems to the economy in England amounted to £105 billion in 2010, of which £30 billion is work related. [6]More than £2 billion is spent annually on social care for people with mental health problems. [7]

4.4 Healthy lifestyles

Smoking related illness accounts for approximately 900 deaths per year in Sheffield, costing the city an estimated £137 million approximately each year. Smoking is still the biggest, reversible cause of ill health and early death in Sheffield as well as nationally. It is the largest single cause of health inequalities, accounting for over half of the difference in all middle-aged deaths between the highest and lowest socio-occupational groups. A smoker's lifespan is shortened by about five minutes for each cigarette smoked and those who die through smoking-related illnesses such as heart attack, lung cancer or chronic respiratory disease do so 10 to 15 years prematurely. The health benefits of stopping smoking accrue very quickly at any age. For example, breathing and circulatory benefits begin immediately, heart attack risk is halved within a year of quitting and lung cancer risk is halved within about 5 years. The prevalence of adult smoking in Sheffield is estimated to be approximately 20.5% (IHS Oct 2010 – Sept 11). This is slightly higher than the national average, 20.3%. This places Sheffield lowest amongst the Core Cities and fourth lowest in the Yorkshire and Humber region (behind York, 17.3%, North Yorkshire 17.4% and East Riding 17.9%). The average rate of smoking in the Yorkshire and Humber region is 22.1%.

Obesity is estimated to be responsible for over half of all Type II cases of diabetes, around a fifth of heart disease and approximately 10% of some cancers (e.g. colon, kidney). It is estimated that 23/7% of adults are obese (based on HSE 2006-8). Actual data based on self-reported data from the Sheffield Health and Exercise Survey of 2002, more men (55%) were overweight/obese than women (49%). Among men aged 35-64, 47% were overweight and a further 17% were obese. The survey showed that people from South Asian ethnic groups had similar levels of obesity to the rest of the population. There is a higher prevalence of obesity and overweight among lower socio-economic groups (especially women). The prevalence of obesity and overweight increases with age. People of South Asian origin who are categorised as overweight have a higher risk of suffering from obesity-related disorders than the rest of the population. Department of Health estimates suggest around 580 deaths in Sheffield a year could be prevented if diets complied with national nutritional guidelines.

Sheffield has the highest estimated proportion of people aged over 16 years who consume alcohol amongst the 8 core cities with 51,000 estimated to be 'high risk' drinkers. Alcohol is a major contributing factor to levels of ill health and early death,

[4] Layard, R How mental illness loses out in the NHS A report by the Centre for Economic Performance's mental Health Policy Group LSE June 2012
[5] WHO (2008) *The Global Burden of Disease: 2004 update,* available at: www.who.int/healthinfo/global_burden_disease
[6] Centre for Mental Health (2010) The Economic and Social Coasts of mental Health Problems in 2009/10, available at: www.centreformentalhealth.org.uk/pdfs/Economic_and_social_costs_2010.pdf
[7] Department of Health (2009) *Departmental Report 2009: The Health and Personal Social Services Programmes,* available at: www.official-documents.gov.uk/documents/cm75/7593/7593.pdf

including cardiovascular disease, gastrointestinal disease and cancer as well as acute conditions resulting from accidents, self harm and violent assault. Alcohol-related hospital admissions are increasing in Sheffield and currently around 6,500 people are admitted to hospital each year due to alcohol-attributable conditions. Approximately 37% of young men and 33% of young women are thought to be drinking more than the recommended safe levels. This equates to about 14,000 young men and 12,000 young women in Sheffield. A particular local concern arising from these figures is the unplanned, unprotected, regretted and abusive sexual activity linked to alcohol use. The alcohol-related costs to the City are huge. The cost to the health services is approximately £12 million a year and £15.3 million a year for the criminal justice system. In addition, around 250,000 working days are lost and there are 160 reported sexual assaults associated with alcohol consumption per year. Estimates suggest that there are 7,900 children in Sheffield affected by their parents' alcohol consumption.

Appendix 2. Practice Suggestions

Suggestion	How included
Acute Care (Elective)	
Orthotics **ABPI for peripheral vascular disease** Community opportunities - Dermatology (digital cameras), pipelle, wound dressing, DMARD nurse, phlebotomy, pulmonary rehabilitation, fainting/dizziness service, acne/roaccutane, keratitus, ear toilet, provision of cryotherapy, CCP testing	All suggestions passed to elective portfolio lead, for consideration within review of pathways and follow up reduction
Open discharge Minimise follow up	Commissioning only clinically value adding Out patient Follow-up
Acute Care (Unscheduled)	
District Nurses allied to practices (x5)	**Review of community nursing**
A&E discharge notes	**Electronic discharge letters**
Unscheduled care, inc out of hours provision	**New approach to urgent care**
Increasing resources into primary care	**Key theme in this plan**
Practice workload coming from secondary care	Increasing resources in primary care
Long Term Conditions	
Healthcare into care homes	**Review of care Home LES, quality of care in care homes**
Commissioning self care for long term conditions	Commission generic self care programmes
Children and Young People	
Vitamin D deficiency	**To be followed up with practices to understand commissioning action required**
Integrated working between GP practices and community working	Develop integrated practice, improve maternity care
Joint work with police and education	Future Shape Children's Health (and 0-19 Partnership Board)
Reducing high cost out of area placements	Progress the development of a local provision for children with complex needs
Lack of HV provision	Developing integrated practice
Mental Health and Learning Disabilities	
Improving MH provision (x3)	**Several actions address this**
Transition of young people to adult services (esp MH) (x3)	**Included in children's and MH&LD areas**
Alcohol Services	Sheffield City Council responsibility as part of transfer of public health

Quality	
Preserving the NHS	**Reflected in CCG values**
Optimum care for migrant populations, inc Roma Slovak population Immigration assimilation and health issues	**Will be included in CCG health inequalities plan**
Medication review done by pharmacists	**Medicines optimisation & medicines safety**
More systematic education strategy for primary care	**Improving primary care quality**

Appendix 3. National Pledges

Rights and Pledges	2013/14 likely RAG Rating	Risk to delivery	Assurance of Delivery / Mitigating Action
Referral To Treatment waiting times for non-urgent consultant-led treatment			
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%		Low	Performance issues during 2012/13 relating to issues in particular specialities at Sheffield Children's Trust (SCHFT) have been actioned through contractual and performance discussions and will be kept under review as we go into 2013/14.
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%		Low	As above.
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%		Low	As above.
Additional supporting measure for 2013/14 Zero tolerance of over 52 week waiters		Medium	The medium risk and RAG rating reflects the inclusion in this measure of admitted and non-admitted completed pathways over 52 weeks in addition to incomplete pathways which is new for 13/14. The overall impact on 52 week waits of performance issues in certain specialities are being addressed via Performance monitoring meetings with the Trust to ensure action plans are in place. Validation at Trust level is taking place to ensure good data quality and monitoring takes place at 35 weeks to ensure early identification of potential long waits and allow appropriate management plans to be put in place. Small numbers of patients in some specialties, particularly at SCHFT, can place additional pressure on this target.
Diagnostic test waiting times			
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%		Low	The small numbers of patients involved with respect to SCH performance means the impact of just 1 or 2 breaches is significant. Action plans are in place to address the main areas of concern and assurance has been given by SCH that issues will be resolved.
A&E waits			
Patients should be admitted, transferred or discharged within 4 Hours of their arrival at an A&E department – 95%		Medium	STHFT and CCG will continue with actions initiated in 2012/13: • Monthly Executive Performance Review involving CCG Committee GP and the STHFT Medical Director. • Reviewing operational responsibility for delivering performance and ensuring effective escalation. • Optimising the use of the patient discharge lounge. • A second triage stream in Emergency Department at certain times, so that a 'see and treat' service can be carried out.

			• Consider recommendations made from the Clinical Quality Review of the A&E service undertaken in Q4 12/13.
Additional supporting measure for 2013/14 No wait from decision to admit to admission (trolley waits) over 12 hours		Low	Actions in relation to A&E waits will also support sustaining good performance on minimising trolley waits.
Cancer waits – 2 weeks wait			
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%		Low	Continue to keep performance under review and work with STHFT to identify and address and emerging risks.
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%		Low	As above.
Cancer waits – 31 days			
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%		Low	As above.
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%		Low	As above.
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%		Low	As above.
Maximum 31-day wait for subsequent treatment where that treatment is a course of radiotherapy – 94%		Low	As above.
Cancer waits – 62 days			
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%		Low	As above.
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%		Low	As above.
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set		Low	As above.
Category A ambulance calls			
Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)		Low	YAS are putting in place a number of initiatives to identify Red calls more quickly. Assurances have been provided that the plan will improve current performance and support delivery of required performance in 2013/14.
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%		Low	As above
Additional supporting measure for 2013/14		High	The risk and RAG rating for this measure reflects that this is a new measure so requires

Ambulance arrival at A&E to patient Handover delays i) over 30 minutes ii) over 1 hour			further confirmation and discussion with trusts of data sources and plans to ensure delivery.
Additional supporting measure for 2013/14 Patient Handover to Crew Clear delays i) over 30 minutes ii) over 1 hour		High	The risk and RAG rating for this measure reflects that this is a new measure so requires further confirmation and discussion with trusts of data sources and plans to ensure delivery.
Mixed Sex Accommodation Breaches			
Minimise breaches		Medium	Sustain good performance at STH and continue to work with SCH to address and avoid breaches where these are not in the overall best interest of the patient. This is medium risk due to particular factors at SCH relating to balancing target against patients' best interests/clinical factors.
Cancelled Operations			
All patients who have operations cancelled, on or after day of admission (including day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at time and hospital of the patient's choice.		Low	Work with trusts to sustain required performance.
Additional supporting measure for 2013/14 No urgent operation to be cancelled for a 2nd time		High	The risk and RAG rating for this measure reflects that this is a new measure for 2013/14 and so robustness of local data is still being confirmed to inform discussion with trusts of plans to ensure delivery.
Mental Health			
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%		Low	Following drop (from August 2012) in previously good performance plans for mitigating action will continue to be discussed at the quality and performance review meeting, and performance kept under review. We will seek a remedial plan if it's evident that they will struggle to meet this target without a change to working practices.

Appendix 4. NHS SHEFFIELD CCG 2013/14 Allocations as announced on 18 December 2012

BOX A:	Notes	£'000	% change
CCG Opening Baseline			
2012/13 Opening Baseline per submission to DH in July 12 exercise		734,420	
Less local running cost budget within this baseline	E	-13,707	
2012/13 Opening Baseline net of running costs		720,713	
Central Adjustments to baseline exercise:			
Specialised Services Adjustment	A	-41,426	
Re-distribution of 2% headroom	B	-2,670	
Adjustment to Public Health (Local Authority) value	C	-1,281	
Adjusted CCG Baseline Excluding Running Costs Before Uplift		**675,336**	
Cash Uplift			
General cash uplift		15,533	2.3%
CCG Programme (Commissioning) Recurrent Allocation 2013/14	**D**	**690,869**	
Running Costs Allocation 2013/14 - equates to just less than £25 per head	**E**	**14,070**	
TOTAL recurrent allocation for 2013/14		**704,939**	

During the year the CCG will expect to also get a range of non recurrent allocations for specific issues

Box B: **Non Recurrent allocation for joint work between health and social care**	£'000	% change
Funding will be transferred to SCC direct from NHS CB		
2012/13 allocation	7,280	
Increase to this allocation for 2013/14	2,403	33%
2013/14 allocation	**9,683**	

Nationally determined Increase at 33% equates to 0.3% of headline 2.6% uplift to CCG allocations

In addition CCGs will have to separately demonstrate how they have spent their share of £300m re-ablement funding which is within CCG baseline allocations. For Sheffield CCG this is approx £3m and we will demonstrate through our existing investment in community/intermediate care services.

Notes:
A: The national definition set for specialised services to be commisisoned via NHS CB was announced late autumn and this changed the value of services significantly increasing the "topslice" from CCG baseline by £41k. Significant work is still needed to confirm whether this represents an appropriate transfer of resource and how in year risks will be managed.
B: In the baseline exercise Sheffield correctly assessed that 100% of the PCT's 2% headroom resource had been used on CCG business in 12/13. The NHS CB has subsequently stipulated that an element of 2% resource must be allocated to NHS CB due to future requirements of NHS CB direct commissioning budgets to hold a 2% headroom budget. This represents a £2.7m loss of income to the CCG from previous plans.
C: In the baseline exercise the PCT indicated that the PH budget to be transferred to the LA should be lower than per previous exercises. This has not been accepted by the NHS CB and results in further loss of income to the CCG,
D: This is the RECURRENT budget which the CCG has available for commissioning spend in 2013-14, although per note F below 2% must be ring fenced for NON recurrent expenditure.
E: This is the separate budget which the CCG is allowed to spend on its running costs including services bought in eg from CSU and the spend on Locality infrastructure. Should the CCG underspend against this budget resources can be used for commissioning spend.

Appendix 5. Equalities Impact Assessment

Management lead: Tim Furness, Chief of Business Planning and Partnerships
Supported by NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit Equality and Diversity Officer – Elaine Barnes
Date of assessment: 21st February 2013

Context:
The commissioning intentions document describes the CCG's plans for 2013/14, towards achieving its four aims:

1. To improve patient experience and access to care
2. To improve the quality and equality of healthcare in Sheffield
3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield
4. To ensure there is a sustainable, affordable healthcare system in Sheffield.

The table below summarises our initial assessment of the potential impact of the CCG commissioning intentions on people with each of the nine protected characteristics described in the Equality Act.

Protected Characteristics	**Baseline data and research** – What is available? What does it show? Are there any gaps? Use both quantitative and qualitative research and user data Include consultation with users if available	**Is there likely to be a differential impact?** If 'yes', is that impact direct or indirect discrimination?
Gender	The plans apply to both genders.	Yes – direct
Race	This applies to all races. There are specific and appropriate culture needs which would need to be taken into consideration when delivering health care services to black and Minority ethnic groups.	Yes – direct/ Indirect
Disability	Learning disability has been highlighted as an area that required future investment in light of the Winterbourne inquiry and Mid Staffordshire Hospital. The disability needs of children and adults are fully taken into consideration across all the health care provisions.	Yes
Sexual orientation	Sexual health needs are not reflected in the plans.	Yes – direct/ Indirect
Age	The plans apply to all ages and there are specific focus and emphasis on the different needs of children, young people and older people. There are plans to improve transition from children services to adult's services. The growing needs of an aging population have been taken into consideration.	Yes
Religion/Belief	The plans including stopping commissioning procedures for circumcisions for religion	Yes – direct/ Indirect

	reasons. They do not describe any actions to ensure that the needs of people from all religion background including non religion are taken into consideration	
Gender Reassignment	National research has identified that there is a growing numbers of individual who going through the process of gender identify. The commissioning intentions should acknowledge this and ensure that the process involved does not disadvantage individual or groups.	Yes – direct/ Indirect
Marriage and Civil Partnership	There is nothing in the plans that refers to marital or partnership status.	No
Pregnancy and Maternity	There is a remit to improve maternity care, within the children and young people portfolio.	Yes – direct/ Indirect
Human Rights	The commitment of Sheffield CCG to continue to work in partnership Sheffield City Council to reduce health inequalities in Sheffield will continue to support the human rights of the population.	Yes – direct/ Indirect

General

The CCG Commissioning Intentions includes commitment to reducing health inequalities and to ensure compliance with the Equality Act, which should have an impact on people with each of the protected characteristics. The commissioning intentions fully support the recommendations within the Fairness Commission report.

Conclusion

The Commissioning Intentions are likely to have a differential impact on people with most of the protected characteristics. It is not possible to describe the impact as the document does not include details of the service changes proposed. The CCG should ensure that an equality impact assessment is completed with each business case for change, to identify both negative and positive differential impact and set out mitigating action where appropriate.