Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Additional Actions to Manage the Financial Position

Governing Body meeting

7 September 2017

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Purpose of Paper

To present three options to manage the financial position to the Governing Body for decision and to update the Governing Body on other steps being taken to deliver a Quality, Innovation, Productivity and Prevention (QIPP) plan for 2017/18 that meets the CCG's financial requirements.

Key Issues

At the 25 May 2017 meeting in private, the Director of Finance briefed members of Governing Body on the significant risks and challenges being faced by the CCG to deliver the 2017/18 financial plan and commissioning intentions as approved by Governing Body in December 2016. This was in the light of early activity pressures and with c£4m of the QIPP programme having no identified schemes. The QIPP plan needs to be a minimum of £21.6m and at 25 May this stood at £17.7m of agreed schemes. As a result, Governing Body approved a set of seven Financial Management Principles which were set out in the Finance Report to the 6 July 2017 meeting. Work commenced from 25 May to take forward the actions encapsulated in the seven Principles.

In July 2017, Governing Body approved certain additional QIPP schemes taking the plan to £18.5m and requested further work on other proposals. At the same time, Governing Body also agreed an action to consider disinvestment options should insufficient additional QIPP be identified to bridge the gap.

On 3 August 2017, Governing Body held an extra meeting in private session to consider the options presented. £1m of additional QIPP schemes were approved and it was agreed certain other actions would be further developed and presented to Governing Body in September 2017 in the public session for final consideration and approval as appropriate. Decisions would be taken in the light of the Month 4 financial position, which is being presented through a separate report.

Is your report for Approval / Consideration / Noting

Approval, Consideration and Noting

Recommendations / Action Required by Governing Body

The Governing Body is asked to:

Approve the following commissioning policy for implementation:

- Clinical Variation in Primary Care – additional steps to manage unwarranted variation in GP referrals;

Approve consultation for the following policy with a recommendation to be presented to Governing Body on 2 November 2017:

- Suspension of Gluten Free Prescribing for Adults in Sheffield.

Consider the proposal on health optimisation and the supporting evidence provided and to:

- Note that currently there is no evidence that the policy will achieve the desired effect of improving health outcomes for people who smoke in Sheffield;
- Note that as part of the South Yorkshire and Bassetlaw (SYB) work in Commissioning for Outcomes there is potential for the development of a system-wide approach to health optimisation;
- Agree to receive proposals on health optimisation for consideration at a later date based upon this joint SYB work.

Note that an update on further mitigating actions will be provided to the meeting on 6 October 2017.

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?
4. To ensure there is a sustainable, affordable healthcare system in Sheffield

Are there any Resource Implications (including Financial, Staffing etc)?

Failure to deliver the full QIPP target identified for 2017/18 will affect the CCG's ability to deliver its Commissioning Intentions, Operational Plan and Financial Plans and to potentially meet its statutory responsibilities.

Additional staff and clinical input, potentially redirecting staff from other activities, will be required to deliver the proposals set out in this paper at pace,

Have you carried out an Equality Impact Assessment and is it attached?

Please attach if completed. Please explain if not, why not

Completed EIA templates are attached at Appendix 2 to this paper.

Have you involved patients, carers and the public in the preparation of the report?
No, however, the CCG has discussed possible options with a stakeholder group of Sheffield patients and members of the public, their responses are reflected in this paper and proposals.

NHS
Sheffield
Clinical Commissioning Group

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1. Introduction

Governing Body approved the CCG's Commissioning Intentions and financial plan for 2017/18 which incorporated delivery of our share of the South Yorkshire and Bassetlaw CCGs' control total required by NHS England. This required delivery of an ambitious £21.6m QIPP plan.

At 25 May 2017 meeting in private session the Director of Finance briefed members of Governing Body on the significant risks and challenges being faced by the CCG to deliver the 2017/18 financial plan and commissioning intentions as approved by Governing Body in December 2016. This was in the light of early activity pressures and with c£4m of the QIPP programme having no identified schemes. The QIPP plan needs to be a minimum of £21.6m and at 25 May this stood at £17.7m of agreed schemes. As a result, Governing Body approved a set of seven Financial Management Principles which were set out in the Finance Report to 6 July 2017 meeting. Work commenced from 25 May to take forward the actions encapsulated in the seven Principles.

In July 2017, Governing Body approved certain additional QIPP schemes taking the plan to £18.5m and requested further work on other proposals. At the same time, Governing Body also agreed an action to consider disinvestment options should insufficient additional QIPP be identified to bridge the gap.

On 3 August 2017, Governing Body held an extra meeting in private session to consider the options presented. £1m of additional QIPP schemes were approved and it was agreed certain other actions would be further developed and presented to Governing Body in September 2017 in public session for final consideration and approval as appropriate. Decisions would be taken in the light of the M4 financial position, which is being presented through a separate report.

The three proposals under consideration are:

- Clinical Variation in Primary Care
- Suspend Prescribing Gluten Free Foods for Adults
- Health Optimisation – Smoking

2. Background

2.1 Financial Position at Month 4

The Director of Finance's report to this meeting of Governing Body sets out the position in detail. It reports forecast out turn net pressures of £5.2m which are capable of being covered by release of reserves but leaving exceptionally low reserves to meet any remaining risks, challenges and pressures in the last 8 months of the year. The report considers these risks in detail. It summarises a range of risk scenarios, the most likely being £2.3m of uncovered or un-mitigated risk, meaning that if risks crystallise as per this scenario and further actions are not taken, the CCG would fail by this amount against its financial plan.

Possible additional actions as set out in the finance paper broadly fall into 3 categories:

- "Re-double" efforts to deliver existing QIPP schemes where there is slippage which is likely to take significant additional managerial and clinical engagement and effort primarily with our member practices and other key providers across the city. As part of this ensure we focus on schemes which will make "**in year"** savings.

- Ensure that across our health system we are adhering to existing policies and pathways to ensure expenditure and treatment is based on clinical need.

- Proactively work to secure additional income into our local system to target investment on the service changes to make so that our whole system becomes more sustainable. This is in the context that Governing Body has already agreed through the seven financial management principles approved in May 2017 that the CCG is unable to prioritise any further new investment in 2017/18 unless from ring fenced allocations or there is a proven "in year" invest to save case.

2.2. Actions to Improve Efficiency and Reduce Costs

We know that not all our services are as effective or as efficient as they could be. A key part of our QIPP programme is to improve the quality and outcomes of the services we commission while making them as efficient as possible.

To ensure value for money we are:

- reviewing a number of services provided under block contracts (where a fixed sum of money is paid) to ensure we understand the scope and quality of the care provided;
- conducting whole pathway service reviews of 10 key specialties, jointly with our provider Trusts (gastroenterology, ophthalmology, urology, gynaecology, ENT, neurology etc.);

- developing alternatives to hospital care in primary care and the community including dermatology, gynaecology, cardiology, ENT.

Furthermore, each of our provider Trusts (STHFT, SCH, SHSC) have their own internal cost improvement programmes developed in order to balance their own financial plans and are actively seeking to ensure they provide services as efficiently as possible to support this target.

2.3 Developing the 2017/18 QIPP Plan

Although SCCG delivered a significant QIPP saving in 2016/17, which secured circa 67% or £13m of the 2016/17 QIPP target. In order to be assured that the £21.6m requirement for 2017/18 is achieved, the SCCG QIPP Sub-Group determined that an internal QIPP target and plan to deliver £25m be set. This would mitigate the risk of delay or non-delivery by providing a suitable contingency against pressures on the programme.

QIPP proposals were gathered during November and December 2016 as part of Operational Planning process for 2017-19 to reflect the significantly accelerated national timetable requiring contracts to be agreed and Operational and Financial Plans to be submitted by 23 December 2016. As a result of this shortened planning process, there were varying levels of development for individual schemes within the QIPP plan.

This QIPP plan was reviewed by Clinical Commissioning Committee (CCC) on 5 January 2017 and was subject to ongoing refinement and development during the final quarter of 2016/17. On behalf of Governing Body, QIPP Sub-group reviewed the detailed plans by area of spend in February and March 2017 and concluded that the plans at that point provided insufficient assurance of delivery and further actions were agreed.

The development of SCCG QIPP plans was a collaborative process and provider Trusts have been actively engaged in the development and refinement of plans to ensure that the actions required and impact of the schemes is agreed by all partners.

In order to assure Governing Body that a robust plan was in place the QIPP Sub-Group conducted a confirm and challenge process. Meetings were held with the executive director lead, clinical director lead and delivery team for each programme area within the QIPP plan. These meetings were led by the Accountable Officer, Director of Commissioning and Performance and Director of Finance, supported by SCCG officers and included a detailed review of state of readiness of plans for implementation and delivery, anticipated QIPP valuation, risk and mitigation.

A final review was undertaken by finance, commissioning and PMO leads, led by the Director of Finance, to confirm the QIPP plan position at 9 May 2017. All proposed movements from the previous plan were summarised and presented to Senior Management Team (SMT) for approval on 9 May 2017, prior to submission of findings to QIPP sub group on 18 May 2017. The revised plan was reported to Governing Body on 25 May 2017. There was an identified shortfall of c£4m between these confirmed plans and the 2017/18 QIPP target.

It was agreed that a plan would be presented to Governing Body to confirm how this shortfall would be met. A number of opportunities were identified and assessed for viability. In scoping possible additional opportunities SCCG drew on a wide range of information including a further review of RightCare packs and action plans to confirm all opportunities were being considered, assessment of programme budgeting benchmarking, NHS England QIPP guidance and the national 'Menu of Opportunities', local soft intelligence drawn from primary and secondary care and contract performance, a review of QIPP plans developed by local CCGS and the plans of the Accountable Care System (ACS). Ongoing discussions with local providers through the developing Accountable Care Partnership also took place to confirm the position and identify and other steps that could be taken.

Twelve additional schemes were identified for further development, four were removed as they were not considered viable following detailed assessment, of the remaining schemes two were presented for Governing Body approval to proceed and the remaining schemes were presented as pending for approval in principle or for noting and future agreement.

The pending schemes were fully assessed and presented ready for approval by Governing Body as part of a full QIPP plan at the Governing Body meeting on 3 August 2017. One scheme was approved for implementation and three were removed as not viable.

3. Financial Management Principles agreed by Governing Body on 25 May 2017

Concurrently with the development of additional QIPP schemes, SCCG implemented, following approval from Governing Body in private session, a set of financial management principles. These built on the actions recommended in the financial recovery plan developed in 2016/17 to maintain a tight control on CCG expenditure and management overheads. The Financial Management Principles are set out in the Director of Finance's Report to Governing Body on 6 July 2017. The last principle – principle 7, is to consider disinvestment options.

4. Consideration of Other Options to Manage the Financial Position - Disinvestment

4.1 Disinvestment Options

SCCG is committed through our organisational vision and the strategy of the CCG and partners set out in the Sheffield Plan (2016) to create sustainable health and care for the future as well as empowering people in Sheffield to live independently and well and to meet the need of the Sheffield population and improve health and wellbeing outcomes.

To achieve this, SCCG must encourage the people it serves to live the healthiest lives possible; and it must do so within the resources available. Only by doing so will we ensure we get the very best value from the NHS. Exceeding the CCG's resources risks the ability of the NHS to be there when people really need it.

In considering the options available for disinvestment SCCG have sought to identify those that would align as closely as possible with this commitment and limit proposals to those that would be the 'least worst option'.

4.2 Development and Clinically Led Assessment Process

During June and July 2017, SCCG scoped a long list of options for decommissioning or disinvestment. These were based on local intelligence and analysis of contract activity and performance together with a review of actions taken by other commissioners in England. SCCG engaged with NHS England during this process.

The long list was reviewed by a group of locality lead and Governing Body GP members, led by the CCG Medical Director and the outcome of this review was reflected in the further development and assessment of the options. In total 10 options were developed and presented to the SCCG Clinical Senior Management Team for assessment in July 2017.

A set of assessment criteria were developed for this process, these were drawn from the CCG policy *'Commissioning for Value – Decision Making and Prioritisation Framework'* approved in July 2016 and the criteria are set out at appendix 1 to this paper. SCCG also takes into account the views of patients and people in Sheffield as part of any decision-making, in line with our statutory responsibilities and commitment to engaging our local population in commissioning.

Following this assessment process three options were recommended to Governing Body for consideration in private on 3 August 2017. These options were discussed in detail at the Governing Body Meeting in August 2017. Taking into account the reported financial position, the risks and benefits presented by the Director of Finance and the reported QIPP position and risk Governing Body considered that it was necessary for the CCG to proceed to develop these options for implementation and agreed to receive the options for final decision in public at the Governing Body meeting on 7 September 2017.

4.3 Proposed Disinvestment Options for Consideration

Governing Body decided to progress development of the following options for consideration in public on 7 September 2017:

- Clinical Variation in Primary Care
- Suspend Prescribing Gluten Free Foods for Adults
- Health Optimisation - Smoking

The following three sections contain further detail on each of the agreed options for consideration. An Equality Impact Assessment for each option has been completed and is attached at appendix 2 to this paper.

4.4. Public Engagement

SCCG held a stakeholder event in August 2017 to seek views from patients and the public in Sheffield on the types of decisions we are facing in order to support the

financial position. Those attending the meeting included members of GP practice Patient Participation Groups, Involve Me (the CCG reference group), the Citizens Reference Group, and Healthwatch. It aimed to get feedback and suggestions on actions already taken and approaches the CCG is having to consider.

These discussions and feedback from Sheffield clinicians have been considered in the final proposals and recommendations set out in this paper. The key themes identified at the event were:

- the need for people to take greater responsibility for their own health and wellbeing and the provision of information to support this;
- concerns for the pressure placed on NHS staff;
- cross system evaluation of projects and developments to understand the full impact;
- that people were not endorsing cuts but recognised that the CCG was facing some difficult decisions in order to support the sustainability of the system;
- a recognition that difficult decisions needed to be taken to support the sustainability of the system;
- concern about inequity or subjectivity of approach in different areas or practices;
- the potential of some options to increase heath inequality and support for patients who could not advocate for themselves;
- support for practices to implement plans effectively.

5. Clinical Variation in Primary Care

5.1 Summary

Unwarranted variation in healthcare is well researched and documented. Differences in clinical practice, experience and knowledge can all result in differences in outcome, quality and productivity including rate of referral or admission. SCCG has implemented a process to support practices to consider variation and has attached a QIPP plan to this.

These proposals expand on existing proposals and services by increasing utilisation of existing referral advice and support services, further supporting practices to consider observed variation within their peer group and developing actions to address this and finally by establishing prospective peer review for non-urgent referrals that fall outside established advice and support services.

5.2 Background

Addressing unwarranted variation is a key theme of the Elective Care and Demand Management workstream. SCCG is working with Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) to address unwarranted variation in secondary care, focussing on developing new patient pathways, managing consultant to consultant referral, outpatient follow up ratios and intervention rates.

The workstream also has delivery plans in place to develop a number of new services in 2017/18, informed by the ongoing CASES pilot, that will provide appropriate alternatives to secondary care referral, these include cardiology palpitation and 12 lead ECG services, extended gynaecology and contraception services, a community ENT service, and a community dermatology service for skin lesions, eczema and other common skin conditions that cannot be managed in primary care.

Variation within primary care should be addressed similarly. We know from the ongoing information provided by CASES that while the majority of GP referrals are appropriate and of good quality, in Sheffield there is room for improvement. In their analysis, *'Referral Management – lessons for Success*' (London, 2010) the Kings Fund identified several factors affecting referral rates from GPs including non-clinical factors such as tolerance of risk, the clinician's sensitivity and pressure.

5.3 Proposal

By further formalising this process and associated targets it is considered that a greater reduction in outlier activity could be secured and a more significant saving achieved.

The proposal is two-fold, to maximise use of existing clinical advice and review services by reinforcing their uptake in primary care and secondly to strengthen the local approach to unwarranted variation by expediting the roll out of neighbourhood and locality peer review, using locality managers to lead the review process and link with individual practices and to require the prospective review of all referrals made by certain groups of clinicians who may be most likely to refer unnecessarily.

5.3.1 Reinforce Use of Existing Peer Review Services

An audit of compliance with CASES process was undertaken by all practices in June 2017, supported by PCS. The results of this audit will highlight any issues with referral to the current service and this information will be used to improve access and operating processes.

Routine comparative data will be provided to support locality managers and neighbourhoods to understand practice use of CASES and to support review where this is lower than expected. Practices will be encouraged to address this and agree an steps to improve utilisation of CASES

5.3.2 Retrospective Review – Identifying and Addressing the Causes of Variation

Referral benchmarking for Sheffield is now available and will be routinely refreshed on a quarterly basis.

Practices and neighbourhoods, through locality managers, are to be encouraged to review this to understand variation within their peer group and where referral rates are higher than peers to investigate the causes and address these. Routine

discussion on progress will be included in practice visits on a rolling basis to identify any additional support required or learning to share.

5.3.3 Prospective Review of Referrals

Practices should put in place arrangements for the prospective peer review of non-urgent referrals in the following order of priority:

- referrals from physicians associates and nurse practitioners;
- referrals from F 2 junior doctors;
- referrals from the GP registrars;
- referrals from salaried GPS and GP partners within 2 to 5 years of completion of training;
- all other referrals.

Each practice will be asked to develop and implement action plans to deliver internal peer review of all eligible referrals by 30 September 2017 in all specialties that fall outside the CASES pilot or MSK.

Each practice will be able to determine the exact format for peer review that they use as long as it meets the key criteria:

- pro-active i.e. prior to referral being made;
- takes place internally although practices with very small lists sizes may group together);
- conducted by a senior GP in the practice;
- takes place at least once a week to ensure referrals are timely and not delayed.

The exact format of the review is for practice determination, examples of good practice identified elsewhere include:

- buddy system;
- structured meetings;
- lists created on SystmOne and shared across practice for review.

A simple way for review to be undertaken and flagged through the clinical systems will be developed to support practices.

Feedback to the referring GP is essential as the aim of this process is to increase the quality of referrals through improved primary care diagnosis and treatment and develop GP knowledge across practices while improving the quality and consistency of data provided to secondary care providers. Practices should consider an appropriate way to communicate the outcome of review to the GP(s) to support their learning and development.

5.4 Rationale

Lack of experience or absence of knowledge of local services and pathways can significantly affect the clinical decision made on patient management and increase referral rates to secondary care services. New and young GPs, GPs new to the local area and locum GPs are therefore more likely to decide to make a referral.

Variation in referral in primary care is, in part, addressed by the CASES project which offers prospective clinical peer review of non-urgent elective referrals in seven high volume specialties. In addition to this service, clinical triage is in place for musculoskeletal services (MSK) through the Sheffield MSK service and through the PEARS service for ophthalmology referrals made to the single point of assessment.

The CASES service covers approximately 67% of referrals made to secondary care in Sheffield annually (excluding MSK). However, in addition to the specialties not covered by the scope of these schemes, we know that not all referrals that are eligible for triage or clinical advice and assessment are referred through these pathways. A review undertaken in June 2017 indicated that approximately 60% of eligible referrals were being made through the CASES with the remaining referrals being made directly to secondary care services.

To support primary care to understand variation locally, SCCG has developed a benchmarking tool for practices that compares standardised rates for referral, A&E attendance, elective and non-elective spells, and practice achievement of key medicines management priorities with peer group practices in Sheffield. This has been shared through localities and is now available for practices to access and review and to use locally to support the development of actions to address any areas where they may be outliers. A conservative QIPP target of £250k has been associated with this work to date.

In July 2017, NHS England published further expectations as part of the National Elective Care Programme, these included an expectation that be the end of September 2017 all practices would have in place prospective peer review of all routine referrals.

5.4 Delivery

The anticipated benefits of these proposals are:

- Only clinically appropriate patients are attending or booked into secondary care with associated financial savings.
- Improved patient experience.
- Increased quality of referrals through improved primary care diagnosis and treatment.
- Develop GP knowledge across practices through knowledge sharing and joint-working.
- Improve the quality and consistency of data provided to secondary care providers.

- GP's and practice staff are aware of and utilising alternative services available within the community setting to manage patients closer to home.
- Improved patients experience as the best evidence based clinical pathway or management route is adopted and patients do not book an appointment that may subsequently be cancelled and redirected to another service, or rejected.
- Support practices through improved information and communication from the CCG to process referrals to the right provider.
- Reducing demand into acute hospitals by ensuring that all referrals reaching secondary care could only be managed in that setting easing demand on these services resulting in them being better able to manage their constitutional A&E waits and 18 week Referral To Treatment times.

A saving of £250k has been identified based on an additional reduction on outpatient first attendances equivalent to one further referral per practice per week in 2017/18

5.5 Quality Impact

Unnecessary referral to secondary care for conditions that can be effectively managed in the community can lead to poor patient experience and may result in unnecessary diagnostic testing or other interventions.

Effective peer review and challenge can reduce unwarranted variation and improve outcomes and experience for patients.

5.6 Equalities and Health Inequalities

No adverse impact identified. Proposals will support better management closer to home and support the use of SCCG integrated pathways of care.

5.7 Statutory, Regulatory and Legal Position

No legal, statutory or regulatory issues have been identifies with the proposed position.

5.8 Cost

There will be an additional cost for referrals directed through CASES however, assuming the same outcomes split as current referrals this will result in a net saving to SCCG.

Limited additional costs in resource to support implementation and production of monitoring materials may be required.

5.9 Impact and Unintended Consequences

GP time to support weekly prospective peer review – it is anticipated that each practice will undertake this internally for specialties not covered by CASES or MSK referral review processes. However, this approach will support improved patient care and management

Reduced referrals and activity in secondary care resulting in income reduction – providers have been notified of the anticipated outcomes and involved in development discussions.

5.10 Safety/Clinical Risk

Process excluded urgent and two week wait referrals. Senior review will support effective management of clinical risk. Clear timescales will prevent undue delay in patient referral.

6 Suspend Prescription of Gluten Free Foods for Adults

6.1 Summary

In 2016/17 SCCG spent over £340k on the prescribing of gluten free (GF) products. These food products are now widely available, with greatly improved choice and quality from retail outlets in all areas in the CCG plus the greater majority of supermarkets. Their price to the consumer has greatly reduced compared to the significantly higher price the NHS pays for similar products on prescription.

Following consideration of options, the recommendation to the CCG Governing Body is to ask GP's to stop prescribing gluten free products on NHS prescription. Prescribing GP's will be allowed to apply discretion in exceptional but rare circumstances where they are sufficiently convinced that there is a genuine risk that a vulnerable individual is, or will become, undernourished if they do not prescribe gluten free products for that individual alone. The CCG recommends that coeliac patients continue to follow a gluten free diet.

6.2 Background

Coeliac disease is an autoimmune disease caused by a reaction to gluten. Adherence to a GF diet remains the effective means of managing coeliac disease. Many common foods that are naturally GF are widely and generally available to purchase. But gluten is found in wheat, barley and rye, therefore products like flour, bread, pasta, biscuits and cakes typically contain gluten unless they have been manufactured to be gluten free. It is important to note that a number of people may choose to follow a gluten free diet. Availability of gluten free items on NHS prescription is only allowed for individuals with a clinical diagnosis of coeliac disease (established gluten sensitive enteropathy, with or without coexisting established wheat sensitivity).

GF alternatives to a range of common foodstuffs (bread, pasta etc.) have been available on prescription to patients diagnosed with gluten sensitivity enteropathies since the late 1960s when the availability of GF foods was otherwise limited.

There has clearly been a continuing increase of gluten-free products available for purchase, and, while gluten-free products are more expensive, the prices are continuing to fall. If more people are buying gluten-free food it is perfectly reasonable to suggest that competition between retailers will increase variety and reduce costs of products sold.

6.3 Current Position

In 2015, SCCG implemented revised guidelines for GF prescribing. These changes received wide support primary care clinicians/GPs and pharmacists. The changes limited prescribing to staple food types (pasta, bread, flour and bread mixes) to support health eating initiatives and limited the number of units available per month for adults. Current prescribing guidelines limit prescribing to 8 units per month for adults.

NHS England recently launched a consultation on the future of Gluten Free prescribing in England which ended on 22 June 2017. The consultation identified three options for the future:

1. make no change to prescribing regulations;
2. end prescribing of GF foods;
3. limit GF foods available on prescription to bread.

The result of the consultation is currently awaited. However in recent years a growing number of CCGs have taken steps to limit GF prescribing locally.

To date, 50 CCGs in England have locally ceased prescription of GF foods for adults and 10 are currently consulting, awaiting a decision and confirmation of a commencement date to cease prescribing.

In Yorkshire and the Humber CCGs who have ceased adult prescribing of GF foods include Bradford, Bradford Districts, Harrogate and Rural District, Hambleton, Richmondshire and Whitby, Scarborough Ryedale, and Wakefield. North Kirklees and Greater Huddersfield plan to cease prescribing but no start date is confirmed.

6.4 Proposal

Based upon the information available SCCG does not believe that the prescribing of gluten free products to adults represents the best use of NHS resources and therefore, SCCG does not recommend the prescription of gluten free products of adults in normal circumstances.

It is not possible to prohibit the prescription of GF products. Therefore, we are proposing to issue a recommendation asking that GPs stop prescribing GF products for adults (over 18 years old). While this is a clinical recommendation, the CCG is committed to engaging with patients, carers and the public and is proposing a consultation period from 8 September to 20 October to allow people in Sheffield to contribute their views on this proposal. Subject to the outcome of consultation and approval from Governing Body it is proposed implementation commences on 9 November 2017.

Secondly, as prescribing of GF products is often initiated on diagnosis in secondary care, SCCG will seek agreement through the Area Prescribing Group following consultation, to add GF products to the prescribing stop list.

Clinicians will be able to allow exceptionality, for example, should they consider there to be a genuine risk to the nutritional status of a vulnerable individual that will be relieved by the prescribing of gluten free products. This is expected to be very rare.

SCCG would provide clinicians with leadership support to make this change and provide patient information, literature and publicity. Secondary care will be engaged in this transition to ensure that appropriate advice and guidance is made available to newly diagnosed patients.

6.5 Rationale

Following a lifelong GF diet is the only effective way to manage gluten sensitive enteropathies. Patients with refractory coeliac disease continue to experience symptoms even when following a completely GF diet. Failure to follow a GF diet can result in complications including osteoporosis and iron deficiency anaemia. Malnutrition can also occur in patients with severe cases of coeliac disease when a GF diet is not followed.

However, unlike other foodstuffs, gluten containing products are not necessary for a healthy diet and patients with gluten sensitivity can safely exclude it from their diet and still eat healthily without purchasing special foods. Patients can safely eat meat, fish, vegetables, fruit, rice and most dairy products, and there are a wide variety of products now on the market e.g. rice cakes, crackers etc. to allow patients to complement their GF diets safely and obtain their nutritional requirements.

Coeliac UK, the leading national charity, provides advice and guidance to patients with coeliac disease on following a GF diet, and has a range of resources to support them. Their guidelines are used by CCG.

From previous engagement with people in Sheffield on gluten free prescribing, the main concerns raised were around:

- the cost of food for people who currently receive free prescriptions
- Creating greater inequalities
- Availability of gluten free food, particularly if supermarkets change their range

These have been considered and are addressed in the following information.

6.6 Delivery

Prescription of GF products cost the NHS in England over £22m per year. The cost to the NHS to provide a GF substitute produce is often far greater than the retail purchase price to an individual. In Sheffield the 2016/17 cost of prescribing GF products (adults and children) was £342k.

By suspending GF prescribing to adults SCCG could release up to £33k part year effect 2017/18 (£100,000 full year effect) to invest in other services.

6.7 Quality

GF foods are now widely available to purchase and it is possible to have a nutritionally balanced diet without the use of GF substitute products. SCCG has developed a set of assessment measures to identify and adverse impact to patient outcomes or experience and these will be used to review to policy.

6.8 Equalities and Health Inequalities

If prescribing of GF foods to adults ceased then patients would have several options for maintaining a GF diet. NHS England has conducted a full impact assessment of these as part of their consultation, in summary these options are:

- Patients can follow a GF diet by consuming foods that are naturally GF, these include: meat, fish, eggs, fruit, vegetables, rice and most dairy products. Patients are able to obtain all their nutritional needs from these foods and do not need to seek GF equivalents.
- Patients can purchase GF equivalents, such as bread, pasta, cereal and biscuits. These foods are not necessary for a healthy diet and can safely be excluded without any health impacts. These foods are now more widely available for patients who wish to buy them.
- All patients can access dietary advice from their GP, community dietitian or pharmacist. It is also important that the patient attends a review appointment with their clinician at the recommended intervals to ensure any health complications arising from coeliac disease can be identified and treated. This is the case regardless of whether GF food is being prescribed.

A coeliac patient can choose not to adhere to a GF diet, this is a risk for all patients regardless of access to GF food on prescription. Adherence rates are shown to be 65.7% in adults, no evidence has been identified that demonstrates a clear link between the provision of GF foods on prescription and increased adherence.

NHS England’s review has identified four main areas that could impact a patient's ability to follow a GF diet if any changes were made to prescribing legislation. These are:

Availability - GF foods are now more widely available to purchase from supermarkets, health food shops, and online retailers. They are also available in some budget and local convenience stores, although ranges in smaller retailers are limited.

Affordability - research has shown that GF foods can be more expensive than their equivalents. This is especially the case for bread, and could impact upon adherence to a GF diet. However, a direct comparison between bread products is not accurate as GF bread may be more nutritionally complete meaning a patient would require a lower quantity. A comparison undertaken by NHS England on product prices between GF food staples and non-GF products is shown in figure 1.

Figure1: Table of Cost Comparisons (NHS England)

Product	NHS indicative price (price per 100g)	GF product price per packet (price per 100g)	Branded non-GF equivalent price per packet (price per 100g)
White bread	£3.69 (92p)	£1.94 (43p)	£1.00 (12.5p)
Pasta	£6.73 (£1.34)	£1.57 (45p)	£1.22 (22.9p)
Cornflakes	£3.48 (93p)	£1.72 (48p)	£1.75 (35p)
Plain flour	£3.10 (62p)	£1.62 (17p)	£1.44 (14.4p)
Oats	£2.78 (56p)	£2.30 (49p)	£1.04 (20.9p)
Biscuits	£3.46 (£1.73)	£2.08 (£1.37)	£1.36 (45.3p)
Total price (one of each item)	£23.24	£10.47	£7.81

Access to dietary advice - coeliac patients should receive advice on maintaining a healthy diet and avoiding gluten containing foods at diagnosis. GPs may refer patients into the community dietetics service in Sheffield in order to obtain additional support to manage their dietary requirements.

Adherence - those diagnosed with established gluten sensitive enteropathies should adhere to a lifelong GF diet to avoid health complications. The National Institute for Health and Care Excellence (NICE) provides guidance to clinicians on the diagnosis and management of coeliac disease. Figures on patient adherence rates, based on a model from 2005 and quoted by NICE are: adult adherence rates of 65.7%, and 84% in children. No evidence has been identified that demonstrates a clear link between the availability of GF foods through prescription and increased adherence to GF diets among patients with gluten sensitivity enteropathies. Systematic reviews of this issue show that the existing evidence for factors associated with adherence to a GF diet is of variable quality and that options for the standardised evaluation of adherence remain unsatisfactory.

6.9 Cost

No additional costs have been identified but this position will be routinely monitored, in particular to confirm that the community dietetics service is able to support any additional demand resulting from this change.

6.10 Impact and Unintended Consequences

Possible short term increase in request for dietetic support – this will be addressed with STHFT to ensure adequate provision is in place prior to the suspension of prescribing.
Possible limited increase in GP appointments in short term to support individual requirements at the point of suspension.

6.11 Assessment and Evaluation

SCCG would monitor the impact of suspension of prescribing GF products in adults and report to Governing Body in twelve months together with recommendations for future actions.

The evaluation and assessment would take the following form:

1. Patient and clinician experience survey – survey a sample of patients and clinicians to identify the perceived impact and experience of the change on individuals
2. Financial analysis – track the financial impact of the suspension in prescribing costs and seek to identify any additional costs (increase GP appointments) using a sample of practices
3. Patient compliance and health impact – NICE guidance recommends annual medical appointments to review the patient's health, adherence and access to a GF diet and many coeliac patients who do not access GF food on prescription still attend a health review with their GP or dietitian. Using a sample of practices in would be possible to track any change in compliance and outcomes for existing coeliac patients following the implantation of new guidance.

6.12 Statutory, Regulatory and Legal Position

In developing this proposal, the CCG has taken into account the feedback received from patients when changes were made to GF prescribing recommendations in 2016. While this is a clinical recommendation, the CCG is committed to engaging with patients, carers and the public and is proposing a consultation period from 8 September to 20 October to allow people in Sheffield to contribute their views on this proposal.

7 Health Optimisation

7.1 Summary

Smoking causes a range of diseases and is also associated with lower survival rates, delayed wound healing, increased infections, prolonged hospital stays and repeated admissions after surgery. The strong association between smoking and both physical and mental ill-health means that referral to secondary care presents an opportunity to use interventions of proven effectiveness and cost effectiveness to initiate and support stop smoking attempts.

The proposal would implement a pause of up to 6 months prior to referral for active smokers to offer an opportunity, supported by NHS services to cease smoking prior to referral. A review of evidence and issues was undertaken by Clare Offer for the West Yorkshire Sustainability and Transformation Partnership in December 2016 and this evaluation has been used in this proposal together with proposals developed and implemented in North Yorkshire.

7.2 Background

The life choices we make will affect our long term health. We know smoking harms us. We know being active is good for us. As individuals we live with our decisions and the lifestyle we choose. However, if those choices impact on the ability of the NHS to provide services for everyone, the CCG should act - to preserve the ability to get the best value from NHS resources.

Being harmed while playing sport or in a road traffic accident is an inevitable risk of living an active life. We would never discourage that and whilst rules in sport and safety laws on the road try to minimize such events they will never be completely eliminated. Other harms caused by, for example, smoking; obesity and inactivity; and alcohol are potentially preventable. In light of the current financial pressures on the NHS we believe that to preserve the ability to get the best value from NHS resources the CCG should try to prevent any avoidable use of NHS resources.

One of the many expectations on CCGs in the NHS Five Year Forward View is to prioritise action on preventable ill health including smoking, obesity and diabetes. We also have a requirement to prioritise financial sustainability, show leadership and reduce health inequalities. For the public this means we need to ensure that we all get the best value from our health services and that it is there for when we really need it.

Two CCGs in Yorkshire and the Humber have introduced policies restricting the provision of elective surgery to patients who smoke or are overweight or obese, and two others are preparing proposals.

These policies implement a pause in the referral process. Adult patients who are current smokers or whose BMI is >30, and who require elective surgery, will be required to complete a six month ‘health optimisation’ period before referral. During this time they will be referred to smoking cessation and/or weight management services.

If the patient achieves a 4 week smoking quit or reduces their BMI to below 30 in that period, they may revisit their GP and be referred for surgery immediately. At the end of the six month period patients will be reassessed by their GP and if they still require surgery would then be referred whether or not there has been any lifestyle change.

If the need for elective surgery is uncertain, patients may be referred for a consultant opinion but the consultant must then discharge them back to the GP to undertake the health optimisation period. The GP is required to re-refer the patient when the health optimisation period is complete.

Variations on this policy have been introduced by some CCGs in other areas. The most long standing policies appear to be in place in East and North Hertfordshire CCG, and North East Essex CCG. Very few policies have been in place for longer than two years. No formal evaluation of the policy has been undertaken, and they do not have any information available that demonstrates that the policy has had a significant impact on individual/ population health, or on CCG finances.

7.3 Proposal

SCCG does not routinely commission referral to secondary care for routine, non-urgent elective surgery for patients who are active smokers. Patients who are active smokers are to be offered a referral to smoking cessation services or offered other advice or support to enable completion of a period of health optimisation for 6 months before referral for surgery unless a quit status is confirmed by smoking cessation services, whichever is sooner.

A confirmed quit means that a person has been smoke free for 4 weeks after their individual quit date. This will allow a period of health optimisation. Patients who only use electronic cigarettes will be classified as a non-smoker for the purposes of the policy.

If a clinician feels that there are exceptional circumstances then the patient may be referred to the Individual Funding Request Panel for consideration.

7.3.1 Exclusions to the Position

Patients with the following are excluded from this policy:

- Patients undergoing surgery for cancer;
- 2WW Referral for suspicion of cancer;
- Patients with severe mental health illness, Learning Disability or significant cognitive impairment;
- Referrals for interventions of a diagnostic nature e.g. endoscopy;
- Children under 18 years;
- Frail Elderly;
- Referral for urgent procedures or patients with red flag symptoms.

7.3.2 Implementation

As part of the implementation process a clear and comprehensive communications and engagement process will take place with Primary Care colleagues, and information will be produced to inform the public regarding this strategy.

Clinicians will be provided with clear guidance regarding the process of implementation and GPs will be supported with materials to educate patients and inform them of the benefits of their health optimisation period

7.4 Rationale

Tobacco smoking remains the single greatest cause of preventable illness and premature death in England. It is also the largest single cause of inequalities in health and accounts for about half of the difference in life expectancy between the lowest and highest income groups. Deaths caused by smoking are 2 to 3 times higher in low income than in wealthier groups.

Smoking causes a range of diseases including cancer, cardiovascular disease and respiratory diseases. It causes many other debilitating conditions such as age-related macular degeneration, gastric ulcers, impotence and osteoporosis. Further, it can cause complications in pregnancy and is also associated with lower survival rates, delayed wound healing, increased infections, prolonged hospital stays and repeated admissions after surgery.

In England in 2011, an estimated 79,100 adults aged 35 and over died as a result of smoking (18% of all deaths) and nearly half a million hospital admissions of adults aged 35 and over (5% of all admissions) were attributable to smoking. Treating smoking-related illnesses cost the NHS an estimated £2.7 billion in 2006. The overall financial burden of all smoking to society has been estimated at £13.74 billion a year.

The strong association between smoking and both physical and mental ill-health means that many people who use secondary care services are smokers. When smokers use these services, it presents a valuable opportunity to use interventions of proven effectiveness and cost effectiveness to initiate and support stop smoking attempts.

Locally, cancer and cardiovascular disease are the leading causes of premature death in Sheffield and make a major contribution to the gap in life expectancy between the City and England as whole. As such these diseases, and the principal factors that cause them, should continue to be prioritised within health improvement plans.

There is good evidence that smokers have a higher rate of complications when undergoing general anaesthetic and surgery. This is mostly related to compromised pulmonary function (Threadom and Cropley, 2006) and delayed wound healing. The joint briefing ‘Smoking and surgery’, produced by ASH and endorsed by FPH and the Royal Colleges of Surgeons/Anaesthetists/GPs is also a good recent summary of the evidence (ASH, 2016).

The evidence is more mixed around how far ahead of surgery patients should aim to quit to realise the benefits of reduced complications. The findings vary between studies but former smokers appear to have a complication rate somewhere between current and never smokers. However, a systematic review suggested that smokers who quit eight weeks or more before surgery were most unequivocally likely to benefit from reduced complications (Threadom and Cropley, 2006), and this has been supported by subsequent studies. Eight weeks is therefore recommended as the optimum ‘lead time’, where possible. In many cases however this could be accommodated within the normal waiting time for elective surgery of 18 weeks RTT.

However, the Royal College of Anaesthetists recommend that quitting at any point, or even simply abstaining on the day of surgery, will carry benefits in relation to the anaesthetic. Studies have also demonstrated that even post-operative cessation can deliver benefits to the patient’s recovery (Threadom and Cropley, 2006).

NICE guidelines (PH48, 2013) recommend that anyone who comes into contact with secondary care should be identified as a smoker and offered intensive support to stop. Secondary care settings should be smoke free and patients should be offered

support to comply with this. This is supported by Public Health England's recent call to create a 'tobacco free NHS' and to use the encounter with secondary care as a key opportunity to engage patients in smoking cessation: (https://publichealthmatters.blog.gov.uk/2016/12/06/its-time-for-a-truly-tobacco-free-nhs/)

If a patient is unable to quit completely then NICE also recommends that harm reduction should be offered in the form of NRT (PH45, July 2013). The ASH briefing notes that no major concerns have been identified in relation to e-cigarettes and surgery, and a PHE evidence review notes that they can be an effective way to quit or temporarily abstain from smoking (PHE, 2015).

There is some evidence that intensive smoking cessation interventions can be effective in supporting smokers to quit perioperatively. A Cochrane review (Thomson et al, 2014) showed that for brief interventions, smokers were no more likely to be quit on the day of surgery than control groups, and no more likely to be smoke-free at 12 months post surgery. However, for two small trials of intensive face to face interventions with multiple appointments, about 50% of smokers in the intervention group were quit on the day of surgery, ten times more likely than controls. At 12 month follow up, they were still twice as likely not to be smoking as people in the control group.

There is no evidence as to whether the added 'incentive' of a delay to desired surgical treatment has a positive effect on smokers' ability to quit. It is possible that it may vary depending on the diagnosis and the characteristics of different patient groups referred.

It is worth noting that both the ASH briefing (ASH, 2016) and the PHE call for a 'tobacco free NHS' (PHE, 2016) specifically recommend actions and interventions. Neither recommends a blanket 'delay' policy on elective patients as an effective intervention. The interventions they do recommend are:

- identification of the smoking status of every patient who is referred or admitted to secondary care;
- that all smokers should be informed of the risks of smoking prior to surgery by all relevant professionals (referring GP, consultant, anaesthetist being examples);
- that all smokers should be offered a referral to specialist smoking cessation support;
- that all smokers have the option of behavioural support to help them quit;
- that smokers have access to medication/ harm reduction approaches to support a quit attempt or temporary abstinence during surgery or an admission;
- 'Smoke free' site policies in secondary care trusts, including the building and grounds.

Public Health England's 'Menu of Preventative Interventions' (PHE, November 2016) is a useful resource here and contains a range of recommendations relating to smokers coming into contact with secondary care.

7.5 Smoking Cessation Services in Sheffield

The local Smoking Cessation service is commissioned by Sheffield City Council. The aim of the 'Stop Smoking Service' is to contribute to a reduction in smoking prevalence in Sheffield in all adults, priority groups, pregnant women, and children.

The service offers:

- Screening for tobacco dependence using Very Brief Advice (VBA) for Smoking Cessation;

- Stop smoking interventions for adults 18+ (behavioural and pharmacological) in community settings using an abrupt cessation model comprising a:

    - Universal Service for stop smoking interventions as an "open access" community-based service providing behavioural support groups, with over-the-counter stop smoking medicines self-funded by the service user, in order to achieve a 4-week carbon monoxide (CO) verified quit;

    - Priority Quits Service for intensive stop smoking interventions in high prevalence groups, providing behavioural support and fully funded prescribed stop smoking medicines, in order to achieve a 12-week CO verified quit.

In 2017/18 the service budget was reduced to reflect the fact that capacity within the service was not fully utilised. It would be prudent to assume some additional investment in order to ensure services are available to meet the demand created by additional referrals.

7.6 Delivery

A financial benefit may accrue from the implementation of health optimisation. This would be a short term effect resulting from the implementation of a pause in referral for people who smoke. The effect is non recurrent as once patients are referred after either a successful, documented quit or the end of the health optimisation period cost of treatment will be incurred. Savings expectations assume that provider(s) maintain waiting lists at the current level and do not reduce waiting times further.

SCCG has estimated a saving in 2017 of £750k for health optimisation based upon an extrapolation of analysis undertaken by Wakefield CCG. SCCG is able to derive information on smoking status from the risk assessment tool. Using this SCCG has been able to identify the number of procedures undertaken in secondary care in 2016/17 where the individual is identified as a smoker to develop baseline monitoring.

Allowing for urgent and 2 week wait referrals (excluded specific specialties and assumed 20% across all others) a potential non recurrent delay of £750 is reasonable. However, this does not take into account the number of patients who stop smoking in year and are referred thereafter.

SCCG has been unable to obtain any evaluation or evidence from areas where health optimisation has been implemented that confirms the impact of the introduction of the policy however, informal information suggests that the anticipated reductions in cost have not been realised.

7.7 Monitoring and Evaluation

The effectiveness of this policy would be monitored for impact through contract performance measures – activity and spend against plan, referral position and waiting list size.

SCCG would undertake an evaluation of the impact of the proposal at 6/12 months and report these findings to Governing Body with recommendations for future action.

7.8 Quality

Concerns have been raised in some CCGs about who holds responsibility for the patient during the period of health optimisation. If there were to be an adverse event during the health optimisation period that could potentially have been avoided through surgery at the time of referral, it is unclear which organisation or clinician would bear the responsibility for this.
Similarly it will be necessary to ensure the responsibility on primary care to flag the patient and ensure they are re-referred at the end of the health optimisation period. Further development of clinical governance principles will be necessary and of that reason it is recommended that the start date is deferred to 1 October 2017.

7.9 Equality and Health Equalities

The NHS Constitution creates a duty on NHS commissioners to promote equality through the services it provides and specifically, to *'pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.'*
Smoking and obesity are strongly linked to deprivation, nationally 12.4% of people in managerial or professional occupations smoke, compared to 28.4% in routine and manual occupations.

In Sheffield 27.7% of routine and manual workers smoke and 12.5% of pregnant women in Sheffield are smoking at the time their baby is born; 40% of people with mental health issues; and 77% of homeless people smoke. Those with mental health issues are more heavily addicted and spend proportionally more of their income on tobacco. Tobacco makes life economically harder for those on low incomes.

It is therefore likely that this policy will disproportionately delay access to necessary treatment in more deprived populations, potentially exacerbating inequalities in health. The barriers are potentially cumulative in that a patient will have to first approach their GP and get referred, then undertake the 'health optimisation' period, and then return to the GP for re-assessment. At any stage there is a risk that patients will 'lose heart' and fail to re-present themselves for treatment, and this is again more likely in less articulate or educated individuals.

The economic impact on patients may also be disproportional as, the impact of the condition for which referral is made on ability to work is more likely to be greater in lower socio-economic groups (manual workers) and may be more significant for patients who live in more deprived communities where they are more likely to be in low-paid occupations which offer limited job security and sick pay protection.

A six month delay to treatment, despite the potential health benefits, could have catastrophic economic consequences for some patients. Since we know that overall, the ability to work is also highly beneficial to a person's health, it is important to consider this fuller picture.

Patients in more deprived communities are already more difficult to engage with health services, and this policy has the potential unintended consequence of smokers or obese patients failing to present for treatment that they really need if they understand the message as 'smokers and the obese don't get NHS treatment'.

7.10 Impact and Unintended Consequences

Any potential short term impacts on people with lifestyle risk factors will be balanced by a more long term reduction in health inequalities. Although people excluded in the policy will not be expected to complete a 6 month health optimisation period if they smoke or are obese, they will be supported to address lifestyle factors.

7.11 Statutory, Regulatory and Legal Position

The NHS Constitution, which is legally binding, states in its list of patients' rights that:
'*You have the right to access NHS services. You will not be refused access on unreasonable grounds.'*

'You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.' ('Access to Health Services')

and

'*You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.*
You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence...' ('Nationally approved treatments, drugs and programmes')

The above rights mean that refusing an NHS service altogether to a group of patients, based on lifestyle factors alone, is likely to be contrary to the NHS Constitution and thus illegal. The Constitution would not, of course, preclude a commissioning policy or individual patient decision based on sound clinical evidence that the risks of a certain treatment outweighed the benefits in the case of that patient or group. It does underline the importance of ensuring that such decisions are made on very defensible clinical evidence indeed.

A period of delay for 'health optimisation' is much more defensible under the NHS Constitution, since the patient will ultimately receive the service. NHSE's recent

decision to allow Vale of York's policy to be re-launched following a formal review certainly implies that NHSE consider a policy of delay to be compatible with the Constitution. It is, however, important to recognise that this has not been tested in the courts.

7.12 Cost

- Financial risk incurred through increased numbers of referrals (for exceptional circumstances) sent through the IFR panel.
- Financial risk incurred through patients attending urgent care during Health Optimisation period.
- Additional GP appointments will be required (pre and post Health Optimisation period).
- Additional investment required in smoking cessation services to support increased volumes of patients
- No financial saving in-year as Trusts are able to maintain activity position by treating patients on existing waiting lists

8 Other Approaches

A review of the likely financial impact of the three disinvestment proposals indicates the maximum anticipated benefit in 2017/18 would be c£1m. If health optimisation is discounted this is reduced to c£0.3m.

In section 2.1 above we outline the 3 areas of further action. The rest of this section provides some further detail on a range of potential actions to address the shortfall in the £2.3m mitigations required.

8.1 Control and Focus on Existing QIPP Programme

Delivery of QIPP is assured on behalf of Governing Body by the Integrated QIPP Working Group and SCCG has a Programme Management Office (PMO) in place to support the delivery of QIPP and other CCG projects. The PMO is currently rolling out new programme management software to support the management and reporting of QIPP and have recently undertaken organisation wide training on the programme management approach used by SCCG.

SCCG is refocussing efforts on the delivery of current QIPP schemes and a workshop with executive and clinical directors and programme leads will be held in September to review progress, identify constraints and blockages at agree actions to achieve delivery on all programmes.

8.2 Commissioning for Outcomes

On 7 September 2017 Governing Body will also receive a paper on the South Yorkshire and Bassetlaw (SYB) approach to Commissioning for Outcomes. This sets out plans to develop a shared commissioning position on procedures of treatments which are either not routinely commissioned or where clinical thresholds or restrictions are in place. Phase one of this work is to align a common set of existing policies, phase two is to implement additional policies in quarter four 2017/18.

SCCG is currently implementing phase 1 and supporting the ongoing development of phase 2. SCCG will have phase 1 policies signed off by Clinical Reference Group for consultation with providers by the end of September and implementation in October 2017. SCCG intend to expedite implementation of phase 2 proposals ahead of the SYB timetable with implementation by 1 November 2017. However, while these schemes are already part of the additional QIPP schemes approved by Governing Body it is not yet possible to quantify the opportunity, therefore it is anticipated that an additional benefit will result from the adoption of these policies.

8.3 Pre-Operative Assessment

This scheme was assessed as one of the additional QIPP opportunities and while it was considered a viable proposal it was concluded that, due to the scope and complexity of the project, no benefit could be anticipated in 2017/18.

Further discussion suggests that it may be possible to expedite progress on elements of the scheme working with localities and Primary Care Sheffield (PCS) as well as secondary care providers. A full assessment will now be undertaken to determine the resource and benefits required to deliver this in-year.

8.4 High Cost Drugs

The over performance against the secondary care high cost drugs budget has been reported to Governing Body. SCCG concerns have been raised in correspondence between the CCG Accountable Officer and the Chief Executive of STHFT. A meeting has been held to discuss the causes and potential actions to mitigate or correct the position between the CCG and STHFDT Medical Directors. A number of key lines of enquiry actions have been identified; these will be developed into an action plan with agreed timescales by the end of September.

9.Action for Governing Body / Recommendations

The Governing Body is asked to:

Consider the proposals set out in this paper and to approve the following commissioning policies for implementation:

- Clinical Variation in Primary Care – additional steps to manage unwarranted variation in GP referrals;

Approve consultation for the following policy with a recommendation to be presented to Governing Body on 2 November 2017:

- Suspension of Gluten Free Prescribing for Adults in Sheffield.

Consider the proposal on health optimisation and the supporting evidence provided and to:

- Note that currently there is no evidence that the policy will achieve the desired effect of improving health outcomes for people who smoke in Sheffield;

- Note that as part of the SYB work in Commissioning for Outcomes there is potential for the development of a system-wide approach to health optimisation;
- Agree to receive proposals on health optimisation for consideration at a later date based upon this joint SYB work.

Note that an update on further mitigating actions will be provided to the meeting on 6 October 2017.

Paper prepared by: Abigail Tebbs, Deputy Director of Strategic Commissioning and Planning
Brian Hughes, Director of Commissioning and Performance
Julia Newton, Director of Finance

On behalf of: Brian Hughes, Director of Commissioning and Performance

30 August 2017

APPENDIX 1

Disinvestment Assessment Criteria

Domain	Criteria
Quality Impact	• clinical effectiveness • patient experience • outcomes (life expectancy /quality)
Equalities and Health Inequalities	Would any group, including the nine protected characteristics, be disproportionally affected
Strategic Impact	Impact on achievement of system/place/CCG priorities: • CCG priorities, 5YFV, ACP/ACS • adverse impact on CCG performance/IAF
Legal	Does the proposed policy conflict with the duties and responsibilities of the CCG
Cost	What is the cost of intervention, resource to implement, pathway/how would funding be released
Impact and unintended consequences	What would be the impact of the policy and are there any consequences to: • services elsewhere • workforce/provider • reputation/relationships Can any unintended consequences be effectively mitigated
Consultation	What would be required to implement the policy
Safety/clinical risk	Would there be an adverse impact as a result of suspending intervention or service

Equality Impact Assessment

Title of policy or service:	Clinical Variation in Primary Care	
Name and role of officer/s completing the assessment:	Abigail Tebbs, Deputy Director of Strategic Commissioning and Planning	
Date of assessment:	30/08/17	
Type of EIA completed:	**Initial EIA 'Screening'** ☒ ***or*** **'Full' EIA process** ☐	*(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	Expand on existing proposals and services by increasing utilisation of existing referral advice and support services, further supporting practices to consider observed variation within their peer group and developing actions to address this and finally by establishing prospective peer review for non-urgent referrals that fall outside established advice and support services. • Only clinically appropriate patients are attending or booked into secondary care with associated financial savings. • Improved patient experience. • Increased quality of referrals through improved primary care diagnosis and treatment. • Develop GP knowledge across practices through knowledge sharing and joint-working. • Improve the quality and consistency of data provided to secondary care providers.

Identifying impact:

- **Positive Impact:** will actively promote or improve equality of opportunity;
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information

This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.

(Please complete each area)	What key impact have you identified?			For impact identified (either positive and or negative) give details below:	
	Positive Impact	**Neutral impact**	**Negative impact**	**How does this impact and what action, if any, do you need to take to address these issues?**	**What difference will this make?**
Human rights	☒	☐	☐	Improved support for patients	
Age	☒	☐	☐	Reducing unnecessary referral and supporting treatment closer to home	
Carers	☒	☐	☐	Supporting treatment closer to home and reducing unnecessary hospital visits	
Disability	☒	☐	☐	Supporting treatment closer to home and reducing unnecessary hospital visits	
Sex	☐	☒	☐	None anticipated	
Race	☐	☒	☐	None anticipated	
Religion or belief	☐	☒	☐	None anticipated	
Sexual orientation	☐	☒	☐	None anticipated	
Gender reassignment	☐	☒	☐	None anticipated	
Pregnancy and maternity	☐	☒	☐	None anticipated	
Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐	None anticipated	
Other relevant	☐	☒	☐	None anticipated	

groups					
HR Policies only: Part or Fixed term staff	☐	☒	☐	None anticipated	

IMPORTANT NOTE: *If any of the above results in '* ***negative'*** *impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Having detailed the actions you need to take please transfer them to onto the action plan below.

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**	**Abigail Tebbs**	**Date of next Review:**	**30/08/18**

Once completed, this form **must** be emailed to Elaine Barnes, Equality Manager for sign off: elaine.barnes3@nhs.net.

Elaine Barnes signature:	

Equality Impact Assessment

Title of policy or service:	Gluten Free Prescribing - Adults	
Name and role of officer/s completing the assessment:	Abigail Tebbs, Deputy Director of Strategic Commissioning and Planning	
Date of assessment:	30/08/17	
Type of EIA completed:	**Initial EIA 'Screening'** ☐ ***or*** **'Full' EIA process** ☐	*(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	Suspend prescribing for gluten free products for adults in Sheffield.

Identifying impact:

- **Positive Impact:** will actively promote or improve equality of opportunity;
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information

This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.

(Please complete each area)	What key impact have you identified?			For impact identified (either positive and or negative) give details below:	
	Positive Impact	**Neutral impact**	**Negative impact**	**How does this impact and what action, if any, do you need to take to address these issues?**	**What difference will this make?**
Human rights	☐	☒	☐	None anticipated	
Age	☐	☒	☐	Children are excluded from this policy. Where GPs have concerns about vulnerable adults they may be excluded from this policy	
Carers	☐	☒	☐	Where GPs have concerns about vulnerable adults they may be excluded from this policy	
Disability	☐	☐	☒	For people currently receiving gluten free products on prescription, there will be the cost of buying gluten-free food which could negatively impact on those with low incomes / on benefits, therefore create greater inequalities **Action** GPs able to make discretionary decisions about whether to continue to prescribe based on individual circumstances	Will allow discretionary decisions to help mitigate against creating greater health inequalities

Sex	☐	☒	☐	None anticipated	
Race	☐	☒	☐	None anticipated	
Religion or belief	☐	☒	☐	None anticipated	
Sexual orientation	☐	☒	☐	None anticipated	
Gender reassignment	☐	☒	☐	None anticipated	
Pregnancy and maternity	☐	☒	☐	None anticipated	
Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐	None anticipated	
Other relevant groups	☐	☒	☐	None anticipated	
HR Policies only: Part or Fixed term staff	☐	☒	☐	None anticipated	

IMPORTANT NOTE: *If any of the above results in '* ***negative'*** *impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Having detailed the actions you need to take please transfer them to onto the action plan below.

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**
For people currently receiving gluten free products on prescription, there will be the cost of buying gluten-free food which could negatively impact	GPs able to make discretionary decisions about whether to continue to prescribe based on individual circumstances	Evaluation and monitoring are built into the proposal to identify any adverse impact on health outcomes.	12 months	Abigail Tebbs

on those with low incomes / on benefits, therefore create greater inequalities				

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**		**Date of next Review:**	

Once completed, this form **must** be emailed to Elaine Barnes, Equality Manager for sign off: elaine.barnes3@nhs.net.

Elaine Barnes signature:	

Equality Impact Assessment

Title of policy or service:	Health Outcomes - Smoking	
Name and role of officer/s completing the assessment:	Abigail Tebbs, Deputy Director of Strategic Commissioning and Planning	
Date of assessment:	30/08/17	
Type of EIA completed:	**Initial EIA 'Screening'** ☒ ***or*** **'Full' EIA process** ☐	*(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	Implement a period of health optimisation prior to non-urgent referral to secondary care for smokers who will be supported to stop smoking prior to referral. Reduce demand on referral for elective surgery. • Improved prevalence rates for obesity, pre-diabetes and diabetes • Overall improvement to the health and well being of our population • Any negative impacts on health in the short term are mitigated by the net long-term health gains • Positive impacts on health outcomes

Identifying impact:

- **Positive Impact:** will actively promote or improve equality of opportunity;
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information

This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.

(Please complete each area)	What key impact have you identified?			For impact identified (either positive and or negative) give details below:	
	Positive Impact	**Neutral impact**	**Negative impact**	**How does this impact and what action, if any, do you need to take to address these issues?**	**What difference will this make?**
Human rights	☐	☒	☐	None anticipated	
Age	☐	☒	☐	Patients who are frail elderly or children are excluded from this policy	
Carers	☐	☒	☐	None anticipated	
Disability	☐	☒	☐	Severely disabled / people with low mobility should be able to partake in and benefit from smoking cessation services. Patients with severe mental health illness, Learning Disability or significant cognitive impairment are excluded from this policy	
Sex	☐	☒	☐	None anticipated	
Race	☐	☒	☐	None anticipated	
Religion or belief	☐	☒	☐	None anticipated	
Sexual orientation	☐	☒	☐	None anticipated	
Gender reassignment	☐	☒	☐	None anticipated	
Pregnancy and maternity	☐	☒	☒	None anticipated	

Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐	None anticipated	
Other relevant groups	☐	☒	☐	None anticipated	
HR Policies only: Part or Fixed term staff	☐	☒	☐	None anticipated	

IMPORTANT NOTE: *If any of the above results in ' **negative'** impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Having detailed the actions you need to take please transfer them to onto the action plan below.

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**		**Date of next Review:**	

Once completed, this form **must** be emailed to Elaine Barnes, Equality Manager for sign off: elaine.barnes3@nhs.net.

Elaine Barnes signature:	