Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Governance Report

Governing Body meeting

C

4 September 2014

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Is your report for Approval / Consideration / Noting

Consideration and noting

Are there any Resource Implications

None

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?

This paper supports the following principal risks identified in the assurance framework:
1.1 Supports public confidence through good communication
5.4 Supports the development of leadership
5.5 Adheres to governance arrangements to support the Nolan Principles

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? No

If not, why not? Not applicable

PPE Activity

How does your paper support involving patients, carers and the public?
Not applicable

Recommendations

The Governing Body is asked to:

- Note NHS England's approval of the CCG's revised Constitution
- Consider the implications of terms of office for GP members of the Governing Body
- Note the arrangements for planning of the next Members' Council
- Note the new governance management arrangements
- Approve the proposed dates for Governing Body meetings for 2015/16

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1. Introduction

This report updates the Governing Body on four areas of governance:

- NHS England's approval for minor revisions to the CCG's Constitution;
- The tenure of locality nominated GP members of the Governing Body and possible impact on the current Chair role.
- The process for planning the October Members' Council
- Arrangements to cover the Company Secretary / Head of Corporate Governance role following their departure on 28 August.

2. Revisions to the NHS Sheffield CCG Constitution

At the July meeting of the Governing Body I reported that, following due process, minor revisions to the NHS Sheffield CCG Constitution had been submitted to NHS England.

NHS England has agreed that the proposed changes comply with the particular requirements of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and accordingly, the changes are now formally approved. Therefore, in accordance with section 14J of the Act, the revised constitution is now published and available at:

http://www.sheffieldccg.nhs.uk/Downloads/CCG%20Corporate/CCG%20CONSTITUTION%20revised%20July%202014.pdf

3. Governing Body Locality Nominated GP Members

In accordance with the NHS Sheffield CCG Constitution, the GP membership of the Governing Body comprises:

- 4 GPs (elected city-wide representatives)
- 4 GPs (nominated locality representatives)

The original appointments for all GP Clinical Leads on the shadow Governing Body ran from October 2011 to October 2012. However, at its May 2012 meeting, Governing Body agreed that the stringent programme for authorisation assessment due in September 2012 would require measures to ensure stability for the CCG. Therefore the tenure of all of the Governing Body GPs (city-wide elected and locality nominated) was extended to October 2014.

However, in April 2013, a further review recognised that by having all GPs Clinical Leads (elected and nominated) with the same length of tenure, the CCG was at risk of the Governing Body not being fully constituted at all times. To address this, a cyclical

programme was put in place that would ensure no more than 50% of seats are offered at any one time. Following due process the Membership mandated the four city-wide GPs for a further three years until October 2016.

In addition, in April 2013, it was agreed that the procedure for nominating the four locality representatives should be no less robust than the process for electing the four city-wide representatives and the localities agreed to confirm a consistent approach to recruiting their GP representatives across the CCG.

To summarise:

Date of Decision	Decision
October 2011	All GPs (locality and city-wide) initial term of office until October 2012
May 2012	All GPs (locality and city-wide) extended to October 2014
April 2013	City-wide GPs mandated until October 2016

Locality Managers have confirmed the process for locality nominations and are asked to submit details of their nominated representative to Tim Furness, Director of Business Planning and Partnerships by 31 October.

4. Chair of Governing Body

The current Chair of the Governing Body is mandated to 31 October 2015 and is also a Locality nominated GP. Should Dr Moorhead decide not to put himself forward for locality nomination, or fail to be nominated by the locality, the position of Chair will become vacant. Governing Body is reminded that, in accordance with the CCG Constitution and Standing Orders:

- The Chair is elected by the Governing Body and chosen from one of the four locality nominated GPs or one of the four city wide elected GPs.
- Only members of the Governing Body are eligible to vote, either by a show of hands or private ballot.
- The individual must be a GP from a Member practice, must meet the required competencies for the role as set out in paragraph 7.4 of the Constitution and in terms of the initial appointment have passed the national assessment centre for CCG Clinical Leaders.
- The Chair will be nominated for a term of office up to three years
- The Chair must give at least three months' notice
- The Remuneration Committee will oversee the appointment process.

Should Dr Moorhead not remain on the Governing Body after 31 October 2014, the Governing Body will need to elect a new Chair in accordance with the above.

5. Members' Council

At the April Members' Council, members debated a number of key issues (appendix 1). The matters raised have been considered by the appropriate Portfolio Manager and a draft response will be presented to the Commissioning Executive Team and Planning and Delivery Group. The final response will be presented to members at the next Members Council (16 October). Kate Laurance, Senior Commissioning Manager, is the overall lead for this work.

A survey has been undertaken to assess Members' preference for timing and venue for future meetings. A "virtual" planning group, comprising of clinicians and managers from primary care is developing the agenda and structure for the October meeting.

6. Governance Management Arrangements from 29 August 2014

A major focus of the Company Secretary's role was initially on establishment and authorisation of the CCG. With that achieved, the Executive Team has decided that, rather than recruit directly to the same role, the following will be put in place:

- The Director of Business Planning and Partnerships, will assume Executive responsibility for Governance, including Governing Body level matters and chairing the Governance sub-committee
- A Head of Governance and Planning will be recruited to undertake most of the governance aspects of the previous company Secretary role and to lead the planning function.
- The Membership Office, under the Chief Operating Officer's direction, will be responsible for membership issues including the Members' Council
- The Chief Operating Officer will be responsible for the quarterly assurance process with NHS England.

7. Dates for Diaries

- Members are reminded that the Annual General Meeting will take place on Thursday 11 September 2014 from 2.00 pm to 4.00 pm, at the Workstation, 15 Paternoster Row, Sheffield S1 2BX.
- Proposed dates for Governing Body meetings for 2015/16 are:

2 April 2015
7 May 2015
4 June 2015
2 July 2015
3 September 2015
1 October 2015
5 November 2015
3 December 2015
14 January 2016
4 February 2016
3 March 2016

8. Recommendations

The Governing Body is asked to:

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Paper prepared by Linda Tully, Company Secretary and Head of Corporate Governance
On behalf of Ian Atkinson, Accountable Officer
26 August 2014

APPENDIX 1 – Key Messages from Members' Council 30 April 2014

Discussion Topic	Key Themes	Response Lead
1. Spread and adoption of new services, clinical pathways, etc.	• Members would like to see improvements to SysemOne and the PRESS portal. • Clinical Reference Group could be more proactive in securing clinician buy in more broadly at the design stage • Evaluations of new pathways should be disseminated to incentivise wider take up.	Linda Cutter
2. Reducing attendances for minor illness at A&E	• Self-care amongst the public, including use of pharmacy (eg minor ailment schemes) should be promoted • We should support and empower A&E to redirect inappropriate attendance	Tim Drowley
3. Primary care capacity to meet demand, when work transfers	• Balancing a generalist role with increasing trend towards specialisation is a pressure. • There are capacity and demographics issues, particularly for practice nurses; we need to plan for succession to expand numbers and build skills. • Practices may not be able to sustain delivery by working alone (eg diagnostics) and collaboration will become more important	Katrina Cleary
4. GP commissioners reducing health inequalities	• GPs must work collaboratively with the City Council (eg determinants of health and wider social factors) • GPs need to work at a macro level by targeting more resources on populations that need a higher level of health intervention • At practice level GPs can proactively case find and deliver effective care and support for people at risk	Tim Furness
5. Cancer care reviews	• The short time-window in which to carry the review out poses practical difficulties for the practice. • Method of review delivery should be re-appraised to improve the current methodology and add more clinical value.	Sarah Burt
6. Care Planning	**Positives: -** • Care Planning has discovered some undiagnosed conditions which needed treatment; • Care Planning assists goal setting for the patient around quality of life. **Negative:-** • The reviews are time consuming. The template is long and difficult to use. • The reviews are not adequately reimbursed, leading to a loss of income for practices • Patient engagement can be low with high number of DNAs.	Sarah Burt
7. Early deaths in people with learning disability and people with mental illness	• More training and awareness raising (eg reasonable adjustments and about risk factors) required for all primary care staff. • Improve liaison with secondary care (eg in referral letters) needed when planning an admission • Improve planning to support patients and families through the hospital episode of care needed.	Heather Burns

8. Linked health visitors	• Desire for improvements to service re continuity of staffing, communication • Desire to improve focus on preventative work • Issues re teams not fully coterminous with some practices.	Kate Laurance