Unadopted Minutes of the meeting of NHS Sheffield Clinical Commissioning Group Governing Body held in public on 7 September 2017 in the Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU

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Present:
Dr Tim Moorhead, CCG Chair, GP Locality Representative, West (Chair)
Dr Amir Afzal, GP Locality Representative, Central
Dr Ngozi Anumba, GP Locality Representative, Hallam and South
Mrs Nicki Doherty, Interim Director of Delivery - Care Outside of Hospital
Dr Terry Hudsen, GP Elected City-wide Representative
Mr Brian Hughes, Director of Commissioning and Performance
Dr Annie Majoka, GP Elected City-wide Representative (from partway through item 91/17)
Dr Zak McMurray, Medical Director
Mr Peter Moore, Director of Strategy and Integration
Ms Julia Newton, Director of Finance
Mrs Maddy Ruff, Accountable Officer
Dr Leigh Sorsbie, GP Locality Representative, North
Mr Phil Taylor, Lay Member
Dr Chris Whale, Secondary Care Doctor
Mr Tony Williams, Lay Member

In Attendance:
Dr Trish Edney, Healthwatch Sheffield Representative (on behalf of the Chair of Healthwatch)
Ms Jane Harriman, Head of Quality (on behalf of the Chief Nurse)
Mrs Carol Henderson, Committee Secretary / PA to Director of Finance
Ms Susan Hird, Consultant in Public Health (on behalf of the Sheffield Director of Public Health)
Mrs Kate Laurance, Head of Commissioning – Children, Young People and Maternity (for item 99/17)
Mrs Nikki Littlewood, Infection Prevention and Control Nurse (for item 101/17)
Mr Nicky Normington, Locality Manager, North
Mrs Eleanor Nossiter, Strategic Communications and Engagement Lead
Mr Gordon Osborne, Locality Manager, Hallam and South
Mr Rob Townsend, Consultant Microbiologist, Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) (for item 101/17)

Members of the public: There were seven members of the public in attendance. A list of members of the public who have attended CCG Governing Body meetings is held by the Director of Finance.

ACTION

84/17 Welcome

The Chair welcomed members of the Sheffield Clinical Commissioning Group (CCG) Governing Body and those in attendance to the meeting. In particular, he welcomed Mr Tony Williams, Lay Member, to his first meeting.

The Chair also thanked Mr Peter Moore, Director of Strategy and Integration, who would be leaving the CCG at the end of September 2017, for his contribution to the CCG over the past year.

85/17 Apologies for Absence

Apologies for absence had been received from Dr Nikki Bates, GP Elected City-wide Representative, Mrs Penny Brooks, Chief Nurse, Ms Amanda Forrest, Lay Member, Professor Mark Gamsu, Lay Member, and Dr Marion Sloan, GP Elected City-wide Representative.

Apologies for absence from those who were normally in attendance had been received from Mrs Katrina Cleary, Programme Director Primary Care, Mr Greg Fell, Director of Public Health, Sheffield City Council, Dr Mark Durling, Chair, Sheffield Local Medical Committee, Mrs Judy Robinson, Chair, Healthwatch Sheffield, Mrs Rachel Dillon, Locality Manager, West, Mr Phil Holmes, Director of Adult Services, Sheffield City Council, Sheffield City Council, and Mr Paul Wike, Joint Locality Manager, Central.

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The Chair declared the meeting was quorate**.**

86/17 Declarations of Interest

The Chair reminded Governing Body members of their obligation to declare any interest they may have on matters arising at Governing Body meetings which might conflict with the business of NHS Sheffield Clinical Commissioning Group (CCG). He also reminded members that, in future, not only would any conflicts of interests need to be noted but there would also need to be a note of action taken to manage this. The Chair reminded members that they had been asked to declare any conflicts of interest in agenda items for discussion at today's meeting in advance of the meeting

Declarations made by members of the Governing Body are listed in the CCG's Register of Interests. The Register is available either via the secretary to the Governing Body or the CCG website at the following link:
http://www.sheffieldccg.nhs.uk/about-us/declarations-of-interest.htm

The Locality GPs declared a conflict of interest in section 5 of item 11 (paper G): Proposed Changes to the CCG Constitution and Other Governance Matters, Update on GP Locality Representative Nominations.

The Director of Finance advised members that this item was for information only and hence no actions required by relevant GPs in the meeting.

There were no further declarations of interest from items to be discussed at today's meeting.

87/17 Chair's Opening Remarks

The Chair advised Governing Body that he had no further issues to advise them of this month.

88/17 Questions from the Public

Two members of the public had submitted questions before the meeting. The CCG's responses are attached at Appendix A, along with the CCG's response to questions submitted to Governing Body on 25 May 2017 and 6 July 2017.

89/17 Minutes of the CCG Governing Body meetings held in public on 6 July 2017

The minutes of the Governing Body meeting held in public on 6 July 2017 were agreed as a true and correct record and were signed by the Chair.

90/17 Matters Arising

There were no matters arising that were not on the agenda.

91/17 Month 4 Finance Report

The Director of Finance presented this report which provided Governing Body with the Month 4 results and the key risks and challenges to deliver the planned year end surplus of £13.2m. She reminded Governing Body that, as members were aware, the CCG's financial plan contained the requirement for significant efficiency savings which were always going to be challenging. Unfortunately, the level of existing and potential pressures as assessed at Month 4, indicated a heightened level of risk to delivery of the plan. The executive summary at section 1 of her report highlighted that she had changed the forecast Red Amber Green (RAG) rating to Red as there was now significant risk of non delivery which meant that further urgent action were needed to mitigate the risks.

The Director of Finance advised Governing Body that, at Month 4 the CCG was still able to forecast that it would meet the planned surplus overall but this had necessitated releasing the majority (ie £5m) of the general contingency reserves leaving the CCG with very limited reserves to manage any new risks for the rest of the year. She highlighted that the overspends were in a variety of areas, but mainly planned and unplanned acute care.

The Director of Finance then drew members' attention to Table 2 (page 6): net financial risks and potential mitigations. She explained that the top half of the table was designed to show the key financial risks which the CCG was facing over and above pressures incorporated into the reported position. She had presented these in three scenarios, which showed a range between £16m and £4m risks, with the assessed most likely scenario of £8m risk. She then explained that the CCG was

required by NHS England to have mitigating actions in place in order to address these risks, particularly in the most likely scenario. She highlighted that the bottom half of the table was designed to show the potential mitigations against the seven financial management principles which Governing Body had previously approved in May 2017. The mitigation for the most likely scenario was £6m, thus this meant the CCG was carrying at least a £2m uncovered or unmitigated risk which, if this crystallised, would mean the CCG would fail against its financial plan by this amount. This would most likely result in additional savings requirements in 2018/19 and the loss of any Quality Premium income as delivery of prior year financial plan is a "gateway" requirement for any such income.

She advised that proposed additional actions to manage the position would be discussed under item 8 (paper D) later in the meeting.

The Director of Finance then sought any clarification questions.
Dr Sorsbie highlighted the apparent discrepancy between non elective admissions being lower than plan but costs being higher. The Director of Finance advised that work continued with STHFT to understand the reasons but it looked like a combination of the new HRG4+ currency, particular issues regarding coding for sepsis and acuity of patients.

Dr Majoka joined the meeting at this stage.

The Director of Commissioning and Performance advised that work also continued with STHFT on the scope for re-profiling of activity plans but still meeting the national Ready To Treat (RTT) requirements where the trust had activity levels above plan.

Dr Afzal commented that in GP practices the introduction of the Clinical Assessments, Services, Education and Support (CASES) model that supports making sure patients get the right treatment at the right time in the right place, was creating the need for additional diagnostic tests and queried whether this was resulting in extra costs to the CCG.

Post Meeting Note: Discussion with the Elective Portfolio clinical and managerial leads regarding each CASES pathway concluded that the tests that are requested (mainly MRI, CT, Ultrasound, are all unbundled diagnostic costs under tariff and therefore are not included in the standard outpatient tariff price and hence there should be no extra costs. The portfolio clinical lead confirmed that if a referral is made, STHFT would not, under the agreed pathway protocol, repeat the test at the first outpatient appointment.

The Governing Body:

- Considered the risk assessment and existing mitigations to manage the risks to deliver the CCG's year end control total of a £13.2m surplus.
- Approved the Better Care Fund (BCF) budget changes set out in section 5.

92/17 Additional Actions to Manage the CCG's Financial Position

The Director of Commissioning and Performance presented this report which outlined three options to manage the financial position and updated Governing Body on other steps being taken to deliver a QIPP Plan for 2017/18 that met the CCG's financial requirements. He reminded members that they had discussed progress with the QIPP schemes in August, and throughout the year, and advised that efforts would be re-doubled to try and ensure their delivery and to secure as much additional income into our local systems as possible. He drew Governing Body's attention to the key highlights.

Section 2.3 outlined the QIPP plan journey and analysis. He advised Governing Body that they had started with the principles being to meet the needs of our population, and only by doing this we would ensure we get the very best value from our NHS.

With regard to options available from disinvestment, they had sought to identify those that would align as closely as possible with our statement 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., and had taken forward three options for consideration:

1. Clinical Variation in Primary Care – additional steps to manage unwarranted variation in GP referrals.
2. Approve consultation for a policy to suspend prescribing gluten free foods for adults.
3. Health Optimisation – smoking.

The Director of Commissioning and Performance advised members that they had already implemented a system for practices to consider clinical variations in primary care and the proposal today expanded on that existing work. He advised that the final part of this peer review fitted with the national expectation, and we anticipated that going further in this could deliver an additional benefit of £250k this year.

Dr Sorsbie advised Governing Body that she would be more than happy to engage with this work, especially as it was an area where the biggest efficiencies could be made.

The Chair commented that it would undermine the CCG's efforts and credibility if we continued to pay for unwarranted hospital activity. Our Member practices needed to understand that we were trying to encourage the justified referrals to hospital as a referral should be tailored to suit the patient, but it was not acceptable that some colleagues were referring in a wasteful manner. He commented that we could protect the small amount of investment we could earmark this year if we could manage this unwarranted variation in referrals.

The Director of Finance advised members that the CCG was aware that

the activity at STHFT may not cease immediately as they already have an ‘order book’, but if we did this across the city and referrals to the trusts go down, then the trust will have a lower ‘order book’ or none at all.

The Accountable Officer commented that this was very much about how we worked with our providers when we could show them how our activity with them, and it was very much about both this and next year.

With regard to the proposal to suspend prescribing gluten free foods for adults, the Director of Commissioning and Performance advised Governing Body that this prescribing currently cost the NHS in England c.£22m each year, a cost that was often far greater than the retail price of these foods. He advised that up to £33k could be released this year, with a £100k full year effect, which could be re-invested. He reminded Governing Body that products were currently prescribed to adults with coeliac disease and that a number of CCGs were taking up the option to stop prescribing. He advised that the CCG had taken into account feedback from patients when the CCG had originally reduced this prescribing in 2016. It was proposed that implementation of this proposal, if adopted, would commence on 9 December 2017 but prescribing GPs would be allowed to use their discretion.

The Director of Commissioning and Performance also drew Governing Body’s attention to the Equality Impact Assessment (EIA) (attached at pages 34-37) and advised that if the proposal was adopted he would recommend that the impact of this would be evaluated and reported back to Governing Body in 12 months time. The paper outlined how that evaluation would be undertaken.

Dr Sorsbie commented that she absolutely understood the principles behind this proposal, and supported it, however, there were areas of the city where people had very little money to buy these foods, and there were also some areas of the city where some of the foods were not readily available for people to buy, and so welcomed the clause that would allow clinicians to use their discretion, for example if they thought there would be a risk to the nutritional status of a vulnerable individual. She also welcomed the option for a review after 12 months.

The Accountable Officer advised that there was some significant work to be undertaken to see where these products could be accessed, but that a number of the discount stores were now offering a large range of these products. She requested that this information be included in the consultation paper. **BH**

The Healthwatch representative asked how much of a saving had been made when the CCG had reduced prescribing of these products in 2016. The Medical Director responded that there had been savings of between £150k to £200k, with savings this time expected to be between £40k to £50k He also advised that the reaction from patients had not initially been very good but there had not been a huge amount of push back afterwards, so it had felt that the request had been reasonable.

Dr Anumba acknowledged that this was a difficult area but accepted the issues and commented that all the GPs had the responsibility to understand that when they were writing out a prescription it was like writing a cheque. She also commented that, whilst it had been difficult initially when the number of products that could be prescribed had been reduced to eight, but people had understood, and she also advised Governing Body that, in the Patient Participation Groups (PPGs), some people had been amazed that the CCG prescribed these products.

Health Optimisation – Smoking: the paper outlined the impact of smoking that it has on life and health, with the proposal to implement a pause of six months prior to referral for active smokers to offer an opportunity, supported by NHS services, to cease smoking prior to referral. The Director of Commissioning and Performance advised that one of the expectations in the Five Year Forward View (FYFV) was to priories action to focus on prevention of ill health and, in this respect, advised that a number of CCGs had introduced policies to restrict elective surgery on patients that smoked or were obese. He also advised that, at the request of Governing Body, the CCG had very few policies that had been in place for more than a couple of years.

The Director of Commissioning and Performance advised that, at this stage, he was not recommending the implementation of this proposal, as it was subject to further work across South Yorkshire and Bassetlaw.

Dr Sorsbie welcomed this, especially as it was a very difficult decision made on the back of a challenging financial position, and commented that it would be very easy to follow what was being done elsewhere. However, there was insufficient clinical evidence to support it at this stage, and we were aware that if we were denying health care it would be more likely to affect people in areas of deprivation, which means that we knowingly increase health inequalities.

The Director of Commissioning and Performance commented that, if the proposal was to be successful, there was already a smoking cessation service in existence in Sheffield, which was hosted by Sheffield City Council (SCC). However, in 2017/18 the service budget had been reduced to reflect the fact that the service was not fully resourced (workforce). He reported that the statutory regulations and legal position on our proposal was variable, but because we would be implementing a period of delay in offering this service, it would be defensible.

Mr Williams asked what SCC was planning for its budget for smoking cessation in 2018/19. The Consultant in Public Health explained that SCC had recommissioned the Sheffield Tobacco Control Programme, of which smoking cessation was part, for the next three years, and was committed to that budget envelope. She was not expecting that to change, but would provide clarity on this as a post meeting note for the minutes of this meeting. **SH**

Post meeting note: The budget for the Tobacco Control Programme

is £987,000 per year, running from April 2017 to March 2020. Slide attached shows all the work packages within the overall programme. The new smoking cessation service starts on the 1st of October 2017. The budget for the stop smoking service per year is £580k.

The Consultant in Public Health advised that there was a Tobacco Control Board established in the city, to which the CCG had been invited to attend but had not attended to date, with the exception of a member of the CCG's Medicines Management Team (MMT). She advised that SCC would welcome working together with the CCG on this and the Tobacco Control Board gave the opportunity to do that.

The Chair commented that smoking cessation was the most modifiable and effective factor in reducing health inequalities.

Dr Whale asked if the CCG could circulate the evidence when it was available. The Director of Commissioning and Performance explained that the evidence we had used was based on the two areas that had already implemented the policy. We continued to work with them and, as the evidence became more available, we would use that in our approach.

Dr Hudsen suggested also looking at peri-operative outcomes as these had a much higher complications rate in those people that smoked

The Healthwatch representative was pleased that the implementation of this proposal had been put on hold and commented that it took a lot of courage for some people to visit the doctor with something that needed an elective referral. She also welcomed the fact that patients with mental health problems had been excluded from the proposal.

Dr Anumba commented that smoking cessation was a real problem for her as a GP as there were real pockets of deprivation in her practice area. She felt that this was something that was going to be difficult to deliver, and it needed a mechanism to try and get people to understand.

The Director of Commissioning and Performance advised Governing Body that the CCG was still continuing to progress other areas, which were detailed in the paper, and included continued focus to drive the QIPP schemes, aligning our processes across South Yorkshire and Bassetlaw (SYB), and looking at a further scheme regarding pre-operative assessment, the benefits of which would be seen in 2018/19 but which we were looking at to see if it could be implemented earlier. Discussions were also taking place regarding the prescribing of high cost drugs.

The Chair commented that the emphasis put on these three proposals was on the three most important areas, but that it felt like a more difficult set of decisions than usual that Governing Body was being asked to make. However, it was just commissioning and Governing Body had to play their part in the NHS and work through these proposals as best it could. The Chair also drew members' attention to section 2.2 and the

actions in place to try and improve efficiency and reduce costs. He commented that he had seen strong feeling on both sides about some of the proposals but members needed to respect each other's opinions when they had these discussions.

The Medical Director advised members that the CCG was still really concentrating on the QIPP areas where we really having the most success, for example medicines management in our Member practices. With the limited financial resource we had available, we would also be undertaking a drugs waste avoidance campaign with the public that would commence in the next few months

Dr Majoka advised Governing Body that her practice had audited the reaction of the patients to the 'Stop Prescribing' letter sent from the CCG to GPs, and reported that only one out of 13 patients had been in full agreement, with the other 12 in agreement but still asking for some of their drugs still to be prescribed.

Mr Taylor reminded Governing Body that we were anticipating £5.3m of QIPP slippage. He commented that the three recommendations were realistic, the clinical variations proposal had the potential to improve patient care, Governing Body was being asked to approve going out to consultation on the proposed suspension of Gluten Free prescribing for adults in Sheffield, and that it seemed to adopt a South Yorkshire and Bassetlaw approach to Health Optimisation – Smoking.

Dr Sorsbie commented that it felt as though a lot of work was being undertaken, with activity figures going in the right direction. In this respect she asked if there could be any flexibility from NHS England when we show them the work we are doing, as it is our statutory duty to come in on budget at year end. The Chair explained that representation on how difficult it was, was being made at national level, both as an individual CCG and alongside other CCG colleagues, as to that some flexibilities might be helpful. The Director of Finance reminded members of the letter to NHS England's Director of Finance she had circulated the previous day that made them aware of the issues, however, it was doubtful they would be agreeable to any flexibilities.

Dr Hudsen reminded Governing Body that over the past few months the media had reported on the significant sums of money that would be available to CCGs for referral management and asked if the CCG would see some of that money to support our work. The Chair responded that he was not aware of any formal announcements and that if it was 'real' money we would be seeking it. He drew members' attention to the finance paper which detailed where we had managed to attract money into the system.

The Accountable Officer suggested adding an additional recommendation about undertaking further work on engaging with our Governing Body GPs on a range of things that we could be doing to health the health of our population. **BH**

The Governing Body:

- Approved the commissioning policy Clinical Variation in Primary Care – additional steps to manage unwarranted variation in GP referrals, for implementation.
- Approved consultation for the Suspension of Gluten Free Prescribing for Adults in Sheffield Policy, with a recommendation to be presented to Governing Body on 2 November 2017.
- Considered the proposal on health optimisation and the supporting evidence provided.
- Noted that currently there was no evidence that this policy would achieve the desired effect of improving health outcomes for people who smoke in Sheffield.
- Noted that, as part of the South Yorkshire and Bassetlaw (SYB) work in Commissioning for Outcomes, there was potential for the development of a system-wide approach to health optimisation.
- Agreed to receive proposals on health optimisation for consideration at a later date based upon this joint SYB work.
- Noted that an update on further mitigating actions would be provided to the Governing Body meeting on 5 October 2017.

93/17 Commissioning for Value for the Sustainability Transformation Plan (STP) Area

The Director of Commissioning and Performance presented this report which updated Governing Body on the progress and discussions taking place within the elective and diagnostic Sustainability Transformation Plan (STP workstream, in relation to developing a common SYB approach to commissioning for outcomes, with an initial focus on procedures that were not routinely commissioned and those with commissioning controls in place. He advised Governing Body that the paper asked for support to convert some of the commissioning for outcomes and work to adopt those and move to the development of a common SYB policy of how we commission.

The Interim Director of Delivery – Care Outside of Hospital referred to section 4.4 and asked if the CCG understood the costs / savings of this common policy. The Director of Commissioning and Performance responded that the first stage was to understand what this meant, a stage that could possibly slow down Phase 2 but one that we needed to try and accelerate where possible. He advised members that we would still retain a Right to Veto if we thought our own policy was further and better than the SYB one.

The Medical Director commented that we needed to maintain the strong evidence we have for this, and to run it through the Clinical Reference Group (CRG) to get a feel as to whether or not there was strong clinical support, as we should do for any other policies we adopt from elsewhere. This would fit with our current processes and he would be comfortable to support it.

The Chair suggested that we would need some local flexibility when drawing up these proposals otherwise we would lose local sensitivity,

and we needed to adopt it in the areas where it would be in our interests to adopt it.

The Governing Body:

- Supported the principle of converging approaches to commissioning for outcomes, with an initial focus on procedures that are not routinely commissioned and those with commissioning controls (clinical thresholds and criteria).
- Approved the development of a common SYB policy that where possible and appropriate covers a consistent set of procedures, criteria by which they are commissioned and approach to ensuring compliance, acknowledging that this would be developed in a way that it does not inhibit local progress.
- Supported the direction of travel towards SYB decision making process, through the established Joint Committee of Clinical Commissioning Groups.

94/17 Governance Route for the Urgent Primary Care Pre-Consultation Business Case

The Director of Finance presented this report which set out a proposed process in line with the CCG's Constitution that would meet the CCG's governance requirements for a way forward on the pre-consultation business case for urgent primary care.

The Director of Finance advised that due to conflicts of interests for the majority of GP Governing Body members, she was asking Governing Body to give delegated authority as set out in the paper, to the Primary Care Commissioning Committee (PCCC) whose voting members would have no conflicts of interest. She also clarified that the GP non voting members of PCCC would not be able to take part in the discussion.

The Governing Body:

- Approved delegation of consideration, and if appropriate, approval of the pre-consultation business case to the Primary Care Commissioning Committee (PCCC), extending PCCC's powers to do so.
- Assuming that PCCC approved the pre consultation business case, approved that all other decisions relating to the Urgent Primary Care public consultation and any final business case for implementation of the chosen option were delegated to the PCCC.

95/17 Proposed Changes to the CCG Constitution and Other Governance Matters

The Director of Finance presented this report

i) <u>Changes to NHS Sheffield CCG Constitution</u>

The Director of Finance presented proposed changes to the CCG's Constitution. She reminded Governing Body of the process for approval which was that, following approval by Governing Body, the

proposed changes would be shared with our Member practices who would be asked to approve the changes by the way of voting slips, and then NHS England for final approval.

The Director of Finance drew members' attention to the list of proposed key changes that were set out in Appendix A, which included the establishment of a formal committee, rather than a group, for engagement, changes to the executive structure, and changes to some of the responsibilities of some of the individual directors. She asked Governing Body that one further change be made in that the responsibility for acting lead for transforming care (learning disabilities) should show as a responsibility of the Chief Nurse. **JN**

The Governing Body approved the proposed changes to the NHS Sheffield CCG Constitution and recommended to Member practices that they accept the proposed changes for final approval by NHS England.

ii) Schedule of Governing Body Meetings for 2018/19

The Director of Finance presented the proposed schedule of dates for 2018/19 Governing Body meetings to be held in public and strategic development sessions, as set out in Appendix B. She advised that it was proposed to hold a full Governing Body meeting in July as well as in September to make the meeting schedule as practical as possible.

The Governing Body approved the proposed schedule of Governing Body meetings to be held in public and strategic development sessions for 2018/19.

iii) The Talbot Trusts – Appointment of Nominated Trustees

The Director of Finance asked Governing Body's to confirm the appointment of Dr Mike Sawkins as a CCG nominated trustee to the Talbot Trusts for the period October 2017 to September 2021. She explained Dr Sawkins' experience and hence that he was a suitable person for Governing Body to be recommending as a Talbot Trustee.

The Governing Body confirmed the appointment of Dr Mike Sawkins as a CCG nominated trustee to the Talbot Trusts for the period October 2017 to September 2021.

iv) Update on Locality GP Representative Nominations

The Director of Finance reminded Governing Body that tenures for three of the four locality GP representatives would come to a conclusion at 30 September 2017. She advised that North and West localities had each received one application and was pleased to be able to advise that Dr Sorsbie and Dr Moorhead had been nominated by their respective localities. However, as two applications had been received by Central Locality, an election process was now being undertaken, the results of which should be known the following week.

The Governing Body received and noted the update with regard to Locality GP Representative nominations.

v) Nominated Lay Member with Responsibility for Emergency Preparedness Resilience and Response

The Director of Finance advised members that, since the time of writing, there had been a change to this nominated Lay Member, in that as Mr Tony Williams had advised that he had some knowledge and expertise in this area, it was now proposed that he should take forward this role.

The Governing Body noted the arrangements in place with regard to the Lay Member with responsibility for Emergency Preparedness, Resilience and Response (EPRR).

96/17 Update to NHS Sheffield CCG's Standards of Business Conduct and Conflicts of Interests Policy and Procedure

The Director of Finance presented this report which set out proposed minor revisions to the CCG's Standards of Business Conduct and Conflicts of Interest Policy and Procedure to reflect changes small amendments included in the recently published further guidance issued by NHS England. She advised Governing Body that the proposed changes would normally have been presented to the CCG's Audit and Integrated Governance Committee but had been unable to do this due to the timing of meetings and the deadline of 16 September for revised documents to be uploaded to the CCG's website by 16 September 2017. She also advised that the revised policy and procedure, with tracked changes, had been included in the previously circulated noting pack for members' information.

The Governing Body:

- Approved the proposed changes to the Standards of Business Conduct and Conflicts of Interest Policy and Procedure to ensure compliance
- with the revised statutory guidance on Managing Conflicts of Interest for CCGs.
- Noted that if the changes outlined in this paper were approved, an updated document would be uploaded to the CCG's website with immediate effect.

97/17 NHS Sheffield CCG Emergency Preparedness, Resilience and Response (EPRR) Assurance 2017/18

The Director of Commissioning and Performance presented this report and advised members that this was a robust piece of work to ensure the CCG was able to provide assurance to NHS England of its readiness to respond to emergency situations, but had to be presented to Governing Body for approval instead of being delegated elsewhere. He advised Governing Body that we collaborated significantly across SYB as Category 2 responders, and that we were not front line as NHS England

would act on our behalf in this respect. He advised that our proposed level of compliance was 'Substantial'. He drew Governing Body's attention to three of the 52 standards in particular.

Standard 45: Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions. This standard related to our involvement and engagement in the event of an incident. He reminded members that at a point earlier in the year we had moved to the NHS being 'Critical' which meant that NHS England could action us to step up to respond to the incident.

Standard 49: Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents. The Director of Commissioning and Performance advised members that he would be working with Mr Williams to develop a training plan. **BH/TW**

Standard 51: Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises. The Director of Commissioning and Performance commented that it would be good to get lay members and executives to get involved in this work.

The Director of Commissioning and Performance advised Governing Body that he would present the CCG's self assessment regionally against the core standards. **BH**

The Governing Body:

- Noted the self-assessment.
- Approved the proposed Statement of Compliance.

98/17 Update on NHS Sheffield CCG Governing Body Assurance Framework and Risk Register

The Director of Finance presented this report which provided assurance to Governing Body that the CCG's strategic risks were being actively reviewed, changed and measured. She reminded Governing Body that they had approved the 2017/18 framework in May 2017 and that this was the first opportunity for them to review it in-year. She advised that the report provided them with assurance that the CCG's Senior Management Team (SMT) had considered their own individual risks and had reviewed the framework collectively agreeing that there did not need to be any changes in the 17 principal risks, prior to it being presented to, and discussed by, the Governance Sub Committee (GSc) in August, and hence to the Audit and Integrated Governance Committee (AIGC) in October. She advised that page 4 of her report gave an overview of both the position during Quarters 1 and 2 and the challenges by the SMT and whether the risk scores had moved up or down.

Mr Taylor drew Governing Body's attention to Appendix 1 that identified the actions that were in place to address any gaps in control and assurance. He especially drew their attention to principal risk 2.3: that the CCG fails to achieve Parity of Esteem for its citizens who

experience mental health conditions, so reinforcing their health inequality and life expectancy which had both gaps in control and assurance and so had more to address than other areas of risk. The Director of Finance advised Governing Body that this linked to the work that the transformation was undertaking on mental health and suggested that an update on progress in this respect be presented to Governing Body.

The Governing Body:

- Considered the Governing Body Assurance Framework at Quarter 2.
- Did not identify any strategic risks they thought should be added.
- Did not identify any further actions to be taken to mitigate against the risks identified.

99/17 Local Maternity System (LMS) Development Update

Mrs Kate Laurance, Head of Commissioning – Children, Young People and Maternity, was in attendance for this item and presented this report which updated Governing Body on progress with the development of a Local Maternity System in the South Yorkshire and Bassetlaw (SYB) Accountable Care System (ACS) area. She drew members' attention to the key highlights.

Local Maternity systems (LMs) have to come together to develop a transformation plan to change maternity services, the final of which has to be submitted to the national team by 31 October 2017, and then has to be implemented by 2020/21. This was subject to an assurance process, with the 2nd checkpoint meeting with NHS England just having been undertaken.

With regard to recommendations of areas for improvement from audit of the Better Births publication, four Task and Finish Groups had been established and were meeting regularly, with the aim being to develop a plan to meet the recommendations assigned to each of these groups. Ms Laurance advised that Sheffield was well engaged on these groups and was supporting the clinical conversations and what needs to change. She advised that she did not have any concerns at this stage.

The Chair commented that, as this was an important workstream, it was regrettable that the paper stated that there was not a lot of GP commissioner involvement in the process, as he would like to think that it was integrated and so needed to recruit GP representation, which did not need to be someone with an interest in children's and maternity services, but it would be helpful if they had a commissioning role..
Dr Anumba advised Governing Body that this was an area that she was interested in and suggested that Ms Laurance contact her to discuss this further. The Chair suggested that if Dr Anumba found this difficult to take on then he would prefer to have a GP who could actually commit to it, however, the CCG would do everything it could do to support Dr Anumba.

Ms Laurance advised Governing Body that she would present an update to them in due course. **KL**

The Governing Body:

- Considered and noted the update.
- Agreed to enabled staff time to attend appropriate meetings / groups.
- Sought GP representation to support the LMS Board, as noted above.

100/17 Quality and Outcomes Report

The Director of Commissioning and Performance presented this report which reflected the CCG's statutory responsibilities. He drew members' attention to the following key issues.

i) New Ambulance Quality and Performance Standards: A new set of standards for the service to move to had been published but not implemented as yet as there was no firm date as to when it would go live nationally. The Director of Commissioning and Performance advised that he would send Governing Body the link to an 'easy read' summary of the standards, which outlined what it would mean for the population, and why standards have changed, etc. He advised that it would change fundamentally the way the service will respond, but the challenge for the CCG would be as to how to reflect the changes in the contract negotiations with the Yorkshire Ambulance Service NHS Trust (YAS) that would follow shortly.

Dr Hudsen advised Governing Body that, at the last meeting of the Quality Assurance Committee (QAC), they had expressed concerns about YAS's performance against some of the targets, especially relating to performance against Stroke 60 measures, and about the service's ability to work to the proposed new system for hyper acute stroke centres. The Interim Director of Delivery – Care Outside of Hospital advised Governing Body that work was being undertaken to address this and that, as per the stroke pathway, ambulances were currently going to the Northern General Hospital and Royal Hallamshire Hospital. However, figures showed that once YAS had arrived at the hospital with the patient, the appropriate care was being provided.

The Accountable Officer raised concerns about ambulance handover times which were Red for three of the four measures and asked if this was being addressed within the work being undertaken.

The Director of Strategy and Integration explained that there had always been a difficult with this, and advised that there was a 'halo' model that ambulance services, apart from YAS, adopt, and it was also about incorporating that within their department. However, their performance did fluctuate between some really good and some challenging performances, which needed to be taken through the urgent care network. The Accountable Officer advised members that she had been assured that YAS would have regular

representation at the Urgent and Emergency Care Transformation Delivery Board, and would keep Governing Body advised of progress on this in this regard. **MR**

ii) CCG Improvement Assessment Framework (IAF): The Director of Commissioning and Performance advised Governing Body that the national CCG ratings for 2016/17 had been published in July, with Sheffield being assessed as 'Good', which was an improvement on last year.

iii) Quality

The Head of Quality advised Governing Body of the following:

a) Clostridium Difficile: The position at STHFT had improved in June, mainly due to the re-opening of a 'decant' ward allowing other wards to be deep cleaned. A presentation on the overall Sheffield CCG position would be given later in the meeting under item 101/17.

b) Clostridium Difficile: The position at STHFT had improved in June, mainly due to the opening of a 'decamp' ward that could be deep cleaned. A presentation on the overall Sheffield CCG position would be given later in the meeting under item 101/17.

iv) Other Issues

Patient Experience of GP Services: Dr Anumba commented that Sheffield seemed to be consistently above the England average, especially around access and making appointments. She commented that it would be helpful to see how we compared with the other core cities, rather than England as a whole. The Accountable Officer agreed to take this forward. **MR**

Compliments and Complaints: Dr Sorsbie commented that there was a huge difference between the two. The Accountable Officer responded that the CCG was aware that some of our Member practices were struggling with access and we were supporting our GPs with that.

Provider Performance Issues: Dr Hudsen advised Governing Body that the QAC had also raised concerns about workforce issues, especially around retention, sickness absence rates, return to work and recruitment and wanted to seek reassurance that, as an accountable care system, that we were prioritising and advertising our region as a really good place to work in..

Care Homes: Dr Hudsen advised Governing Body that the QAC had commended the work of the CCG's quality team on the work they had undertaken around care homes and care at home. However, they felt that the team needed to be fully resourced for them to be able to deal with things in a more strategic way and, in this respect, they sought assurance that the Local Authority was doing everything it could to support this.

The Accountable Officer responded that she would respond to Dr Hudsen, **MR**

through the QAC, on both of these latter two issues.

The Governing Body:

- Noted Sheffield performance on delivery of the NHS Constitution Rights and Pledges.
- Noted the key issues relating to Quality, Safety and Patient Experience.

101/17 Sheffield Community Clostridium Difficile Annual Report 2016/17

Mrs Nikki Littlewood, Infection Prevention and Control Nurse, and Mr Rob Townsend, Consultant Microbiologist, Sheffield Teaching Hospitals NHS Foundation Trust (STHFT), were in attendance for this item and presented this report and gave a presentation which provided Governing Body with an analysis of the Clostridium Difficile (C.Diff) community cases during 2016/17, compared the data from 2014/15 and 2015/16 where possible, outlined the range of the disease, the risk factors, the disease process, the national C.Diff targets, the Sheffield picture, changes from the total target to "Lapses in Care", what was being done to manage the cases, and details of the remit of the Antimicrobial Stewardship Group. The following issues were raised and discussed.

With regard to testing, Mr Townsend explained that, even though there was national guidance on when to test patients, the interpretation of when to test patients was variable nationally. He reported that STHFT took a more blanket view and tested everyone that was at risk, whereas some trusts only tested if it was requested. He advised that STHFT did not test the patient on admission and acknowledged that the patient could have come into hospital with it. The Chair suggested that we ought to be making representation to NHS England that all the other CCGs should be using the same algorithms for testing.

The Medical Director advised Governing Body that Proton Pump Inhibitor (PPI) / anti-ulcer medication prescribing was one of the areas the CCG would be picking up with the neighbourhood pharmacists, especially given that the total number of community C.Diff cases on a PPI or anti-ulcer medication was 52, with 11.3% of all Sheffield patients having a current repeat prescription written for a PPI.. Mr Townsend responded that he could not think of anything else to improve these rates over and above what the trust was already doing and explained that PPI was known to be not causative.

Finally, the Medical Director commented that we were sometimes good at keeping all our successes under the radar and, in this respect, thanked Mrs Littlewood and Mr Townsend and their respective teams for all the hard work they were undertaking.

The Governing Body:

- Supported the continued need for Root Cause Analysis (RCA) to be undertaken on all Clostridium Difficile cases.
- Supported the recommendation that, through the RCA process,

establish for patients on a PPI whether there is a relevant clinical indication for it and that information would be provided as part of the RCA process and also in the GP Bulletin.

102/17 Communications, Engagement, and Equality and Diversity Update

The Strategic Communications and Engagement Lead presented this report which provided Governing Body with a summary of communications and engagement activity and impact between April to July 2017. She advised members that she had tried to align the report to show them how the team was working to support the CCG's priorities.

The Interim Director of Delivery – Care Outside of Hospital advised Governing Body that there was a gap in assurance which related to whether the CCG was going to suppose communications and engagement activity. In this respect, she advised that this would be discussed in more depth by the Clinical Senior Management Team (CSMT), especially as to how we better plan communications and engagement resource and what we put our energies in to. The Interim Director of Delivery – Care Outside of Hospital commented that a lot of the work going through the communications and engagement team were ones that the teams raising them should be able to do themselves. However, we needed to embed engagement as part of our commissioning and this should be something that we were aspiring to.

The Chair questioned as to whether the team felt communications and engagement was undertaken in a silo or if it was everyone's job and to use every opportunity to broadcast it. The Strategic Communications and Engagement Lead explained that, with regard to the CCG's priorities, it was very much a two-way process, with the teams working with members of different communities to share our messages and secure feedback, with the onus on us to make sure we were explaining what was happening.

Dr Majoka asked that, in considering how to better communicate and engage, the CCG did not forget its Member practices. The Accountable Officer explained that she and the Strategic Communications Lead were looking at how better to communicate key issues in a 'snappy' way and would appreciate some feedback from Governing Body GPs in this respect. She also commented that there seemed to have been a higher proportion of reactive press releases, which the Strategic Communications Lead suggested was purely down to a capacity issue within the team. The Strategic Communications Lead advised Governing Body that she and her job-share were reviewing this and the planned programme of things they needed to work on.

The Healthwatch representative commented that there was a huge difference between consultation and communications, and that it was sometimes very clear that a plan was not going to be changed following consultation which meant it was communication, and the CCG needed to take this into consideration when planning its public meetings (for example its Annual Public Meeting (APM). Her thoughts were that the

public were quite able to take the message but needed to be told that it was something that they could not change..

The Governing Body noted the communications and engagement work undertaken and its impact.

103/17 City-Wide Locality Group (CLG) Update

Dr Sorsbie presented this report which updated Governing Body on the key highlights, progress and risks in localities and asked them to answer some key questions. She reminded members that the report was a way of trying to get some communication and debate at Governing Body.

Dr Sorsbie drew Governing Body's attention to the key highlights, which included that there was a greater sense of collaboration between practices, that was leading to them making huge differences, and there was a feeling of optimism and where they sit within the CCG. However, there were a large number of vacancies which meant they were still under a lot of pressure.

The Chair advised that the paper was partly to update those members that were not able to go out to see practices as much as they would have liked, partly for information, and partly to bring to Governing Body's attention what was mainly concerning the practices right now.

The Interim Director of Delivery – Care Outside of Hospital reflected that, over the past few months, the practices' different ways of working had begun to start to feel really real.

Governing Body considered the key questions outlined at section 5.

1. **Practices know an outline of the plans for Sheffield and South Yorkshire and Bassetlaw through the Accountable Care Partnership (ACP) and Accountable Care System (ACS), however, practices would like to know more what this means for them as member practices and providers in Sheffield.**

The Accountable Officer advised that a specific piece of work was being undertaken by the CCG and ACP communications teams to produce a two-page summary document, which would be sent out to Member practices.

2. **As neighbourhood and out of hospital initiatives gain scale, pace and impact, how do we ensure that where we have activity/cost reducing initiatives we are able to fully release the associated acute spend and reinvest it in primary care and communities? What actions can localities take to support?**

The Interim Director of Delivery – Care Outside of Hospital referred the Governing Body back to earlier conversations in the meeting where it was described that we were seeing this activity reduction in hospital activity

but costs had also increased. Work was already underway to fully understand this.
Also discussed earlier was the additional work required to understand how we would be able to do this, which would likely be an ask of the Accountable Care Partnership (ACP) Finance group. A real challenge for the ACP as we move forward would be demonstrating behaviours and actions that make this money work for the system..

3. **How does the Sheffield estate strategy support the city's expectations for an integrated primary and community service, and how can we work together with partners to use vacant space to our collective benefit (both providing services and releasing cost)?**

The Interim Director of Delivery – Care Outside of Hospital advised that the Sheffield Primary Care Estates Strategy would be presented to Governing Body for approval in November 2017, the localities were currently receiving a presentation from the Programme Director Primary Care or a member of the team setting out what the strategy says in relation to what needs to be done and the challenges.

4. **What process will be developed for neighbourhoods to access funding in order to deliver their local initiatives?**

The Interim Director of Delivery – Care Outside of Hospital reminded Governing Body that at this point in time there isn't a pot of money to support this. She further advised members that this could be done in a number of different ways that needed to be properly worked through. There were 125 business cases potentially ready to go and we would work with localities, neighbourhoods and Primary Care Sheffield Ltd (PCS) as to the best way to respond to these. Some of these may be part of a wider commissioned service and some may be invest to save cases. The Director of Delivery also noted that in some instances the business cases were more appropriate for the neighbourhoods themselves to commit to.
The Locality Managers would also be involved the LMC/CCG/PCS co-produced workshops on the future contractual framework .

5. **What budget and finance information will be provided in order for neighbourhoods to measure success in their objectives**

The Interim Director of Delivery – Care Outside of Hospital suggested that if the localities / neighbourhoods describe to the CCG the measures that they need then we will do our best to support them, including helping to provide the evidence.

6. **What will be the ask of practices in the delivery of Urgent Care**

The Interim Director of Delivery – Care Outside of Hospital advised Governing Body that there would be a number of options but a full formal public consultation would not be undertaken until the options had been presented to, and approved by, the Primary Care Commissioning

Committee on 25 September 2017.

Dr Whale commented that workforce was a key issue and asked how the CCG would attract local expenditure across localities, especially given that there had been a lot of pressure within hospitals to drive down locum expenditure. The Director of Finance explained that this was not something that the CCG held data for. Dr Sorsbie advised members that every practice has a different policy and they will know that information as it was part of their business planning. She commented that they were going to need that workforce resilience if we were going to move services out to the community.

The Interim Director of Delivery – Care Outside of Hospital suggested that what the CCG had not done was to give the neighbourhoods some sort of framework to help structure what they should usefully be focussing on. In this respect, she advised Governing Body that at a recent locality meeting there had been a view that more things like the virtual ward would be really helpful as it provided a shared purpose to the neighbourhood. She also suggested that it was worth taking the locum issue back to the CLG and for us to think about how we might want to support practices and what their plans are to move away from using locums.

Finally, the Chair asked members to let him know if they would like the format of the paper changing to something more useful.

The Governing Body did not have any questions to ask of the CLG.

The Governing Body:

- Considered and noted the update from the City-wide Localities Group
- Responded to the questions listed in the report, as noted above.

104/17 Reports Circulated in Advance for Noting

The Governing Body formally noted the following reports:

- Chair's Report
- Accountable Officer's Report
- NHS Sheffield CCG's Revised Standards of Business Conduct and Conflicts of Interests Policy and Procedure (to support main agenda item 12 (paper H)
- Governing Body Assurance Framework Quarter 2 (to support main agenda item 15 (paper K)
- Report from the Primary Care Commissioning Committee
- Report from the Quality Assurance Committee
  Dr Hudsen advised Governing Body that the Quality Assurance Committee had had a discussion that there needed to be some assurance around Primary Care Sheffield Ltd (PCS) as a provider due to the amount of primary care work they were picking up. The Director of Commissioning and Performance advised that quality would be a specific item on the agenda for the CCG's formal Contract Management Board (CMB) meeting with PCS the following week, with the outcome of that discussion reported formally through the QAC.

The Governing Body formally noted the following reports:

- Report from the Audit and Integrated Governance Committee
- Annual Audit Letter 2016/17
- Emotional Wellbeing and Mental Health (EWBMH) Annual Report 2016/17
- Update on Quality, Innovation, Productivity and Prevention (QIPP) Plan
- Complaints and MP Enquiries Quarterly Update

105/17 Any Other Business

There was no further business to discuss this month.

106/17 Date and Time of Next Meeting

A short meeting in public will take place on Thursday 5 October 2017, 2.00 pm – 3.00 pm, Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU.

The next full meeting in public will take place on Thursday 2 November 2017, 2.00 pm – 5.00 pm, Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU

Appendix A

Questions to the CCG Governing Body 7 September 2017

Question 1: The efforts of the CCG to set up involvement networks are generally appreciated but please can more thought be given to devising more appropriate ways to run public consultation meetings which focus on actual or potential proposals for service reductions. Two recent meetings left a significant proportion of participants feeling uncomfortable and even to some extent disrespected although the provision of information was valued.

CCG response: *We understand that the two meetings referred to are the one held on the hospital services review which was organised by the Accountable Care System (ACS) team and one held by the CCG to discuss the financial challenges we are facing and how we make difficult decisions around spending.*

We have passed on these comments to the ACS team, along with some other feedback that we have received on the event from attendees, to help inform future planning.

The feedback we had from the CCG event was overwhelmingly positive but we are sorry to hear that some people did not find it such a positive experience. From further discussion with you to understand the specific issues, it appears that some people felt uncomfortable with what they perceived was responsibility for making difficult decisions so we will take on board your helpful suggestions about approaches to avoid this in future.

We also appreciate the importance of ensuring proper facilitation for group discussions and allowing sufficient time for tasks and feedback. It is always a difficult balance as many people do not want to attend long events but the topics often generate lengthy discussions, as well as very useful feedback.

We greatly value the time that people take to work us and give us their views and are continually looking at ways to improve our engagement so thank you for your feedback and suggestions.

Question 2: At these recent consultation meetings considerable concern and some anger was expressed about mental health services across the Working Together area. I have asked Governing Body about Sheffield services several times and have appreciated the trouble taken to provide lengthy answers and invitations to meet officers. Unfortunately I and many others remain unclear about what is actually happening to services. Despite progress and good practice in some areas, we hear about the unavailability of in-patient beds, continuing difficulties in accessing services and stresses from many sources on community based teams whether commissioned by the NHS or the local authority.

Unfortunately I and many others remain unclear about what is actually happening to services. Despite progress and good practice in some areas, we hear about the unavailability of in-patient beds, continuing difficulties in accessing services and stresses from many sources on community based teams whether commissioned by the NHS or the Local Authority.

CCG response: *As you will be aware, we have been working closely with Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) to ensure that we strengthen the provision of*

community services, which has enabled us to reduce the number of acute inpatient beds. This has been undertaken over a number of months in a planned and co-ordinated way; focusing on the development of alternative approaches in line with the aspirations of the national Crisis Care Concordat. Our focus is on ensuring that people have access to improved support before they reach crisis point.

As a consequence we have developed a Crisis House service with a 24 hour helpline, we have increased the capacity of the Crisis Resolution and Home Treatment Service and we have introduced Clinical Psychologists to provide person centred interventions on the inpatient wards. In addition, we have invested in the Mental Health Liaison Service, Improving Access to Psychological Therapy Service (IAPT) and also have further plans to invest in the Early Intervention in Psychosis service.

These measures have all been introduced to reduce the reliance on acute hospital beds, so that people receive the most appropriate care in the least restrictive environments to best meet their needs.

Future policy direction, as outlined in the Mental Health Five Year Forward view is to ensure that acute care pathways focus on community prevention and early intervention, rather than over-relying on acute inpatient beds. Sheffield is seen nationally as leading positive practice relating to this aspiration, having had no out of area placements for three years, which is a considerable achievement.

Question 3: We fear that a target-driven focus on IAPT may lead to the downgrading of other types of service and note that achieving Parity of Esteem is at high risk.

CCG response: *The targets for IAPT are set nationally, and as a health community we have to achieve these. In Sheffield we have been under close scrutiny around these targets, particularly given the agreement we have with SHSCFT that they will work with people with more complex needs. Whilst this does of course potentially impact on the achievement of national targets, it does mean that our service is far more inclusive than other services across the country (which have far more stringent access criteria).*

In addition, you may be aware that we have recently been successful in our bid for national pilot money to extend the IAPT service so that it also encompasses long term conditions, across 10 physical health pathways. This includes, for example, diabetes, gastroenterology, cardiac and neurology. Sheffield actually won the largest bid for this pilot service in the country. This project is part of our approach to progressing Parity of Esteem, as it is aimed at recognising and valuing the mental health needs of people with long term conditions, and to get physical health services to be more responsive to the mental health needs of their patients.

Question 4: Announcements about cuts to the Health and Social Care Trust and obscure statements about finance changes like that in the QIPP update (Item 20j pp2-3 Note 1) add to an insecurity which is damaging to all parties.

CCG response: *As previously noted and subsequently discussed, the mental health component of the CCG's QIPP programme is being delivered through the Sheffield Mental Health Transformation Programme, which aims to secure better joined up services and better value for money, through economies of scale, reducing overlaps, eliminating wastage and through innovation and creativity.*

Taking this holistic approach will genuinely promote parity of esteem by strengthening support across the wider health system for people with mental health problems who tend to (a) have

more negative experiences and outcomes when they receive health care, and (b) place a disproportionate level of demand on general health services. It will also help us to focus on the wider determinants of mental ill health and develop more preventative services.

As you will be aware we are approaching the programme very much in the way QIPP was intended. This is not therefore simply a series of cuts; it is about addressing what are predominantly long-standing issues, whilst remaining focused on quality, innovation, productivity and prevention. The latter 'P' of QIPP is particularly important and is a key component of the wider mental health transformation programme; tackling ill health at the earliest opportunity. If we get this right, this will not only improve the outcomes for individual service users but will ultimately deliver better value for money as we will rely far less on secondary health care services. This aspiration therefore underpins the entire transformation programme, and remains a joint commitment from all partner organisations.

Question 5: At a time when the emphasis is on a shift to community-based services, managers and indeed some clinicians often seem not to understand the fragility of community service networks where threats or changes to one link can have immediate effects on many others as well as often unforeseen effects on users of services.

Is it not time for the CCG, the Local Authority and Sheffield Health and Social Care Trust to present a unified, comprehensible and acceptable explanation of their developing joint intentions?

CCG response: *The CCG has been working with Sheffield City Council on an integrated commissioning approach to developing mental health services, and are also working in partnership with SHSC to enable better joined up working. As you will be aware (and as noted above) this partnership working is underpinned by the Sheffield Mental Health Transformation Programme, which has instilled a genuine sense of collegiate and collaborative working, coupled with a degree of joint accountability. There is therefore cross-organisational commitment to ensure that the programme is delivered in full.*

We are also working more closely with the 3rd sector to look at better ways of integrating this valuable resource into the pathways that people can access more easily.

In addition, we acknowledge the need to engage with the public on emerging ideas and plans, and the development of the Sheffield Mental Health Strategy. It is clearly important to seek their views and experiences at every opportunity. We plan to run a public event around November, and are also working closely with Healthwatch to explore how we might work with them to ensure that people with experiences of using mental health services are able to contribute and help us shape our plans.

Question 6: I write to request that the CCG considers the position regarding enabling Type2 diabetes to self test their blood glucose levels.

It does appear that the NICE guidelines are being misinterpreted all across the UK as being "routinely not offered" rather than "not routinely offered".

There are many reasons why encouraging diabetics to self test can potentially save money for the NHS in the long term. I am diabetic myself and can state that support services, including educational courses, etc, are becoming harder to access lately.

CCG response: *As a result of your enquiry, we have reviewed the local guidelines, for self-testing blood glucose.*

The local guidelines state “NICE do not recommend the routine use of Self-Monitoring of Blood Glucose (SMBG) in type 2 diabetes (T2D)2 and to only offer SMBG in adults if: “ whereas the latest version of the NICE guidelines say “Do not routinely offer self-monitoring of blood glucose levels for adults with type 2 diabetes unless: ”. The sheffield guidelines are similar to the NICE guidelines and were written in the same spirit as the NICE guidelines, however as there appears to be a subtle difference between the two sets of wordings I have asked the Formulary Subgroup of the Area Prescribing Committee to review the guidelines to look at whether the wording should be changed to more closely match the NICE guideline.

The interpretation of the guidelines remains down to the individual clinician in practice, whether they are using the national or local guidelines both would give similar access to patients. Sheffield CCG has not told practices that they cannot prescribe blood glucose testing strips to patients who fall within NICE guidelines. Sheffield CCG continues to support prescribing according to NICE guidelines. We continue to work with practices to ensure that were SMBG is appropriate for patients is required that the most cost effective option is used