NHS
Sheffield
Clinical Commissioning Group

Minutes of the meeting of NHS Sheffield Clinical Commissioning Group Governing Body held in public on 6 April 2017 in the Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU

Ai

Present:
Dr Tim Moorhead, CCG Chair, GP Locality Representative, West (Chair)
Dr Nikki Bates, GP Elected City-wide Representative (from item 23/17)
Mr John Boyington, CBE, Lay Member (from item 34/17(d))
Mrs Penny Brooks, Chief Nurse
Mrs Nicki Doherty, Interim Director of Delivery - Care Outside of Hospital
Ms Amanda Forrest, Lay Member (up to item 37/17)
Professor Mark Gamsu, Lay Member
Dr Zak McMurray, Medical Director
Ms Julia Newton, Director of Finance
Mr Matt Powls, Interim Director of Commissioning and Performance.
Mrs Maddy Ruff, Accountable Officer
Dr Marion Sloan, GP Elected City-wide Representative (from item 34/17(i)(c))
Dr Leigh Sorsbie, GP Locality Representative, North
Mr Phil Taylor, Lay Member

In Attendance:
Mr Joe Fowler, Programme Director for Neighbourhood Delivery and Mental Health Transformation (for item 27/17)
Mrs Kate Gleave, Interim Deputy Director of Strategy and Integration (from item 34/17)
Ms Carol Henderson, Committee Secretary / PA to Director of Finance
Mr Alastair Mew, Head of Commissioning, Urgent Care (for item 35/17)
Mr Jim Millns, Assistant Director of Contracting (for item 36/17)
Mr Nicky Normington, Locality Manager, North (Designate)
Mr Gordon Osborne, Locality Manager, Hallam and South
Mrs Judy Robinson, Chair, Healthwatch Sheffield
Mr Paul Wike, Joint Locality Manager, Central (from item 34/17(i)(c))

Members of the public:
There were eight 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

20/17 Welcome

The Chair welcomed members of the Sheffield Clinical Commissioning Group (CCG) Governing Body and those in attendance to the meeting.

The Chair also welcomed, Mr Nicky Normington, Locality Manager, North (Designate) to the meeting.

21/17 Apologies for Absence

Apologies for absence had been received from Dr Amir Afzal, GP

Locality Representative, Central, Dr Ngozi Anumba, GP Locality Representative, Hallam and South, Dr Terry Hudsen, GP Elected City-wide Representative, Dr Annie Majoka, GP Elected City-wide Representative, and Mr Peter Moore, Director of Strategy and Integration.

Apologies for absence from those who were normally in attendance had been received from Mrs Katrina Cleary, Programme Director Primary Care, Mrs Rachel Dillon, Locality Manager, West, Dr Mark Durling, Chair, Sheffield Local Medical Committee, Mr Phil Holmes, Director of Adult Services, Sheffield City Council, Sheffield City Council, and Mrs Eleanor Nossiter, Strategic Communications and Engagement Lead.

The Chair declared that the meeting would not be quorate until Dr Bates, who had been delayed returning from general practice, joined the meeting, as only three of the eight Governing Body GPs were in attendance (four Governing Body GPs need to be in attendance for the meeting to be quorate). Therefore, any decisions made until her arrival would need to be ratified by either herself or one of the other Governing Body GPs that had sent their apologies, after the meeting, and any such ratifications minuted accordingly.

Post meeting note: no decisions were made during this time.

22/17 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

Professor Gamsu declared a conflict of interest in item 7 (paper C): Social Prescribing Strategy, in his roles as the Trustee - Chair, Sheffield Citizens Advice and Committee Member, Darnall Wellbeing Health Project. Governing Body agreed that Professor Gamsu did not have to leave the room for this discussion and could participate in the discussion, but could not participate in the decision making process.

There were no declarations of interest from today's meeting.

Dr Bates joined the meeting at this stage.

The Chair declared that the meeting was now quorate.

23/17 Chair's Opening Remarks

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

24/17 Questions from the Public

A member of the public had submitted questions before the meeting. The CCG's responses to these are attached at Appendix A.

25/17 Minutes of the CCG Governing Body meeting held in public on 2 February 2017

The minutes of the Governing Body meeting held in public on 2 February 2017 were agreed as a true and correct record and were signed by the Chair.

26/17 Matters Arising

a) Briefing Note regarding Domiciliary Care Providers in the City (minutes 139/16, 149/16(e), and 07/17(c) refer)

The Chair advised members that Mr Phil Holmes, Director of Adult Services, Sheffield City Council, had circulated this briefing note earlier in the day, and that hard copies were available for members at the meeting.

b) Community / Independent Sector Support (minutes 139/16, 149/16(e), and 07/17(c) refer)

The Interim Director of Commissioning and Performance advised that he had circulated a briefing note with examples as to how we were measuring success and where we were truly shifting resources from the hospital to the community as part of our commissioning.

The Chair commented that it was helpful to write down what we were achieving.

c) Update on Winter and Urgent Care (minutes 162/16 and 07/17(d) refer)

An update on progress on providing members with the impact of the six key focus areas against their metrics would be given under minute 35/17.

The Accountable Officer Governing Body that we now had nine high impact changes, and was expecting to present a paper to Governing Body on 25 May with our plans for urgent and emergency care. **MR**

d) Feedback from West Locality Meeting 1 February 2017: Gynaecology Services (minutes 160/16 and (07/17(f) refer)

The Interim Director of Commissioning and Performance advised Governing Body that he had circulated a briefing note on the response from the CCG's elective care team to the letter from West Locality expressing their frustration on the lack of pace of delivering gynaecology services from the hospitals to the community.

He also advised members that a service specification had been presented to the CCG's Clinical Commissioning Committee (CCC) on 2 April 2017 asking them to agree the direction of travel for gynaecology services.

e) Review of Governing Body Committees and Sub Committees Terms of Reference (ToR) (minute 09/17 refers)

The Accountable Officer advised Governing Body that discussions had still to take place regarding the proposal to establish the Strategic Public Experience Engagement Equality Group (SPEEEG) as a committee or sub committee of the Governing Body. **MR/EN**

f) Operational Plan and Commissioning Intentions 2017/18 and 2018/19 (minute 10/17 refers)

The Interim Director of Commissioning and Performance advised Governing Body that he and the Strategic Communications Lead had met with the Chair of Healthwatch Sheffield to discuss and take on board her suggested amendments / rephrasing to certain sections of the plan.

The Interim Director of Delivery – Care Outside of Hospital advised Governing Body that a summary version of the plan was just in the process of being signed off and would be published shortly.

g) Finance Workshop for Governing Body Members (minute 11/17 refers)

The Director of Finance reminded members that she had arranged this workshop for the afternoon of 16 February, however, would be looking to arrange a further session for those members unable to attend on 16 February.

h) Mental Health Funding (minute 11/17 refers)

Ms Forrest advised members that the action to brief her on discussions relating to mental health funding was still outstanding. **PM**

Members noted that the Equality Impact Assessment (EIA) on the 2017/18 Quality, Innovation, Productivity and Prevention (QIPP) with Sheffield Health and Social Care NHS Foundation Trust (STHFT) was still to be completed and be brought back to Governing Body at a later stage. **PM**

i) Update on Update on Quality, Innovation, Productivity and Prevention (QIPP) Plan for 2016/17 (minute 13/17 refers)

The Interim Director of Commissioning and Performance advised that he had circulated a position statement on the legal advice he was seeking with respect to how best we could optimise the void space in primary care Local Improvement Finance Trust (LIFT) buildings under the terms of the lease arrangements, and would circulate a further update once he had received that definitive advice. **MP**

j) A&E Maximum 4 Hour Wait (minute 14/17(b) refers)

The Chief Nurse advised that she would give an update on the two 12 hour trolley waits breaches within A&E under minute 34/17.

27/17 Social Prescribing Strategy

Mr Joe Fowler, Programme Director for Neighbourhood Delivery and Mental Health Transformation, attended for this item and presented this report which sought Governing Body's commitment to social prescribing and a plan and investment strategy for making social prescribing a more integral and impactful part of the health and care system, and defined social prescribing in the Sheffield context more widely. In this respect he advised that it had been discussed with many groups in Sheffield, was being linked to activities and things that could increase people's health and wellbeing. He advised that the paper was about a social prescribing model worked on with partners and to put a plan together that makes social prescribing more fruitful. Professor Gamsu commented that it was a responsibility for the two commissioners (the CCG and Local Authority) to jointly develop that.

Mr Fowler advised Governing Body that whilst we were benefitting from social prescribing in Sheffield, due to information governance issues it remained a challenge to get up to date data for the service evaluation as to whether social prescribing had reduced demand on the health and care system. However, it was hoped to have fairly conclusive data for July.

Mr Fowler advised Governing Body that, whilst a lot of people in Sheffield were really struggling to get by, they were unaware that they could apply for a referral for a 'linking' conversation or for things like attendance and carer's allowance. He commented that one of the key things was to give people living in poverty some money, which the social prescribing infrastructure had helped to do. The evaluation of the service would imminently be concluded, however Mr Fowler advised Governing Body that there was a pressing need to agree continued investment and he clarified that the ask of Governing Body was for them to support the Executive Management Group (EMG) to move forward on a financial investment strategy and plan. He explained that the current social prescribing infrastructure was a primary care facing service, with other two thirds of referrals coming from primary care, and also that social care was not, at this time, allowed to refer someone who already had a social care package.

He advised Governing Body that it had been a challenge but the model was starting to work, and people were working together.

Professor Gamsu commented that it was primarily about community support workers, and there remained a much bigger issue to take a more thoughtful strategic approach, and to have a range of services in the city that were properly engaged, which the paper did not properly address. He also commented that the Local Authority and CCG needed to undertake a systematic review of the challenges faced by the Local Authority in terms of community support, in order to be able to take a more considered approach to develop a strategy that builds on the infrastructure already there.

Mr Fowler advised Governing Body that there were currently two independent reviews on social prescribing infrastructure and community support workers being undertaken by the Sheffield Universities. He drew their attention to Annex G: social prescribing outline plan that, he reported, had been worked on for a while and commented that we would probably produce a more informed and better forward plan than any review. He also advised, that with regard to community support workers, we were not wedded to having Sheffield City Council employed workers delivering that role as we would need to employ them directly as we would need them to access and have information governance rights to health and social care.

Ms Forrest referred to the table at section 6.9 (page 12) which set out the proposed investment in social prescribing in 2017/18 across the components of the model, the funding organisation, and by direct and indirect investment, and commented that she wanted to be really clear as to what money there would be available to support it. Mr Fowler explained that there would be some new recurrent funding due to rationalising and changing other budgets and had been actively reshaping the contracts to facilitate that. There would also still be some existing funding going into health trainers and champions. He also advised that Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) would potentially be looking to receive about 1500 referrals next year and we needed to make sure the investment was there to fund these.

The Accountable Officer advised Governing Body that every GP could make a referral and, if local arrangements weren't available could refer to a central hub who could make that that referral was dealt with by someone locally. She also commented that previously it had depended on where you lived and the particular arrangements in your neighbourhoods.

The Interim Director of Delivery – Care Out of Hospital advised Governing Body that social prescribing is mentioned in many patient stories and it definitely warranted being taken forward and made broader in the future. She commented that we needed to think about our forward strategy and how we sustainably invest. The Accountable Officer advised that the South Yorkshire and Bassetlaw Sustainability Transformation Plan (STP) had social prescribing as a priority area for the whole of the area, and all the areas were looking at this and how we invest in a sustainable approach. She also commented that there was a question about

sustainability of the supply chain and the funding of those organisations and about building their capacity to engage in health systems. She commented that the paper was a good start but there was a bigger picture and she looked forward to seeing the outcomes of the reviews.

Mr Fowler advised Governing Body that £300k was now being put by Sheffield City Council into the infrastructure to voluntary organisations / community partnerships to develop neighbourhood referral hubs and support systems. We needed to be thinking about the strength of this infrastructure or it would not have anything to link to.

Dr Sorsbie reminded Governing Body that she worked in an area where there was high psychological need but there were lots of really good patient stories, with people becoming volunteers as they feel so inspired, and that sense of wellbeing was so transformational.

Professor Gamsu suggested that Governing Body committed to continuing to take a systematic review and to commit to working with the Local Authority to undertake a process of review. The Interim Director of Delivery – Care Outside of Hospital reminded Governing Body that we had an agreed out of hospital care strategy and that there and been a review of the implementation plan to support that. She offered to present an update as to what that means, to Governing Body in a few months' time. She also advised that these conversations, including discussion of this paper, were also taking place as part of the Active Support and Recovery (AS&R) Board.

Finally, the Director of Public Health advised Governing Body that he would be SCC's interim lead for social prescribing following the departure of Mr Fowler, until the new lead had been clarified.

The Governing Body

- Agreed the social prescribing model advocated in the paper.
- Agreed the plan for making social prescribing a more impactful and integral part of the health system and sought an update on the implementation of the plan in July 2017.
- Supported the proposal for EMG to agree the forward funding strategy and plan for social prescribing
- Recognised social prescribing as a priority for investment of any new / invest to save funding for 2017/18.

28/17 Future Child Health Service Model (Acutely Unwell Child)

The Interim Director of Commissioning and Performance presented this report which asked Governing Body to consider the outline strategic case for change and support the development of further work and development, as set out under section 3, proposed next steps.

He reminded Governing Body that they had already considered an initial draft in private when they had agreed for the Commissioners Working Together (CWT) Partnership Vanguard to undertake a scenario appraisal alongside the write up of the current challenges facing provision and that

they were now asking for approval to proceed to the next stage of the work that would include an options development and appraisal, equality impact assessment (EIA) on options, financial planning and analysis against options, public engagement and potential consultation, STP links and support, a Yorkshire and Humber Senate review of options, and links to the due NHS England assurance processes.

Professor Gamsu commented that he did not feel like either the voice of the parents or of the general public was included as yet and his thoughts were that it would really add some quality to the perspective. This needed to be moved on as quickly as possible before options were agreed. The Accountable Officer advised Governing Body that the papers had been written with a professional perspective, however, the CWT communications and engagement team could easily present information that the public could understand, especially in light of the two recent consultations that had taken place to gather the views of patients, members of the public and others with an interest in proposals to change the way hyper acute stroke and children's surgery and anaesthesia services were delivered across South Yorkshire, Bassetlaw and North Derbyshire.

Mr Taylor commented it was about the degree of urgency but could not find a timetable included in the report. The Interim Director of Commissioning and Performance agreed to raise this with the CWT Team. **MP**

The Chair advised Governing Body that, with regard to the hyper acute stroke and children's surgery and anaesthesia services, it had taken two years to get to the public consultation stage, although was unsure as to whether this consultation could be undertaken more quickly, even though the urgency was there. Mr Taylor commented that the consultation needed to be undertaken properly and follow due process, but it was urgent and so the timetable needed to be reviewed to see how they could get to the end product quicker.

The Governing Body:

- Considered the outline strategic case for change
- Supported the development of further work and development of options to support sustainable care across providers within the context of the sustainability and Transformation Plan (STP).

29/17 Update on NHS Sheffield CCG Governing Body Assurance Framework (including 2017/18 refresh) and Risk Register

The Director of Finance presented this report which provided an update with regard to the Governing Body Assurance Framework (GBAF) and arrangements in place for managing strategic risks during Quarter 4 and up to 20 March 2017, and a refresh of the framework for 2017/18. She highlighted that all high level risks had been reviewed by the executive leads during this period. Two of the 16 strategic risks had been identified as having both gaps in control and assurance, which would be included within the Annual Governance Statement for 2016/17. She also advised that, as at 20 March 2017, two risks had been rated as very high, one as

high, and 13 as medium.

Governing Body Assurance Framework 2017/18

The Director of Finance reminded Governing Body that, at the development session on 12 January 2017, they had confirmed that the CCG's eight goals for the Commissioning Strategy and the five strategic objectives remained relevant for 2017/18. She also advised that the CCG's Executive Directors had met on 7 March and 21 March 2017 to review and refresh the GBAF for 2016/17 and 2017/18 and to discuss the refreshed risks and risk scores. She drew Governing Body's attention to the key highlights.

The Executive Team had reduced some of the risk scores when they had reviewed Quarter 4 and the year end, and had made some small changes to the strategic objectives for 2017/18 and reassessed the risks. She advised that the risks relating to the Sustainability Transformation Plan (STP) and Accountable Care Organisation (ACO) remained and would be reviewed over the next few weeks due to the changing landscape.

With regard 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; and principal risk 2.4: Insufficient resources across health and social care to be able to prioritise and implement the key developments required to achieve our goal of giving every child and young person the best start in life, potentially increasing demand for health and care services; Mr Taylor commented that these had been rated as 16 during 2016/17 and continued to do so in 2017/18 and questioned as to whether they had been specified properly. The Director of Finance explained that specific goals for these two objectives for mental health and children's services had been included and showed where we were for the service transformation in these two areas. She explained that these risks were reviewed at least once a quarter but would review them again, taking all these comments on board.

With regard to principal risk 1.1 Insufficient communication and engagement with patients and the public on CCG priorities and service developments, leading to loss of confidence in CCG decisions and formal challenge, Professor Gamsu advised Governing Body that he was the Lay Member that led the CCG's engagement committee (Strategic Public Experience Engagement Equality Group (SPEEEG)) and also advised that the group had lost a Governing Body GP member which meant that engagement was weaker but was not reflected in the risk. The Chief Nurse advised Governing Body that the Deputy Chief Nurse was now a member of that group and together they would be undertaking a piece of work on how to bring it up to the level of other groups. **PB**

The Governing Body:

- Noted activity with regard to risk management during Quarter 4 with regard to the GBAF.
- Considered and approved the content of the refreshed GBAF for 2017/18, as reviewed by the CCG's Executive Team.

30/17 Review of the Yorkshire and Humber Fertility Policy

The Interim Director of Commissioning and Performance presented this report which set out the process for the review of the policy that had been adopted and adapted to suit local needs by the CCG in 2013 following transfer of commissioning responsibility for specialist fertility services from the Yorkshire and Humber Specialised Commissioning Group to local CCGs. He advised Governing Body that the review panel had suggested that nine revisions were made to the existing policy, which were highlighted within the document and was asking for their agreement for those revisions to be made.

The Director of Public Health advised Governing Body that these proposed changes were largely consistent with National Institute for Health and Care Excellence (NICE) guidelines. With regard to the proposal relating to update the wording for Embryo transfer to reflect the NICE guidance, he advised that it was expected that the number of transfers was expected to be not more than four.

The Accountable Officer advised Governing Body that one of the areas being looked at in the Sustainability Transformation Plan (STP) was around threshold work, as organisations had different sets of arrangements (for example numbers of treatments), and they were looking at less of a 'postcode lottery' in South Yorkshire and Bassetlaw and more of a standard and getting closer alignment.

The Governing Body supported the revised Commissioning Policy for Access to Fertility Treatment for local implementation.

31/17 The Talbot Trusts – Appointment of Nominated Trustees

The Director of Finance presented this report She reminded members that Sheffield Primary Care Trust (PCT) had previously been given authority to appoint three of the six nominated trustees to the Talbot Trusts, and that it was a matter of law that the CCG as the continuing body for the Sheffield PCT would continue the arrangement. The CCG had given approval that, with effect from 1 April 2013, it would take on this role. She confirmed there would be no other function or responsibility for the CCG as this was an appointing role only. She advised, however, that the CCG now the ability to nominate four of the eight Trustees for terms of four years to service on the Trusts and that the recruitment of these trustees was undertaken by the Talbot Trusts, with nominations made to the CCG. Finally, she advised Governing Body that two vacancies still remained and that the CCG was in discussions with the Talbot Trusts to discuss how it could help them to support the recruitment process.

The Governing Body:

- Confirmed the re-appointment of Dr Zak McMurray as a CCG Nominated Trustee for the period of 10 December 2016 to 9 December 2020
- Confirmed the appointment of Mr Neil Charlesworth as a CCG Nominated Trustee for the period of 1 September 2016 to

31 August 2020.

- Noted that Mr Ronald D Jones stood down as a CCG nominated Trustee on 8 December 2016.

32/17 2016/17 Finance Report

The Director of Finance presented this report which provided Governing Body with the Month 11 results and the key risks and challenges to deliver the planned year end surplus of £3.5m (0.5%). She advised Governing Body that, whilst she was not reporting any material improvements, there had been a slight improvement at Month 11 with an increase in the level of reserves available to mitigate any financial risks in the final month of the year. With regard to Month 12, she advised Governing Body that final activity data from Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) would not be available until the following week.

The Director of Finance drew members' attention to section 2.1.8 that explained the rationale behind the requirement from NHS England (NHSE) at the planning stage that all CCGs held back 1% of non recurrent reserves as uncommitted as they had anticipated that there would be pressures in the whole system and that the Trust sector would be struggling to reach its expected financial position and have an overall deficit position. She advised that a formal instruction from NHSE had now been received advising that all CCGs were to release these reserves at Month 12 which meant that our year end surplus would increase to £11.6m which we would be expected to carry forward, although we would not be able to access that until the end of the planning cycle in 2020/21. She explained that we had also been required to hold 0.5% of our non recurrent reserves as uncommitted in 2017/18

With regard to the key budget movements of £26k Governing Body was being asked to approve, as set out in section 4, the Director of Finance advised that these related to changes to financial contributions from Sheffield City Council budgets to the Better Care Fund, which were required to be signed off by both Governing Body and SCC's cabinet as part of the Section 75 Agreement.

The Governing Body:

- Considered the residual risks and challenges to delivery of the planned £3.5m surplus.
- Noted that this surplus was expected to rise to £11.6m at year end with the release of £8.1m reserves as required by NHS England.
- Approved the Better Care Fund budget changes set out in Section 4.

33/17 Update on Quality, Innovation, Productivity and Prevention (QIPP) Plan for 2016/17

The Interim Director of Commissioning and Performance presented an update on progress with implementation of the CCG's Quality, Innovation, Productivity and Prevention (QIPP) Plan for 2016/17. He drew Governing Body's attention to the key highlights.

At month 11 we had achieved £11.352m (66%) of our £19.4m QIPP plan, £5.72m behind plan, and at year end were forecasting a £12.7m delivery, £6.7m behind target. For 2017/18 we had a QIPP target of c.£21m, but felt we needed an internal stretch target of £25m. An update in terms of developing, and the documentation around our 2017/18 QIPP plans was set out on pages 5 and 6. The Interim Director of Commissioning and Performance advised Governing Body that we were also putting together a series of meetings with the teams to look at the plans in more detail and to put them in place, with the onus being to deliver. He also advised that there was a collective responsibility to deliver those plans and, in this respect, we needed to a workforce that was skilled to deliver, had an understanding of programme management, and would ensure that plans were transacted on the ground.

Mr Taylor, Chair of the QIPP Sub Group, commented that, as we measure our QIPP in financial terms, it was often seen as a cost-cutting exercise, even though it was actually about changing the way we do things. His thoughts were that we were in a much better position in 2017/18 than we had been in 2016/17 when we had started the process late in the year, so should have a much better chance to deliver our plan. He commented that we had a series of schemes totalling £21.5m but there was still work to be done to fully develop a lot of those schemes.

The Chief Nurse commented that it was also about patient experiences in the services we commissioned, that it gets harder every year. We needed to make sure the morale of staff was maintained, acknowledge how hard they had worked to achieve this position, and to ensure they were given all the tools and training they needed to be able to deliver.

The Accountable Officer acknowledged that it was a significant achievement for the staff as savings of approximately £13m had not been made before, even though this was short of the target. She commented that it was true transformation that we were doing now, which did not happen overnight, but was disappointed that some of the plans were not as robust as they could be and, in this respect, advised that the teams were working really hard with the senior leadership team to understand why and there was a real determination for the schemes to be successful.

The Accountable Officer also advised that, in 2016/17, the Medicines Management and Continuing Health Care (CHC) teams had fully achieved their targets and had asked them to present further information on this to Governing Body in May.

Finally, the Interim Director of Commissioning and Performance congratulated the whole organisation, the practitioners across the system, and the patients, for supporting all the changes. He advised that, with regard to the 2017/18 programme, they were now looking at resource plans, and may need to look to Governing Body for support if additional resources were required.

The Governing Body:

- Noted the revised forecast in relation to the total QIPP saving that was

due to be achieved in 2016/17.

- Considered whether there were any issues it would like the QIPP Sub Group to pursue to support the development of the 2017/18 QIPP Programme, as noted above.

34/17 Quality and Outcomes Report

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

a) Referral to Treatment Times for Non-Urgent Consultant-Led Treatment: Both STHFT and Sheffield Children's NHS Foundation Trust (SCHFT) continued to meet the national standard of 92% of all patients waiting less than 18 weeks for treatment to start. However, STHFT had had 17 breaches (seven of which were for Sheffield CCG patients) between December and February of patients waiting more than 52 weeks for treatment to start, which they had advised had been due to a letter created but not printed problem the trust had had with the Lorenzo IT system, but which they had assured us was now resolved.

b) Diagnostic Test Waiting Times: Both acute trusts were achieving above the trajectory of 99% of patients waiting six weeks or less from the date they were referred

c) A&E Waits: Mrs Kate Gleave, Interim Deputy Director of Strategy and Integration, advised Governing Body that NHS England had set targets for March for all providers across the country, with the expectation that STHFT would achieve 89%. She advised that we had fed back to NHSE that, as a system, we felt that we had not achieved the target as the trust had only achieved 87.86%, which had not been accepted by NHSE. She also advised members that SCHFT had achieved 95.33% at the end of March against a target of 96.5%.

Members commented that it would be really helpful for them to know what the A&E attendance rates were as their understanding was that the problems with waiting times were about blockages rather than the department being busier than usual. The Medical Director advised that they did have spikes in A&E but, if anything, it had 'flat lined' in Sheffield over the past few years, and commented that perhaps it was the complexity of the cases that had increased.

Mr Boyington joined the meeting at this stage.

d) Cancer Waits: Although the CCG meeting all the cancer waiting times pledges to date, STHFT's performance for the 62 day maximum wait from urgent GP referral had deteriorated from 85.6% in December to 80.17% in January and they were not meeting three of the pledges in-month in January. The Interim Director of Commissioning and Performance advised Governing Body that some of this related to internal trust issues but some of it was compounded by inter-trust

referrals. He advised that a sub group of the Cancer Alliance had been tasked with looking at that.

e) Mental Health Measures: The Interim Director of Commissioning and Performance advised Governing Body that December data for Access to Psychological Therapy (IAPT) showed that 50% of these patients were now moving to recovery, which meant this, and all other, mental health measures targets were now being achieved.

f) Composition of 2016/17 Quality Premium: The Interim Director of Commissioning and Performance advised Governing Body that the CCG would achieve its planned level of performance for delayed transfers of care (DTOCs) from hospital.

g) Previously Unassessed Periods of Care (PUPOC): The Interim Director of Commissioning and Performance advised Governing Body that we had met our plan and completed our trajectory, therefore no further update in this report was required.

h) Quality

The Chief Nurse advised Governing Body of the following:

(i) 12 Hour Trolley Waits: Together with the Medical Director and Clinical Directors, she had reviewed the two cases in some detail, and had felt reassured that neither patient had come to any harm, and assured about the process undertaken to investigate the reasons for the waits.

(ii) Care Quality Commission (CQC) Regulatory Reviews: The CQC had presented a draft final report on their findings from the inspection undertaken at Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) in November 2016, at the Quality Summit held earlier in the day. The trust had been rated as Good overall, however, two of the areas rated as Not Good related to whether services were safe, and the numbers of staff that had undertaken mandatory training, which was a key performance indicator. The Chief Nurse advised Governing Body that a draft action plan had been produce by the trust, performance against which the CCG would be monitoring.

Ms Forrest, advised Governing Body that the trust's training plan was an issue and concern that was discussed at each meeting of the CCG's Quality Assurance Committee (QAC). The Chief Nurse advised that the trust had advised at the summit that training compliance was now 80% and so felt assured that they understood the problem and their Executive Team was taking this forward.

i) Other Issues

a) The Interim Director of Commissioning Performance advised Governing Body that the number of unwanted pregnancies in the under 18 population had reduced from 50+% to 23.6%, which was

a real step change. The Director of Public Health commented that this was a real success story and advised Governing Body that one of his next target areas over the next few years related to smoking cessation in pregnancies and getting the risk message across to the 800 mothers that were still smoking. Dr Bates advised Governing Body that this had been raised as a big issue at the recent Protected Learning Initiative (PLI). The Director of Public Health also advised that SCC's resources were being directed into enforcement of tobacco control.

b) Professor Gamsu asked if the CCG should be an Exemplar from the Improvement and Assessment Indicator relating to the proportion of people with a learning disability on the GP register receiving an annual health check (page 25). Dr Sorsbie advised Governing Body that she was aware, as part of the monthly learning disabilities portfolio team meetings, of which practices were and were not doing this, but the problems were in inviting people to come in for the checks and for practices to do them. The Interim Director of Commissioning and Performance agreed to seek clarity on this, discuss further with Dr Sorsbie outside of the meeting, and then advise if Governing Body was the right forum for this to be discussed in. **MP**

Dr Sloan and Mr Wike joined the meeting at this stage.

c) Dr Sorsbie drew members' attention to the Improvement and Assessment Indicator relating to people with diabetes diagnosed less than a year ago who attend a structured education course, and commented that Governing Body needed to understand where these people were coming from, and also advised that if they spoke no English then they had no access to that course, which was something that had never been addressed. The Interim Director of Commissioning Performance agreed to seek clarity on this and send a briefing note to members. **MP**

Finally, the Chair commented that there were a lot of positive messages and information included in this report, some of which would be included in the CCG's annual report. The Accountable Officer advised Governing Body that she would be reviewing how this was communicated to members of the public, our own staff, Membership, and partner organisations. **MR**

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
- Noted the assessment against measures relating to the Quality Premium.

35/17 Update on Urgent Care in Primary Care

Mrs Kate Gleave, Interim Deputy Director of Strategy and Integration, and

Mr Alastair Mew, Head of Commissioning, Urgent Care, were in attendance for this item.

Mrs Gleave presented this report which provided Governing Body with an update on progress made over the past month and the actions planned to take place over the next two months. She reminded Governing Body that in November 2016 they had approved a revised Strategic Direction for Urgent Care, which had been divided up into four deliverable work streams, and advised that the team was currently in the process of undertaking a review as what it would look like to redesign the system going forward, which would include looking at right sizing, need and demand in the right areas, and the right service with the right person treating the person in the right area.

With reference to minute 26/17(c), above, Mrs Gleave advised Governing Body that she would ensure that the briefing note that had been prepared to provide them with an update on progress with the impact of the six key focus areas against their metrics was circulated following the meeting. **PM(KG)**

Mrs Gleave reminded Governing Body that in February 2017 they had agreed a process to develop options, undertake a formal consultation on these and implement the resulting option. The team had now passed the stage 1 checkpoint of the Major Service Change assurance process and were progressing towards the stage 2 checkpoint. She noted that the team had reviewed the previously articulated options and were not convinced that they were right for Sheffield. She advised that in the last few weeks the team had been looking to work up a revised set of options and a system that would also encompass urgent care for patients with eye, dental, and mental health problems, as well as urgent care for children. The main aims were to reduce duplication of services, simplifying access, reducing pressure on A&E departments, making sure there was sustainable support and resource for primary care in hours, provided value for money, and was based on what we would need in five years' time. We needed to be considering the whole Sheffield population for either need, access or demand, incorporate all the "must dos", be very clear why we were doing them, what the evidence was for change and how we could make them fit.

She advised that, as a result of this, the team had felt that the timescales were extremely challenging, and so had taken proposals back to the CCG's Senior Management Team (SMT) to elongate these. She advised that the SMT had agreed to elongate the timescales by one month, which meant that options would be presented to Governing Body in public on 25 May and then to go out to formal consultation from 1 June to 8 September, with final recommendations presented to Governing Body in public on 5 October.

Mrs Gleave advised Governing Body that progress over the past month had included preparing a more detailed plan as to what they needed to do over next the few months, with most of the focus being on what the options would look like and testing those out with the wider stakeholders including conversations with vulnerable groups, stakeholder engagement

with providers, and attendance at the Overview and Scrutiny Committee (OSC) and Health and Wellbeing Board.

The Accountable Officer advised Governing Body that part of the Five Year Forward View (FYFV) delivery plan included a nine step delivery plan which included actions that needed to be incorporated into the options for consultation to be presented on 25 May. **PM(KG)**

Professor Gamsu congratulated Mrs Gleave and the communications and engagement team on the work they were doing around engagement which included proactively going out and talking with people in focus groups, with students, and with vulnerable people. He commented that the challenge was how to capture and share that in the report and then to consider how we could embed some of these approaches into our broader discussions.

Finally, the Interim Director of Commissioning and Performance congratulated Mrs Gleave on her excellent delivery of this report and update.

The Governing Body:

- Noted the progress made over the last month.
- Noted the actions planned for the next eight weeks.
- Considered and accepted the intention to present revised options in outline at the 25 May Governing Body meeting.

36/17 Delivering Quality, Innovation, Productivity and Prevention (QIPP) and the Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) Contract

Mr Jim Millns, Assistant Director of Contracting, was in attendance for this item and presented this report which provided members with a further briefing on the approach the CCG was taking with regard to the delivery of the QIPP and the SHSCFT contract. He advised Governing Body that the approach taken had included undertaking a series of workshops over the past few weeks, to which other interested parties (ie senior clinical and operational staff from the CCG, SHSCFT and Sheffield City Council) had been invited to attend. He advised that, from these workshops, 27 project areas had been identified, which had now been whittled down to 13 costed areas and three still to be costed. Of these, four major schemes had been identified (as set out in section 2.1) which would form the foundations of the transformation programme: supporting independent living, dementia care pathway, liaison mental health, and developing a primary care mental health and wellbeing service. He also advised that around two thirds of the overall mental health QIPP should be achieved, and that there was a desire to work together, with enthusiasm continuing to manifest, but there was a lot of work to be done.

Mr Millns advised Governing Body that, although not much consultation with service users, carers and the general public had taken place so far, it was planned to consult more proactively once service plans for those four areas had been worked up. The Interim Director of Delivery – Care

Outside of Hospital advised Governing Body that the CCG's engagement team would be doing everything it could to help shape and support how best to do that.

Ms Forrest asked how much time had been lost with procurement of the mental liaison service following the withdrawal of financial support from STHFT. Mr Millns explained that, as set out in section 2.1, the tender process had been paused in November 2016, as STHFT, as our co-commissioner, had withdrawn their financial support, and so we were in the process of undertaking a review of all hospital based psychology services in the city, which had previously been excluded from the liaison specification. However, we were not in the implementation stage at the moment, but the resource for existing services had been maintained and there had been no reduction in service during this intervening period.

The Medical Director advised Governing Body that the amount of clinical buy-in to this was huge and it felt as though we were really starting to join this together, and needed to use the resource that was there, and to consult the public on it.

The Governing Body:

- Considered and accepted the report.
- Agreed to accept a further update midway through the year, once the delivery stage was well underway.

Ms Forrest left the meeting at this stage.

37/17 City-wide Localities Group Report

Dr Sorsbie presented this report which, she advised, had been developed by the City-wide Localities Group (CLG), and reported on all the key themes across the localities as well as specific locality initiatives. She advised that the CLG had requested that Governing Body consider the themes and activity, the issues and pressures within localities and the questions they would like Governing Body to respond to. She reminded Governing Body that they had felt that previous reports had not reflected the amount of work going on at locality level, and the collaboration and joint working between the localities. The report was the first attempt to try and communicate that formalisation.

Dr Sorsbie advised Governing Body that key issues currently being discussed included urgent care and the GP Five Year Forward View (GPFYFV). With regard to the latter, she advised Governing Body that the CCG's Programme Director Primary Care and the Primary Care Co-Commissioning Manager had put together a programme for Practice Managers which had included a very successful practice managers' meeting that had received good feedback. She also advised that over 50 practices had signed up to take part in the Productive General Practice Programme.

Dr Sorsbie advised Governing Body that neighbourhood working was still at a really early stage, and it was about practices starting to learn how to

work together in a way they had not done before. The Neighbourhood Strategy would give them the way to do that and do it consistently across the city. However, the challenges were huge, especially around workforce and the vacancies that were starting to appear.

Dr Sorsbie drew members' attention to the questions for Governing Body from Member practices and localities, that were set out at section 5:

5.1.1 What process will be developed for neighbourhoods to access funding in order to deliver their local initiatives?
5.1.2 When will recurrent funding be available to neighbourhoods to develop local services for their population needs?
5.1.3. What budget and finance information will be provided in order for neighbourhoods to measure success in their objectives.
5.1.4 What will be the ask of practices in the delivery of Urgent Care.

The Chair commented that he was aware that some members of Governing Body were not aware as to what was going on and, in this respect, advised that the neighbourhoods and general practices was where it all got synthesised back together again. He advised that the most transformational part of the STP was around what people were doing in communities and this was the most important part of how we were making it happen. The CCG's partners needed to be confident that we have services and capacity to shift those services from secondary to primary care and it was also around confidence in the CCG by members of the public. He commented that the influence of Governing Body on these developments had been great and would continue to be great but only if we could find the resource to support it.

With regard to the questions asked of Governing, the Chair commented that he would particularly pick the third one: What budget and finance information will be provided in order for neighbourhoods to measure success in their objectives, but if we were going to make significant investment that we would need to have data that backed up what we were attempting to do. He also felt that this report should be presented to Governing Body on a regular basis so people could be kept informed about what was going on.

The Interim Director of Delivery – Care Outside of Hospital advised Governing Body that there was a process for developing and supporting local developments, and there was becoming an eagerness in general practice to get some developments going. She commented that this would be looked at first to recognise if it was a city-wide scheme or a neighbourhood development, and also looking at the CCG;s locally commissioned service approach, how to support it better, and do it through a neighbourhood investment. She also advised Governing Body that the Central Locality Manager had recently circulated a primary care dashboard to support the FYFV which we needed to bring forward to support neighbourhoods and to help practices and localities understand where they really need to be.

The Central Locality Manager advised Governing Body that we needed to be able to measure what the primary care budget is as well as

demonstrate variance between practices so that we can start to understand why. The Interim Director of Delivery – Care Outside of Hospital commented that the ambition would be to create the space for where we need a continuity of care response at the same time as providing the urgent care response and from a neighbourhood we would be setting that out. She advised that we would be developing a maturity index and linking it to the locally commissioned services and, to support some of that, would be writing to the neighbourhoods asking them what the offer of support was that they would be looking at. The Accountable Officer suggested wrapping this into the paper that the Interim Director of Delivery would be presented to the 4 May Governing Body strategic development session.

The Director of Public Health commented that this report was one of the most important papers presented today and he asked what the method was for co-ordinating this as a partnership. The Interim Director of Delivery explained that at the moment it was very much about active support and recovery that included localities, health care trusts and the voluntary sector so from a partnership point of view it was very well informed, and was about process and culture, and not about governance arrangements. The Central Locality Manager advised that they had tried to engage with the Local Authority but sometimes struggled to identify who to engage with. The Director of Public Health would provide contact names and details.

The Director of Delivery suggested to bring further updates back on a bi-monthly basis initially, and suggested to accompany it with a report from the commissioners and what they were doing in response to the neighbourhoods.

The Governing Body considered and commented on the report, as noted above.

38/17 Reports circulated in advance of the meeting for noting

The Governing Body formally noted the following reports:

- Future Child Health Service Model (Acutely Unwell Child) *(to support*
- *main agenda item 8 (paper D)*
- Chair's Report
  The Chair drew members' attention to the report included at Appendix A that summarised the headline findings and concluding comments from the two consultations, as part of Commissioners Working Together (CWT) that had taken place to gather the views of patients, members of the public, and others, with an interest in proposals to change the way hyper acute stroke and children's surgery and anaesthesia services were delivered across South Yorkshire, Bassetlaw and North Derbyshire. He commented that it was interesting to see these responses and to get so many different perspectives and recommended it to Governing Body for reading.

The Governing Body formally noted the following reports:

- Accountable Officer's Report

- Report from the Quality Assurance Committee meeting held on
- 8 March 2017
- Joint Committee of CCGs Minutes
- South Yorkshire and Bassetlaw Collaborative Partnership Board Minutes
- Update on Serious Incidents
- Complaints and MP Enquiries Quarterly Update
- Sheffield Green Commission Update
  Dr Sorsbie advised Governing Body that one of the recommendations from the CCG's Medicines Management Team (MMT) was to prescribe a new inhaler (Braltus) where patients get a whole new device each month, rather than just a refill strip, which they have with the previous brand of choice (Spiriva). However, she advised that, whilst this was more cost effective to the CCG, it was not with regard to the carbon footprint as not all pharmacies had the recycling facilities to dispose of these empty containers. She advised that the CCG's Medicines Management Team (MMT) was taking this forward.

39/17 Confidential Section

The Governing Body resolved that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

40/17 Any Other Business

There was no further business to discuss in public this month.

41/17 Date and Time of Next Meeting

There will be a short meeting in public on Thursday 4 May 2017, 2.00 pm – 2.30 pm, when Governing Body will be asked to comment on, and adopt, the CCG's unaudited annual accounts and annual report for 2016/17.

The next full meeting in public will take place on Thursday 25 May 2017, 2.00 pm – 5.00 pm, Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU

Appendix A

Statements and Questions from Mr Mike Simpkin, Sheffield Save our NHS, to the CCG Governing Body 6 April 2017

Statement / Question 1: Paper K on what is called 'Mental Health Transformation' is one of the most dismaying papers we have seen presented to public sessions of the CCG Governing Body. We recognise that the CCG and Council have unified their commissioning budgets in order to work with providers to try and achieve the level of cuts they have set themselves although we cannot support this exercise. We note that the cuts are being classed as QIPP efficiencies, a programme with a chequered history of achievement. This enables commissioners to dress up proposals whose principal driver is cost savings as bringing benefits to patients

CCG response:

We understand your concerns but it is absolutely not the case that this is being driven by cost savings rather than benefits to patients. The purpose of this approach is to improve care and outcomes for patients in Sheffield.

The rationale for NHS Sheffield CCG and Sheffield City Council pooling our mental health commissioning budgets is to ensure that health and social care services are much better co-ordinated around the individual. It is not about making cuts but ensuring that the right care is offered at the right time and in the right place.

All the evidence we have reviewed suggests that integrated care is the right direction of travel for meeting the changing needs of our population, particularly in the context of increasing numbers of older people and people with long-term and complex conditions. It is also very clear that fragmented and disjointed care can have a negative impact on patient experience, result in missed opportunities to intervene early, and consequently can lead to poorer outcomes. Poor alignment of different types of care also risks duplication and increasing inefficiency within the system.

As stated above, the benefits we will achieve for patients in Sheffield are, quite simply, better care and outcomes. These will arise from more effective joined up commissioning and provision of services. This will also deliver better value for public money meaning we can invest in other areas. Pooling our resources (in the widest sense) will enable us to commission whole pathways of care, factoring in other services which were previously not in the scope of traditional commissioning models, such as employment, housing and education.

Historically commissioning plans have been largely developed in isolation by each separate commissioner. Although we have made significant improvements in Sheffield over recent years, segregated commissioning approaches have led to disjointed services and resulted in unintended consequences to different component parts of much wider care pathways. Similarly, opportunities to consider broader clinical and societal benefits, looking at much wider care pathways have never been fully exploited. Our aim is 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.

These proposals do form a key part of our QIPP programme, which we are genuinely approaching in the way QIPP was intended. This is not 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.

We hope this reassures you that improving the quality of care for patients is very much the motivation for this approach. We do envisage that this will ultimately help in terms of addressing the financial pressures faced by both organisations, not by making cuts but by commissioning improved services that will drive out efficiencies.

Statement / Question 2: Many of the assumptions in the four main projects described are open to challenge – for example the talking down of residential care for adults – a stance that, as with children in care, is subject to pendulum evaluation. Residential care may sometimes be the best option

CCG response:

Our assumptions are predominantly based on clinical evidence and national best practice, consolidated through input from a variety of different clinicians. While this doesn't automatically mean that each of the proposals will work in Sheffield, we feel that transformational change needs to be based on robust and fully evaluated evidence rather than preconceived beliefs and aspirations. This is therefore the approach we have chosen to take but we actively welcome any challenges, which will help us in terms of shaping our proposals and ensure we consider all relevant information.

In terms of your point regarding residential care, we totally agree that for some people this will be the best option. However, for many others it will not. Sadly, residential care is often the only option available for some individuals, regardless of their needs or personal choice, and this is what we are committed to rectifying.

Statement / Question 3: The paper complains about the unsuitability and cost of hospital care for people with dementia yet the CCG stood by while Hurlfield View, whose services were intended to reduce the need for hospital was being readied for closure; furthermore the CCG is transferring purchasing for Birch Avenue and Woodland View away from block contract, thus undermining an already fragile care economy. Where exactly will the savings come from?

CCG response:

We have to dispute your assertion that the CCG 'stood by' whilst Hurlfield View was 'being readied for closure'. As you will be aware, Hurlfield View was commissioned by Sheffield City Council to provide residential respite care. Throughout the tender process and subsequent closure programme, we sought and received regular confirmation and assurance regarding all aspects of the programme, including information on the services that have now been commissioned in place of Hurlfield View and how these can be accessed. Services have been commissioned on a like-for-like basis from a number of different organisations across the city. We are therefore assured that there has been, and will be, minimal impact on the care commissioned for this very specific purpose.

In terms of the Birch Avenue and Woodland View nursing home contracts, these continue to be commissioned on a block contract. Whilst you are correct that our longer-term aspiration is that these services will eventually be commissioned on a cost-per-case basis, we feel this is the most appropriate approach. Currently, when there are empty beds at Birch Avenue or Woodland View, these continue to be paid for in full and this money could be better used elsewhere to provide care for people who need it.

As outlined in the paper to Governing Body, savings will come from reducing inappropriate admissions and delayed transfers of care, and introducing a much more seamless care pathway, which promotes independence and personal choice. Again, this is an example of where improvements to current services can be made which will also result in better value for money.

Statement / Question 4: The paper's implication that people with dementia are being deprived of civil rights by being sectioned because appropriate care is not available is highly disturbing especially as the paper reads as if it is more concerned with the overall financial implications – including the inability to charge for hospital services - than with those for patients

CCG response:

We agree entirely that the inappropriate use of the Mental Health Act is indeed disturbing. The paramount issue is absolutely the impact this is having on patients and we are committed to ensuring this is investigated and, where required, addressed immediately.

In addition, there are financial implications which also need addressing, particularly in light of s117 aftercare costs. The issue here is not about trying to avoid paying for an individual's care, it is about eligibility. Isolated clinical practice should not create significant inequity in terms of access to funded aftercare. The Mental Health Act should be administered correctly, which in turn should mean that only those who are genuinely eligible for funded aftercare services receive these. We potentially have a situation where

the Act is being used incorrectly, which is artificially changing eligibility criteria. The CCG has a statutory as well as moral duty to rectify this.

Statement / Question 5: The crucial area of Mental Health Liaison appears to be in chaos and it is not clear how this was or is being tendered for

CCG response:

The Mental Health Liaison development is not in chaos. We are currently reviewing the commissioning arrangements for this with all parties involved and are also using the opportunity to reassess the overall scope of the project so have paused the competitive procurement exercise while this takes place. This has not affected the current service which is continuing as usual.

Statement / Question 6: The issue of appropriate support for people with significant mental health problems who live in the community also reads as if it is based on financial and administrative priorities despite references to 'paternalistic' secondary care. Our own assessment is that the number quoted, 600, is astonishingly low, meaning that transfer to a different system may be more difficult than suggested. The paper recognises issues about patients feeling 'dumped' but seems grossly to underestimate the damage which system transfers can cause or the time and care needed to achieve them – especially when the receiving system (primary care) is under severe challenge. Problems with the budget for social prescribing (paper C) are also relevant

CCG response:

We are starting with an initial 600 patients who Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) have identified as being stable and ready to enter the next stage of their recovery. We are working closely with our primary care colleagues to try and determine what is needed to enhance services to enable this cohort of patients to be transferred back into primary care, safely and with a continued focus on recovery.

This will require some degree of investment but we anticipate that the eventual service will be capable of reducing onward referrals as well as accepting referrals from secondary care. We accept that this is not a straight forward development, and one which will require cultural as well as structural changes. However, the evidence from areas that have already started this process is really encouraging, with reductions in secondary care usage and genuinely integrated primary and secondary care services.

In fact, our aspiration in future is that we stop using terms such as 'secondary' and 'primary' care, and instead focus on the needs of every individual and how these can best be met in line with personal goals and choice. For example, we know that people who have mental health issues are far more likely to have comorbid physical health issues so we want to eradicate the delineation between mental and physical healthcare so that people receive treatment based on their needs rather than organisational parameters. The development of a primary care service will, we feel, genuinely promote this and grow to support far more than the initial 600 patients we are starting with.

Statement / Question 7: It is of course good that commissioners and providers are coming together to try and create a positive approach for how services should change. There are sufficient references in the paper to suggest that they recognise some of the likely effects on patients. What is surely not acceptable is talk about the changes as progressive rather than mitigating the effects of expenditure reduction. There may be genuine positive developments, but it is hard to find credibility in the overall approach. Of course we stand against any expenditure reduction

CCG response:

We do believe that these are progressive changes, which will support our commitment to the parity of esteem principles set out in the Five Year Forward View for Mental Health.

We completely agree that expenditure reduction as an isolated exercise is not justifiable and this is not the driver for our approach. Whilst there are many fantastic examples in Sheffield of high quality, compassionate mental health care, there are some areas that we know can be delivered better and these are the areas that we are focusing on.

We also have a statutory duty to ensure that we get maximum benefit for the money that we spend both in terms of patient experience and clinical outcomes. Focusing on QIPP principles, our aim is to deliver a better offer for people in Sheffield, which we also anticipate will make efficiency savings in both 2017/18 and 2018/19 through more effective working.

Statement / Question 8: How does the scale (what %?) of cuts fit with the CCG's commitment to parity of esteem?

CCG response:

NHS Sheffield CCG is fully committed to parity of esteem, both from a contextual as well as financial perspective. We are still planning to meet the investment standard in both 2017/18 and 2018/19, and have confirmed this to NHS England in a jointly signed letter with Sheffield Health and Social Care NHS Foundation Trust (SHSCFT).

Statement / Question 9: What is the current nature of the procurement for Mental Health Liaison Services?

CCG response:

As explained earlier, the tender is temporarily on hold as we are reviewing the commissioning arrangements and scope of the project.

Statement / Question 10: What levels of disclosure and patient / frontline staff involvement will there be in considering these projects?

CCG response:

Whilst the component elements of the transformation programme are at very different stages, we are committed to ensuring that service users, carers, staff and the general public are actively involved in this work and supported to contribute to individual projects, which we know is essential to achieve improvements for patients. We are currently developing an engagement plan with Sheffield City Council and Sheffield Health and Social Care NHS Foundation Trust, which will include learning from good practice used in other areas of our work.

Statement / Question 11: What will happen if the projected savings are not achieved as quickly as indicated, something which happens a lot under QIPP?

CCG response:

As you are aware, we are undertaking the Mental Health Transformation Programme jointly with Sheffield City Council and Sheffield Health and Social Care NHS Foundation Trust. This has instilled a sense of collegiate and collaborative working, coupled with a degree of joint accountability and there is cross-organisational commitment to ensure that the efficiency programme is delivered in full.

We therefore do not anticipate any underachievement, but to ensure effective programme management, we do have a contingency plan. This is based primarily on the fact that our plan is set to achieve a ‘stretch’ target, which is greater than the actual QIPP requirement, and we have a series of alternative projects to consider if the need should arise.