NHS
Sheffield Clinical Commissioning Group

Minutes of the meeting of NHS Sheffield Clinical Commissioning Group Governing Body held in public on 5 March 2015 in the Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU

A

Present:
Dr Tim Moorhead, CCG Chair, GP Locality Representative, West
Ian Atkinson, Accountable Officer
Dr Nikki Bates, GP Elected City-wide Representative
John Boyington, CBE, Lay Member
Dr Richard Davidson, Secondary Care Doctor
Amanda Forrest, Lay Member
Tim Furness, Director of Business Planning and Partnerships
Idris Griffiths, Chief Operating Officer
Dr Andrew McGinty, GP Locality Representative, Hallam and South
Dr Zak McMurray, Clinical Director.
Julia Newton, Director of Finance
Dr Leigh Sorsbie, GP Locality Representative, North
Dr Ted Turner, GP Elected City-wide Representative

In Attendance:
Dr Margaret Ainger, CCG GP (for item 47/15)
Dr Maggie Campbell, Chair, Healthwatch Sheffield
Rachel Gillott, Deputy Chief Operating Officer (shadowing)
Jane Harriman, Deputy Chief Nurse (on behalf of the Chief Nurse)
Carol Henderson, Committee Administrator
Susan Hird, Consultant in Public Health (on behalf of the Director of Public Health)
Simon Kirby, Locality Manager, North

Members of the public:
Five members of the public were in attendance.
A list of members of the public who have attended CCG Governing Body meetings is held by the Director of Business Planning and Partnerships.

ACTION

37/15 Welcome

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

38/15 Apologies for Absence

Apologies for absence had been received from Dr Amir Afzal, GP Locality Representative, Central, Kevin Clifford, Chief Nurse, Professor Mark Gamsu, Lay Member, Dr Anil Gill, GP Elected City-wide Representative, and Dr Marion Sloan, GP Elected City-wide Representative.

Apologies for absence from those who were normally in attendance had been received from Helen Cawthorne, Local Manager, Hallam and South, Katrina Cleary, CCG Programme Director Primary Care, Rachel Dillon, Locality Manager, West, Dr Mark Durling, Chairman, Sheffield

Local Medical Committee, Professor Jeremy Wight, Sheffield Director of Public Health, Paul Wike, Locality Manager, Central, and Moira Wilson, Director of Care and Support, Sheffield City Council.

39/15 Declarations of Interest

Dr McGinty, who had recently been appointed as one of five new Clinical Directors at the CCG, declared a conflict of interest in the following item and would be asked to leave the meeting for this discussion:

- Clinical Director Remuneration (paper H)

There were no further declarations of interest this month.

The full Governing Body Register of Interest is available at: http://www.sheffieldccg.nhs.uk/about-us/declarations-of-interest.htm

40/15 Chair's Opening Remarks

The Chair reported that he had nothing to bring to members' attention in addition to his Chair's report, appended as part of item 12a on the agenda, at this stage of the meeting.

41/15 Questions from the Public

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

Mr Mike Simpkin, who was attending Governing Body on behalf of Sheffield Save Our NHS, expressed appreciation for Ian Atkinson's contribution to the NHS in Sheffield and conveyed thanks for Mr Atkinson's assistance in supporting public participation in Governing Body meetings

42/15 Minutes of the CCG Governing Body meeting held in public on 5 February 2015

The minutes of the Governing Body meeting held in public on 5 February 2015 were agreed as a true and correct record and were signed by the Chair, subject to the following amendment:

Update on 2014/15 Procurement Plan (minute 28/14 refers)

Penultimate sentence to be added to first paragraph to read as follows:

The Chair of Healthwatch Sheffield asked if the decision to decommission the service was in line with the views of the patients.

43/15 Matters arising from the minutes of the meeting held in public on 5 February 2015

a) Urgent Care / Acute Pressures: Sheffield's Winter Death Index (minute 25/15(a) refers)

The Chief Operating Officer advised Governing Body that as not all the public health and provider activity data was available at the present time, an update could not be presented to Governing Body until May at the earliest. **IG**

b) Update on 2014/15 Procurement Plan (minute 28/15 refers)

The Chief Operating Officer advised Governing Body that the Local Medical Committee (LMC) had been provided with further information along with a copy of the communication that had gone out to practices about the headache and migraine service decommissioning. It was clarified that GPs could refer appropriate patients to neurology if needed, but to be aware that the clinical guidance must be followed in determining what was an appropriate referral to secondary care.

44/15 2014/15 Finance Report

The Director of Finance presented this paper confirming the financial position to the end of January 2015 and the key issues to be managed during the final quarter of the financial year. She advised Governing Body that she had no material changes to notify Governing Body about and reported that we were on track to deliver all our year end targets.

The Chair commented that, despite the reported urgent care system pressures during the winter period, Sheffield's figures for January showed that A&E activity had been below plan, so it was much more of a nuanced picture than had been reported by the media. He suggested that it would be helpful to know in due course what the learning has been for the winter period. He asked if the Chief Operating Officer could pursue this through the System Resilience Group (SRG) and circulate the detail to Governing Body. **IG**

The Chair drew attention to section 2.1.1 of the report, acute hospital activity, and expressed disappointment, as he had done in February, that Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) had not been able to take full advantage of the extra national funding available for the 18 week referral to treatment initiative as the outpatient waiting list still remained higher than the target waiting list of 13,928 patients, even though it had reduced slightly from the previous month. It was noted that whilst January activity was higher than plan, the casemix was lower than plan. Partly this reflected pressure on critical care facilities needed for more complex patients, despite additional funding being made available for extra critical beds as part of systems resilience arrangements

The Chair asked about the prescribing costs which were reported as being £42k per day more compared to the same time last year. The Director of Finance responded that both the pricing and volume of prescribing were up, with over one million items prescribed in January. This had been reviewed by the CCG's Medicines Management Team who had advised that a large amount had been prescribed for patients with respiratory problems. She also reported that the additional appointments put into primary care could be one of the contributory factors to the increase in prescribed items, although this was difficult to prove.

The Governing Body considered the risks and challenges to delivery of the increased planned surplus of £8.5 million based on Month 10 results.

45/15 Month 8 Quality and Outcomes Report

The Chief Operating Officer presented this report which reflected the CCG's statutory responsibilities and drew members' attention to the following key issues.

a) Maximum 4 hour wait in A&E: Achievement of the target remained a significant challenge at STHFT, with year to date performance at 92.68%year as at 4 March, and they continued to have a significant number of breaches. He reported that there were particular issues of flow through the system that we were aware of, some of which were due to problems with delays in the Local Authority being able to provide care in the home for certain patients, which we were working with them to address. He also advised Governing Body that Sheffield Children's NHS Foundation Trust (SCHFT) continued to be one of the better performing organisations in the country.

b) 18 Weeks: We had not seen the activity at STHFT we had hoped to see to address long waits, so there were still a significant number of people waiting over 18 weeks for treatment. However, over 99% of patients were now been seen for diagnostic testing within six weeks of being referred by their GP.

   Dr McGinty queried why the total waiting list had increased even though the waiting times for diagnostic testing had improved and asked if it could be related to GPs referring patients directly onto the electronic Integrated Clinical Environment (ICE) system. The Chief Operating Officer responded that the reduction in diagnostic waiting times would not benefit all pathways and it would depend on the breakdown of figures, but if it was about data capture and getting people in the system at an earlier stage then the figures should not stay at that level. There was also variation month on month but he did not take this as significant at this early stage.
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c) Cancer: We were still continuing to achieve good performance around cancer waiting times.

d) Yorkshire Ambulance Service NHS Trust (YAS): As their performance was still not sufficiently improving, a joint commissioning approach was

in place, with an action plan that should bring them up to an improved performance.

The Accountable Officer advised Governing Body that the commissioners of the service had commissioned an external review of YAS and had also worked with NHS England and Trust Development Authority (TDA) to help bring about performance improvement, which was not working as yet. He reported that he had chaired a CCG to Board meeting with YAS at which he had been impressed by their commitment particularly their scrutiny of the quality of their service. He also reported that the trust was reviewing every single serious incident / variation in quality, and the Care Quality Commission (CQC) had offered some reassurance to them about the quality process.

e) Public Health Report: Members noted the public health quarterly report attached at Appendix D, which was an important part of the quality and outcomes report.

The Chair commented that, with regard to the national child measurement programme, it looked as though Sheffield continued to be slowing down the rise of obesity in children, which was due to the range of actions being taken.

Dr Sorsbie advised Governing Body that Tuberculosis was more prevalent in the hard to reach groups due to difficulties in screening, and reported that Public Health England recommended screening for entrants from communities with 40/100,000 patients or more. She reported that there was up to a 100% default for follow up appointments from certain groups of patients so we were looking to follow this up and secure some funding from Public Health England. The Consultant in Public Health advised that there was great engagement and enthusiasm from clinicians across the city to get something done.

f) Quality

The Deputy Chief Nurse advised members of the following:

(i) Clostridium Difficile (C.diff): The CCG's performance was currently two cases over our end of year target. However, this was not unusual and had stayed steady and consistent in relation to benchmarking nationally. She advised Governing Body that a significant amount of time had been spent trying to understand C.diff and reviewing every single case that had been reported. A significant audit around medicines management and the long term use of prophylactic antibiotics for UTIs in general practice was underway. She also reported that STHFT were looking likely to meet their C.diff targets, with five reported cases at the moment and only five weeks to go until year end.

The Chair commented that we seemed to have an increase in the number of reported cases year on year. The Deputy Chief Nurse

responded that this was actually the first year that there had not been a decrease in the number of community cases, who had performed well over the previous years.

(ii) Eliminating Mixed Sex Accommodation: Ms Forrest advised Governing Body that the last meeting of the Quality Assurance Committee had discussed the two breaches reported at STHFT in December, which it had been reported had been caused by staff error.

g) Other Issues

(i) Urgent Care: The Chair referred to page 21 that reported that it was now apparent that the most significant contribution to the increase in acuity of patients presenting at STHFT was in elderly respiratory patients with complex needs, who would require admission to hospital, stay longer and have complex needs upon discharge. He asked if it should be something we should think of as commissioners in terms of a response.

(ii) Patient Experience at SCHFT: Dr McGinty drew Governing Body's attention to the fact that there had been no reported compliments and no capture of patients' positive experiences. Ms Forrest advised that the Quality Assurance Committee review feedback left on the Patient Opinion website which showed a lot of things that were positively reported by patients.

The Governing Body:

- Noted Sheffield performance on delivery of the key NHS Outcomes
- 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

46/15 Measuring How Well Services in Sheffield are Meeting People's Needs

The Consultant in Public Health presented this report which discussed some of the issues involved in trying to measure how well services were meeting needs, and outlined some of the options available to the Governing Body including a consideration of the resources that might be needed to achieve it. She advised Governing Body that it had been a challenging but intellectually stimulating paper to write and asked Governing Body for their feedback, comments and thoughts.

Ms Forrest asked if conversations were taking place about the investment, training and support needed for volunteers such as Healthwatch to undertake audits of services. The Consultant in Public Health responded that this work was just about to commence with Sheffield City Council (SCC) and key stakeholders. The Chair of Healthwatch Sheffield commented that this was an incredibly important key aspect of what Healthwatch does.

The Chair of Healthwatch Sheffield asked the Consultant in Public Health if she thought the Joint Strategic Needs Assessment (JSNA) was a good enough assessment of need. The Consultant in Public Health responded that she did, whilst recognising, in discussion with the Director of Public Health, that it was not perfect but that the pursuit of perfection was probably not a good use of resource. She did not see the proposed framework as a stand alone document but rather that it should refer to the JSNA .

The Director of Business Planning and Partnerships advised that we have some positive assurance about how well services are meeting needs in that we know that the JSNA is robust, plus our own Quality and Outcomes report tells us things that give us a level of confidence and assurance. However, there was still probably quite a significant piece of work to do, probably by way of a commissioned project, which would need substantial resources.

The Chair of Healthwatch Sheffield asked about the approach to developing the collection of indicators as her thoughts were that they did not match with the model the Health and Wellbeing Board were looking at. The Consultant in Public Health responded that the approach showed what can be measured rather than what we want to measure.

The Chief Operating Officer commented that some of it was about care planning, which the CCG was working on with public health, and some of it was about actually meeting the need. He reported that we were now investing in the training of the clinicians who were carrying out the care planning and using part of this to see if we actually were meeting the needs of those patients.

The Director of Business Planning and Partnerships and the Consultant in Public Health were asked to work up a proposal for the Commissioning Executive Team (CET) to review. The Accountable Officer suggested they contact the Academic Health Science Network (AHSN) who might have some practical / analytical support they could offer. **TF/ JW(SH)**

The Governing Body:

- Noted and approved the broad framework proposed in the paper including the need to have a line of sight between the JSNA, commissioned services, individual level need, and population level outcomes.
- Considered the complexity involved in developing indicators for Sheffield, alongside the benefits and the resource implications.
- Asked for a proposal to be prepared to pursue measuring how well services are meeting needs in Sheffield

47/15 Best Start Strategy Consultation

Dr Margaret Ainger, CCG GP, was in attendance for this item.

Dr Bates presented this report and reminded Governing Body that Best Start was a joint Local Authority and Public Health Strategy that was

being developed with key partners in health, education and the voluntary sector, and an initial paper outlining this had been presented to them in December 2014. They were now being asked to consider the full strategy as part of the consultation process and its development and would have the opportunity to comment on the development of the next draft.

Dr Ainger drew Governing Body's attention to the key highlights. From 1 October 2015 Local Authorities would take over the responsibility for commissioning services for children aged 0 to 5, which was a huge change. The vision was to make sure that all children have access to services that support healthy outcomes and that every child is ready for school life, by using a 'whole household' approach rather than focusing just on the individual child, with the aim to have a joint assessment carried out on all two year old children in the city, in the hope that they would be ready for school and life without being at a disadvantage. A big emphasis would be placed on empowering the workforce with the knowledge and the skills to be able to do this.

Ms Forrest reminded Governing Body about the work undertaken to pull together the Best Start Lottery Bid submitted in 2014, and expressed concern that this strategy was being looked at in isolation from that bid, which could result in losing the enthusiasm from families and community partnerships that had been developed at that time. Dr Ainger responded that community partnerships were included in the governance section on the latest draft of the strategy.

Dr Sorsbie welcomed the direction of travel, it was a massive challenge there was a desire to make that change, and it was positive for the Local Authority and health service to work together.

Following a lengthy discussion, the Chair summarised the key points as:

- Governing Body recognised and supported the aims in the strategy and agreed the CCG should be signatories to the strategy.
- Much of the content was also supported.
- It was felt the ambitions should be more specifically described and could be more challenging.
- There were quite a number of improvements to be made to the wording and presentation, e.g. map on page 7 five years old, wording in the priorities section insufficiently defined, the use of acronyms, a number of typing errors that needed correction.

Dr Ainger was asked to feedback and discuss the Governing Body's comments with the authors. It was agreed that the Governing Body would receive a final draft of the strategy, after the planned period of consultation, with a view to co-owning the strategy with Sheffield City Council.

48/15 Better Care Fund Section 75 Agreement

The Director of Business Planning and Partnerships presented this report and drew members' attention to the key highlights, which included seeking

approval for the establishment of pooled budget arrangements with Sheffield City Council (SCC) and delegation of authority for signing the Section 75 Agreement to the Chair and Accountable Officer. He advised Governing Body that the final contract would be at least 60 pages long so it was not appropriate to ask Governing Body to consider and approve the whole document. He reported that legal advice was being sought before proposing that the agreement was signed by the Chair and Accountable Officer, with advice from himself and the Director of Finance. He would carry on drafting the agreement with Sheffield City Council if Governing Body was happy with the proposed principles. He also advised Governing Body that Sheffield City Council fully supported the agreement and did not perceive any problems with its Cabinet agreeing to the principles when they received a very similar version of this report in the next couple of weeks.

The Director of Finance advised that the budgets set out were in line with those that Governing Body had been monitoring throughout the year in the private session.

With regard to the organisation to be designated as the host of each pooled budget, she advised Governing Body that discussions were still taking place as to which organisation was best placed to be the host. Further advice on this, including advice from External Audit colleagues, was still being sought.

The Chief Operating Officer commented that, although we have to have the agreement in place by 1 April 2015, it would not be set in stone and could be changed, as necessary, by mutual agreement.

Ms Forrest commented that she was worried that the needs of carers were being underestimated as the report's Equality Impact Assessment (EIA) suggested that it would be the cared for person that would benefit. The Director of Business Planning and Partnerships responded that there was more likely to be a positive than negative impact for carers but we would need to do EIAs of specific commissioning plans, and also ensure that our Carers' Strategy aligned to the responsibilities under the Care Act.

The Governing Body:

- Approved the establishment of pooled budget arrangements to enable integrated commissioning, in line with previous discussions.
- Noted the requirement to have a robust legal agreement in place that underpins our partnership, prevents ambiguity and provides a reference point for problem solving.
- Noted the progress in developing the detailed agreement.
- Approved the proposed content of the S75 Agreement.
- Delegated authority for signing the Agreement to the Chair and Accountable Officer.

49/15 Reports circulated in advance of the meeting for noting:

The Governing Body formally noted the following reports:

- Chair's Report

- Accountable Officer's Report
- Key Highlights from Commissioning Executive Team and CET Approvals Group meetings
- Locality Executive Group reports
- Refresh of Commissioning Intentions
- Staff Survey Results
  The Accountable Officer advised that the question about providing care to patients was a generic national question, even though it was not relevant to commissioning organisations.
- Update on Serious Incidents
- Communications Quarterly Update

50/15 Clinical Director Remuneration

Dr McGinty left the meeting at this stage.

Mr Boyington, Chair of the Remuneration Committee, presented this report that asked Governing Body to approve the decision of the Remuneration Committee which, he reported, had been made without any GPs present, to remunerate the CCG's Clinical Director posts as set out in section 2 of the report.

The Governing Body approved the decision of the Remuneration Committee to remunerate the Clinical Director posts as set out in section 2 of the report.

Dr McGinty rejoined the meeting.

51/15 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.

52/15 Any Other Business

a) Vanguard Site

The Accountable Officer advised Governing Body that Sheffield had been shortlisted by NHS England to become a 'Vanguard' site, as part of its programme focusing on the acceleration of the design and implementation of new models of care in the NHS. If successful, it would give Sheffield the opportunity to work with national partners to co-design and establish new care models whilst tackling national challenges in the process. He reported that he had attended a workshop in London the previous day for shortlisted applicants to present their applications, and we should know by the following week if our application had been successful or not.

He expressed his thanks to Dr Andy Hilton, CCG GP, who had led a large piece of this work to set the clear vision of what the providers and

notably primary care were trying to do in Sheffield to respond to the commissioner requirements for more integrated care.

b) Prime Minister's Challenge Fund Bid

The Accountable Officer advised Governing Body that the announcement of successful applicants was still awaited, but the Sheffield bid was thought to be very strong.

c) CCG Clinical Director Posts

The Accountable Officer advised Governing Body that five Clinical Director appointments had recently been made, who would be at the heart of the decision making within the CCG and lead the work of the portfolios across the city and out localities.

Dr McGinty, who had been appointed to one of the Clinical Director posts, reported that he would be resigning from his Governing Body post at the end of March 2015. He expressed his thanks to Governing Body members, to the CCG's managerial team for their support, and gave particular thanks to Dr Richard Oliver who he felt had been a real inspiration when he had been part of Governing Body as Joint Clinical Director.

Dr McGinty advised that the Hallam and South Locality hoped to be able to nominate a new GP Locality Lead to represent them at the April Governing Body meeting.

d) Oral Update from Quality Assurance Committee Meeting held on Friday 27 February 2015

Ms Forrest, Chair of the Quality Assurance Committee, gave an oral update from the key highlights of the meeting. This included the Committee's concerns about emergency and non emergency patient transport services, especially around the way that the contracting team are involved. They also discussed the evaluation of Healthwatch Sheffield's audit of patient transport services, raised concerns about the Care Quality Commission's (CQC) primary care inspection process and about the delay in receiving CQC inspections reports and if this was helpful to organisations. They noted that the Commissioning Executive Team (CET) were aware of the problems with Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) relating to safeguarding and Deprivation of Liberty (DOLs), discussed the importance of the Commissioning for Quality Strategy for the organisation, and agreed that membership of the Quality Assurance Committee should include the new secondary care doctor, following the resignation of Dr Richard Davidson.

e) Ian Atkinson, Accountable Officer

On behalf of Governing Body, the Chair thanked Mr Atkinson, who would be leaving the organisation at the end of March 2015, for his contribution to the CCG and to Governing Body.

Mr Atkinson advised Governing Body that it had been a huge privilege for him to both start and finish his NHS career in Sheffield, and to work with members of the Governing Body who were a credit to their respective profession(s).

There was no further business to discuss this month.

53/15 Date and time of Next Meeting

Thursday 2 April 2015, 4.00 pm Boardroom, 722 Prince of Wales Road, Sheffield, S9 4EU

Appendix A

Questions from Mike Simpkin, Sheffield Save our NHS, to the CCG Governing Body 5 March 2015

Question 1: What is the relationship between the CCG and the new GP Provider Board?

CCG Response: *The CCG supports the establishment of the GP Provider Board as a very practical arrangement to support practices to work together to deliver more services in community settings and provide more opportunities to increase the efficiency and effectiveness of the provision of primary care. We have provided some advice and support to the GP Provider Board and as with other providers and collaborations shared our commissioning intentions and priorities. There is no formal relationship other than this and none of the GPs at Governing Body or CET have roles with the GPPB. We are, in any event, clear about identifying and acting upon conflicts of interest, should GPs or staff with interests in both organisations occur.*

Question 2: Examples are coming to light across England of services previously run by the NHS which have been damaged and fragmented after becoming subject to local authority procurement rules. The proposed Better Care Fund Section 75 agreement states (para 5.2.3) that each procurement will be led by one partner but that NHS contracts will be used unless the services are clearly non clinical. What is the definition of 'clinical' (e.g. does it include nurse-led provision)? Is the CCG satisfied that this condition is sufficient to ensure that services traditionally provided through the NHS and which have a clinical element will continue to be procured under NHS rather than local authority conditions.

CCG Response: *Yes, this condition will ensure that the NHS standard contract will be used for all clinical services, including those provided by NHS organisations. "Clinical" includes medical, nursing and therapy staff.*

Question 3: The 2014 Staff Survey reported as Item 12f has many positive findings and shows welcome improvements over 2013. However the survey still paints a troubling picture of staff trying to do their best for a patient-centred NHS under mounting and sometimes intolerable pressure. What have been the CCG staffing levels, by occupational category, for each subsequent year compared with the last year of Sheffield PCT? How is pressure on staff likely to be affected by the non-accreditation of Yorkshire and Humberside CSU?

We do not hold information for our predecessor organisation. Staffing levels by Directorate are shown below. The increase shown can be accounted for with the transfer of medicines management staff from the CSU to the CCG. We are working with CCGs in Yorkshire and Humber to determine how we obtain commissioning support following the non-accreditation of the Y&H CSU and do not expect there to be a loss of support as a result, so there should be no increase in pressure on CCG staff.

As a result of the Health and Social Care Act 2012, a number of functions undertaken by the former NHS Sheffield (Primary Care Trust) were discharged to successor

organisations including Clinical Commissioning Groups, Commissioning Support Units, NHS England, Public Health England, NHS Property Services and the NHS Leadership Academy.

The staffing levels for the CCG (headcount) are shown below:

1st April 2013	
Governing Body and Chief Officers	*18*
Clinical Quality	*20*
Finance and Contracting	*23*
Operations	*30*
TOTAL	***91***

1st February 2015	
Governing Body and Chief Officers	*24*
Clinical Quality	*75*
Finance and Contracting	*25*
Operations	*44*
TOTAL	***168***

Information in relation to staffing levels within NHS Sheffield are available from legacy documents via the Department of Health.