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

A

Present:
Dr Tim Moorhead, CCG Chair, GP Locality Representative, West
Dr Amir Afzal, GP Locality Representative, Central
Dr Ngozi Anumba, GP Locality Representative, Hallam and South
Dr Nikki Bates, GP Elected City-wide Representative
John Boyington, CBE, Lay Member
Kevin Clifford, Chief Nurse
Amanda Forrest, Lay Member
Tim Furness, Director of Business Planning and Partnerships
Professor Mark Gamsu, Lay Member
Dr Anil Gill, GP Elected City-wide Representative
Idris Griffiths, Chief Operating Officer
Dr Zak McMurray, Medical Director
Julia Newton, Director of Finance (up to item 197/15)
Maddy Ruff, Accountable Officer
Dr Leigh Sorsbie, GP Locality Representative, North
Dr Ted Turner, GP Elected City-wide Representative

In Attendance:
Dr Maggie Campbell, Chair, Healthwatch Sheffield
Katy Davison, Head of Communications
Rachel Dillon, Locality Manager, West
Carol Henderson, Committee Administrator / PA to Director of Finance
Susan Hird, Consultant in Public Health, Sheffield /City Council (for items192/15 and 196/15)
Phil Holmes, Director of Adult Services, Sheffield City Council (up to item 196/15)
Dr Stephen Horsley, Interim Sheffield Director of Public Health, Sheffield City Council
Simon Kirby, Locality Manager, North
Kate Laurance, Head of Commissioning Children, Young People and Maternity Services (for item 197/15)
Paul Wike, Locality Manager, Central

Members of the public:
There were five 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 Business Planning and Partnerships.

ACTION

185/15 Welcome

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

186/15 Apologies for Absence

Apologies for absence had been received from Dr Marion Sloan, GP

Elected City-wide Representative.

Apologies for absence from those who were normally in attendance had been received from Katrina Cleary, CCG Programme Director Primary Care, Dr Mark Durling, Chairman, Sheffield Local Medical Committee, and Gordon Osborne, Interim Locality Manager, Hallam and South.

187/15 Declarations of Interest

There were no 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

188/15 Chair's Opening Remarks

The Chair had no further comments to make in addition to his report appended at item 14a.

189/15 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.

190/15 Minutes of the CCG Governing Body meeting held in public on 1 October 2015

The minutes of the Governing Body meeting held in public on 1 October 2015 were agreed as a true and correct record and were signed by the Chair.

191/15 Matters arising from the minutes of the meeting held in public on 1 October 2015

a) Quality and Outcomes Report: Cancer Waits (minute 178/15(b) refers)

The Chief Operating Officer advised that he would give an update on the task and finish group looking at the 62 day maximum cancer waits from RTT on a pathway by pathway basis to make sure the issue is addressed under minute 194/15.

The Director of Finance advised that she would send Governing Body an email with an explanatory note as to why there had been a spike of excess bed days at Sheffield Children's NHS Foundation Trust (SCHFT) during the summer holidays. **JN**

b) Unadopted Minutes of the Quality Assurance Committee meeting 28 August 2015 (minute 180/15 refers)

The Director of Business Planning and Partnerships advised Governing Body that work was underway to review individual Governing Body

member's areas of responsibility. Once that piece of work was complete, a deputy for Dr Afzal on the Quality Assurance Committee would be nominated. An update would be given to Governing Body in December. **TF**

192/15 Transforming Public Health: Director of Public Health Report for Sheffield 2015

Susan Hird, Consultant in Public Health, was in attendance for this item.

The Director of Public Health presented his report and gave a presentation that drew members' attention to the key highlights.

In addition to the priorities for action over the next 12 months, the report made three recommendations, two of which were addressed to the Health and Wellbeing Board and one to the Council, which had been supported at the Sheffield City Council meeting the previous day, and were as follows:

(i) The Health and Wellbeing Board should establish a local baseline measure of wellbeing for the city and use this to track change over time and variation across the different communities in Sheffield.
(ii) The Council should provide products which assist residents to reduce the cost of their home energy and the amount they use by:
    - Progressing the business case for a local Energy Service Company to present opportunities to generate local energy, create lower priced energy and address the inequalities balance in fuel poverty – for example by providing prepayment meters with electricity at an uninflated price
    - Assist residents to improve their homes thermally by delivering more attractive financial products than the current ECO and Green Deal, for example by offering a revolving loan scheme.
(iii) It is everyone's responsibility to engage with the Move More message; from creating environments which make being physically active the easiest choice to the individual responsibility of building physical activity into daily lives and just moving more! The Health and Wellbeing Board should ensure schools in Sheffield give all children the opportunity to participate in appropriate exercise.

He reported that Sheffield does well compared to the Core Cities and we want to be much more aspirational in Sheffield and compare ourselves to the rest of England. With regard to the inequalities in life expectancy, this would not improve unless we can change things and so both organisations need to look at where we spend some of our money to make sure we spend it in the right way. He reported that the Health and Wellbeing Board was looking at how to tackle the underlying causes of health inequalities.

Other key highlights of his report included that 23% of children in Sheffield are in child poverty and not all are ready for school by the age of four, with 30% of these needing support. We need health protection in the city, are not making the progress we need to on preventable mortality,

Professor Gamsu thanked the Director of Public Health and his team for

the excellent report and commented that it connected with a lot of the issues the CCG was concerned about. However, he would challenge that Sheffield was doing well compared to the core cities and asked how well would Sheffield do when we look at the poorer part of the city compared to the poorer parts of the core cities. He was pleased to see the information about social determinants and we needed to be thinking about how citizens could use advocacy services, etc, to help themselves and understand what their rights are. He also commented that we should perhaps be comparing our public engagement with organisations such as Sheffield Theatres, etc.

Dr Sorsbie advised, that with regard to the incidence of Tuberculosis (TB), the figures were now higher than shown in the report, especially in the number of child cases. She reported that latent TB screening would be starting on 1 January 2016 for those people coming into the city from countries where they have active cases, and rolled out to key practices from 1 April. However, funding for this from NHS England is limited to adults, which means that children will not be screened, even though they are more vulnerable.

Ms Forrest raised about the role that community and voluntary groups could contribute to the health of the city, however, we had not had a strategy for those groups for a few years and need to think about how some of them have struggled during the past few years. She also commented that there was an Ofsted report for Sheffield that reported that primary schools in the city were performing very badly, however, does benchmark well against the core cities.

The Chair commented that the graph showing the life expectancy at birth for both males and females was disappointing in that Sheffield was not catching up with the national averages, but he was not convinced that the genetics of the population of Sheffield were that different to the rest of the country. His thoughts were that this related to health inequalities, which was the biggest thing we should be trying to address and would make a difference to these outcomes.

The Chair of Healthwatch reported that some of the information that Healthwatch received related to some people not attending follow up appointments as they were worried because they had been advised they needed further investigations, etc,.

The Accountable Officer commended the report saying that it was one of the best, most easily digestible reports she had ever read. She commented that the timing of the report was impeccable as the CCG was currently looking at its planning strategy and would use the report as part of that session. She was pleased that the report gave the CCG only three priorities that focused on the ones the Director of Public Health thought may make the biggest difference in Sheffield, but asked where smoking cessation, especially in pregnancy, fitted in his list of priorities as it was not included. The Director of Public Health responded that smoking cessation was a high priority and probably contributed to health inequalities more than anything else, and there was a staggering

difference in between the wards in Sheffield.

The Governing Body:
- Noted the publication of the report.
- Supported the recommendations it makes.

193/15 2015/16 Finance Report

The Director of Finance presented this report which provided Governing Body with information on the financial information for Month 6 and the key risks and challenges to deliver the planned year end surplus of £7.4m (1%). She advised Governing Body that there had been no material changes since last month in terms of the forecast spend on individual budget lines.

However, she highlighted that there was one important proviso to the information provided. Due to Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) implementing its new Patient Administration IT system during September, contract data was not fully complete as the trust was requiring extra time to input some information onto the new system. Thus a slight reduction in forecast spend at STHFT had to be treated with caution. The CCG had agreed to defer the formal Quarter 2 data reconciliation deadline by a month to January.

The Director of Finance also re-affirmed to Governing Body that, through the Commissioning Executive Team (CET), a number of actions continued to be pursued to ensure delivery of the planned position. The focus remained on making changes which would recurrently deliver service improvements and efficiencies at the same time, not least because of the significant financial challenges which the CCG was likely to face in 2016/17.

She also drew Governing Body's attention to the changes to budgets within the Better Care Fund (BCF) set out in section 4, that she would be asking them to approve in line with the BCF Section 75 Agreement.

The Chair asked for an update on the actions previously discussed to address the overspend against the primary care prescribing budget. The Medical Director reported that proposals had been shared with GP practices and that GPs and the Local Medical Committee (LMC) were broadly supportive of the proposals, and were talking to the specific patient groups it might affect. Anything contentious would be brought back to Governing Body asking for their support.

Dr Sorsbie asked about Appendix E: financial position for the Memorandum Section 75 - Better Care Fund, and noted the underspend on people keeping well in their community which was disappointing when as commissioners we were looking to invest in this "upstream" prevention work. The Director of Finance explained that the underspend primarily related to lack of uptake on some of the schemes, for example care planning. She reported that the Executive Management Group (EMG) had considered updated proposals for 2016/17.

The Governing Body:

- Considered the risks and challenges to delivery of the planned 1% surplus.
- Approved, in line with the BCF Section 75 Agreement, the changes to budgets within the BCF as set out in section 4.

194/15 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) Implementation of Lorenzo IT System at STHFT: He advised members that all hospitals have Patient Administration Systems (PAS) that hold data information about patients, but relatively few have electronic patient records (EPR) and were moving towards the development of this. He reported that the trust had started the full EPR aspect of the Lorenzo IT system in the A&E department, which was a huge change in the way that people work and would provide real time patient information. He advised that he knew of no hospital that had not had problems with its implementation.

He advised Governing Body that due to the problems the trust was having with its implementation, the CCG was in close contact with them several times a day. The problems with implementation had had a knock on effect on the information he had been able to provide in his report as the trust had not been able to provide effective accurate information, on A&E performance for example. He reported that Governing Body needs to be aware that their A&E performance was below 95% due to these operational difficulties, which had knock on effects to the ambulance services. However, he hoped to be able to provide up to date information by the December meeting.

The Director of Public Health asked if the trust was helping the CCG with a timeline for the Lorenzo system to interface with the EMIS and SystmOne systems used in general practice which, he commented, would be needed in social care in the future. The Chief Nurse responded that the trust was driving this and that SystmOne was seen as the conduit to connecting with other systems already in the community.

b) 18 Weeks: He advised Governing Body that, from a commissioner perspective, STHFT still had a number of specialties where they were not meeting the 18 week target, including cardiology which was a particular area of concern. He reported that the CCG had issued another performance notice within the contract for those areas. He reported that the trust have to provide the CCG with detailed plans as to how they would address these issues, which we hoped to receive within the next week.

Dr Gill asked why the CCG tolerated this underperformance which had been going on too long to accept it was going to improve, and could

mean there was a danger that we may be heading back to some waiting lists being self regulating. The Chief Operating Officer advised that the CCG was now at the highest level of escalation through the formal contract route, and reported that two of the CCG's Clinical Directors and the Chief Nurse were now involved in these discussions, as were NHS England as intervention cardiology was specialised commissioning. Dr Afzal was pleased that the two Clinical Directors had become involved and asked if they could come along and report the position to Governing Body. The Accountable Officer understood Governing Body's concerns and agreed to revisit this in December. She could assure Governing Body and members of the public that the CCG understood what the issues were and the trust's plans to address them.

The Chief Nurse reported that he had asked the trust if any patients had come to harm as a result of waiting for cardiology treatment and advised that the care of patients that had died whilst waiting had been subject to a review. The care of two individual patients was being reviewed further and he expected the outcome of those reviews within the next few days.

The Director of Finance explained that the trust's performance was not due to a lack of funding. The CCG had invested a lot of money to support the trust in resolving the issues, and funding was available for the activity that is needed to achieve the targets.

c) Winter Plans: The CCG had gone through an extensive process about assurance about winter plans, which had been overseen by the Systems Resilience Group (SRG). He reported that, at this point in time, the position was probably better than it had been for the past few years and more robust that it had been in the past.

Governing Body requested a report from the SRG on what the plan for winter planning is **TF**

d) Elective Activity: This was under plan, which we would be keeping under review.

e) Yorkshire Ambulance Service NHS Trust (YAS): As YAS had been underperforming this month, across a number of areas, a number of meetings had taken place with them. Wakefield CCG was the main lead commissioner of the service for Yorkshire and the Humber and there was now a real focus on how the CCGs could work with the service in a better way. He reported that Sheffield CCG was facilitating and making sure that discussions were taking place between the service and STHFT.

f) Quality

The Chief Nurse advised members of the following:

(i) Care Quality Commission (CQC): A number of CQC visits to the city

were coming up, including a review of Thornbury Hospital on 25 November and a major review of STHFT. Patients and members of the public were invited to feed in comments on both organisations prior to the reviews, with STHFT also holding a listening event on 1 December in this respect. He reported that the CCG would be responding to the CQC's request for information relating to STHFT.

With regard to primary care inspections, the CCG had been informed that the 70 practices due to be inspected under the new CQC regime, could expect a visit over the next year.

He also advised members that the CQC had inspected the safeguarding arrangements across the city. The CCG had received very positive feedback, with a few recommendations. The formal report was expected within the next few weeks.

Ms Forrest asked if all organisations inspected would expect to receive their reports in a timely manner. The Chief Nurse reminded Governing Body that the Quality Assurance Committee (QAC) had previously expressed concerns about the timing of reports, and reported that these concerns had been known to the CQC as well as concerns about the issues that the CQC had picked up at inspections of some of our provider organisations that they had not informed us about.

g) Other Issues

(i) STHFT Annual Equality and Human Rights Report : The Chair of Healthwatch advised that Healthwatch had noted that the trust had not actioned the second point on this - that patients have an equitable outcome and experience, and reported that Healthwatch were very concerned about this and had asked the trust for more detail. They had advised that they had not addressed an action plan for this but had self reported it.

(ii) Eliminating Mixed Sex Accommodation: Ms Forrest asked if she could discuss the one breach with the Chief Nurse outside of the meeting. **AF/KeC**

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

195/15 Patient, Carer and Public Engagement Report

Professor Gamsu presented this report. He was pleased to be able to advise Governing Body that there was an ever increasing good range of things that were happening and a growing amount of activity. He highlighted three key issues where they wanted to see improvement: supporting general practice and our membership to have a consistent

engagement with the public they serve; undertaking more work to bring together members of the public involved in Patient Reference Groups, Healthwatch, Involve Me, etc, and; engaging more with health champions, health trainers and practice champions.

The Director of Business Planning and Partnerships reported from the Transforming Patient Experience 2015 workshop, hosted by the King's Fund, that had taken place the previous day, to which several CCG staff members had been invited to attend to give a presentation on our engagement work on MSK and respiratory conditions, which had been well received and was a demonstration of how good our work is.

He also drew Governing Body's attention to section 2.1 and the engagement work that had taken place with regard to the 2020 vision of social care in Sheffield. He advised that the full analysis and report would be produced once all feedback had been received which would then be discussed and considered by the partner organisations.

The Director of Adult Services commented that it was a really good body of work that the CCG was putting together. He reported from the listening event on adult social care that had taken place the previous week and commented that the only way to get good adult social care in the city was to restore that connection, which would start to underpin everything that we do.

The Chair of Healthwatch particularly welcomed the 'Speaking with Confidence' briefing outlined in section 4 and suggested that it would be useful to have all those points of information pulled together in those succinct statements. She commented that she would be cautious of focusing on all activity and not on those things that people have told us about and in this respect it would be useful to try and move together on our co-ordination on those sorts of things.

Dr Turner commented that the CCG was moving in the right direction and he would welcome a wider view on where the CCG needed to position itself, especially with its communication and engagement with its member practices. He would be interested to hear ways on how the CCG could facilitate that to happen and how it could be done in a consistent way. The Accountable Officer advised that the CCG had promised to support its member practices with suitable topics to discuss with their patient groups.

Finally, Ms Forrest commented that the CCG could be a bit smarter in how it taps into the different networks of people as there was quite often a huge overlap with its patient and engagement groups.

The Governing Body:

- Noted the patient, carer and public feedback in the 'Speaking with Confidence' briefing in section 4 and the implication this has for the CCG.
- Considered and noted the successes, challenges and areas of interest section.
- Considered and noted the update on progress and development work

sections.

Mr Holmes left the meeting at this stage.

196/15 Measuring How Well Services in Sheffield are Meeting People's Needs

Susan Hird, Consultant in Public Health, was in attendance for this item.

The Director of Business Planning and Partnerships introduced this report and reminded members that they had received a paper in March 2015 that outlined some of the ways in which need could be defined and measured and had a number of recommendations, including getting agreement on the definition of need. The paper summarised the discussion that had taken place at a workshop on 21 May 2015 to establish an agreed definition of need and to explore ways of measuring this, proposed a framework for improving how well the CCG measured whether services were meeting needs, and made recommendations about the next steps.

Dr Horsley asked if the CCG could do more in taking its lead role in Sheffield, especially with regard to getting Sheffield City Council and the provider trusts to come together, which needed to be tackled urgently to get the best out of Sheffield. The Chair commented that the provider trusts were regulated on things that did not really have an impact on outcomes, so the regulatory framework did not help and so we would need a focus on local outcomes measures if we wanted commissioning to be successful.

Dr Horsley drew Governing Body's attention to table 1 and the proposed actions for improving how well services were meeting the needs of different population groups, and commented that there were a few really key things that could be done, for example sharing the data of why people do not attend appointments and how it can collectively be addressed.

Dr Sorsbie commented that it was about a real cultural change and was about how our patients were fitting in with the system we were offering and, if not, what we could do to change this.

The Chair of Healthwatch congratulated Ms Hird on her hard work for pulling this all together and commented that she would not like any of the dimensions included in the report to be lost.

The Governing Body supported continuation of the following actions and asked Ms Hird to identify a handful of key ones for them to feed into the planning process: **TF(SHi)**

- .As system leader, the CCG should work to establish a city-wide consensus and commitment to ensuring services are meeting people's needs as this will reduce health inequalities and improve health. This needs to be at the level of Chief Executive.
- Identify lead(s) to develop the framework and associated actions discussed in this paper. Ideally these leads would come from

commissioning and provider organisations (including the VCF sector) so the work can be developed jointly. This should be a high profile, visible programme of work that includes patient and public participation. It needs to be explicitly integrated into relevant work that's already happening eg the Integrated Commissioning Programme, Prime Minister's Challenge Fund, the Health and Wellbeing Strategy action on 'improving access to services', etc.

- Identify a CCG lead to ensure the framework and relevant actions are incorporated into CCG commissioning, so that it becomes 'just how we do business'.
- Develop monitoring and evaluation as part of the programme so we can measure impact.
- The CCG may need to consider discussions with regulators as there is likely to be tension between meeting national targets and meeting local needs.

The Director of Finance left the meeting at this stage.

197/15 Working Together Transformation Programme: Review of Children's Surgery and Anaesthesia

Kate Laurance, Head of Commissioning Children, Young People and Maternity Services, was in attendance for this item. She presented this report which, she advised, was requesting Governing Body to consider and approve the case for change and to support the next phase of delivery, which included the development of options, and the development of a full business case underpinned by further engagement with patients and the public and key stakeholders and formal public consultation if required.

The Chair commented that the pace for transformation was an issue as change clearly needed to happen. The Chair of Healthwatch advised that Healthwatch regionally has a relationship with the Working Together Programme and requested that this be put on the next agenda for that Board meeting.

The Director of Business Planning and Partnerships asked why the variation in quality of services reported in the paper was not listed in section 3: key messages from the baseline review for Governing Body members. Ms Laurance explained that this was deliberate as the team needed to do more work to evidence what people really observe.

The Governing Body:

- Noted the work to date.
- Approved the case for change.
- Supported the next phase of delivery.
- Requested a further update early in the New Year.
- Noted that the Working Together Programme was a growing area of work for the CCGs.

198/15 Policy and Procedure for the Reimbursement of Expenses for Volunteers and Citizens

The Director of Business Planning and Partnerships presented this report. He advised Governing Body that this policy would normally be presented to the Governance Sub Committee, which had delegated authority through the CCG's Scheme of Reservation and Delegation, to approve corporate policies but, as a number of respondents had strong views about whether volunteers should be reimbursed for their time as well as expenses, he had suggested that it presented to Governing Body for their views and formal approval.

He drew Governing Body's attention to section 7 which outlined circumstances as to when a role would become more than volunteering which could mean that there may be times when a paid role would need to be created. This decision would be made by the Patient Engagement and Experience Group (PEEG) using set criteria. He reported, however, that generally the PEEG felt that the principle of volunteering would get compromised if people were paid for their time. He noted, however, that some organisations, mainly in mental health services, do pay volunteers for their time.

Professor Gamsu advised Governing Body that the proposal to create a paid role would affect only a small number of people and felt that the CCG was taking a model that was very similar to the one used by Sheffield Health and Social Care NHS Foundation Trust (SHSCFT), and was consistent with discussions that had taken place with the CCG's volunteers and with Healthwatch.

The Governing Body approved the Policy and Procedure for the Reimbursement of Expenses for Volunteers and Citizens.

199/15 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 (CET) and CET
- Approvals Group meetings
- Locality Executive Group reports
- Update on Serious Incidents (Sis)
  Mr Boyington expressed concerns about STHFT seeming to consistently miss the requirement to report SIs to the CCG within two days. The Chief Nurse responded that the issue of reporting SIs across all providers had been an issue for the past couple of years. He explained that there was an internal process in place at STHFT that meant they struggled to report an SI to us within two days, but had assured us that the delay in letting us know about the SI would lead to timelier and better reports, although we had not seen evidence of this as yet. He advised Governing Body that the two day reporting standard was a national policy and explained that we had written into our contract with them this year that they must be

compliant. He reported that he had formally raised this with them on more than one occasion and about the quality of their reports when received, and we continued to work with them on this. He also advised that the CCG would be formally raising this as part of our submission to the Care Quality Commission in advance of their visit to the trust.

Ms Forrest advised Governing Body that the Accountable Officer had requested that members of the CCG Governing Body meet with the Trust's Governors to gain a better understanding of each other's work.

200/15 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.

201/15 Any Other Business

There was no further business to discuss this month.

202/15 Date and time of Next Meeting

The next meeting will take place on Thursday 3 December 2015, 4.00 pm, Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU

Appendix A

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

Question 1: **In the latest NHS Atlas of Healthcare Variation:**

a) Sheffield in 2012-13 had one of the highest hospital admission rates in England of people aged 75+ from residential or nursing care homes. Are more recent figures any better? If not, what does the CCG consider to be most likely explanation, and what specific measures are being or can be put in place to lessen the pressure of hospital admissions from care homes?

CCG response: *For reasons set out below Sheffield has adopted particular data recording practices that result in the capture of a lot of care home related hospital activity, so we were not surprised to see we have larger numbers in the national data.*

a) For some years we have had a locally commissioned GP contract in place in the city whereby surgeries provide medical support to named care homes per practice. One of our key monitoring parameters has been admission to hospital from care homes, and a lot of effort has gone into improving data capture, completeness and quality.

b) Care homes was a particular focus for the Sheffield Right First Time partnership programme and again improvements to hospital recording of admissions was a feature.

c) A frailty medical assessment unit (MAU) was opened early in 2012 at the NGH site, and from that point on many of the older people attending A&E in Sheffield are assessed in the frailty MAU. Those attendances are classified as inpatients by STH and consequently they appear as emergency admissions in the national statistics. Most other hospitals classify MAU activity as outpatient attendances and so these do not contribute to their emergency admission numbers. For this reason we are aware that Sheffield has an apparently larger number of elderly hospital admissions, including from care homes, than do comparator CCGs. The CCG is in discussion with STHFT about the classification of such patient attendances.

For the above reasons the apparently higher rate of admission from care homes is to a significant extent reflecting differences in recording practice. However, it is also worth noting that the numbers are still quite small. Hospital admissions from care homes only accounts for less than 3% of our emergency admissions, so the atlas is reflecting relative differences in an already small number of admissions. This is something the CCG and partners will continue to monitor as part of the city's integrated commissioning arrangements. However, with the demise of the PCT the CCG lost its linkage to more detailed data on admissions from care homes, which the Commissioning Support Unit are presently working to restore.

b) South Yorkshire as a region appears to have the highest rate of hospital admissions of children aged 0-4 for dental caries (2010/11-2012/13). How does this finding balance between alarming local tooth decay among local young children and the availability of surgery at Sheffield's Charles Clifford Dental Hospital? What is being done to reduce this rate?

***CCG response**: Tooth decay rates in South Yorkshire and Sheffield are higher than national averages and general anaesthetic rates for dental extraction are also higher. There are 10 different providers of dental general anaesthetic extraction services across South Yorkshire including the dental hospital. There is always going to be an element of services availability creating demand but this needs to be balanced against the impact of the services on reducing the impact of tooth decay on children and their carers' daily lives. Historically there have been high referral rates and short waiting lists with some GDPs relying on the service rather than providing any necessary care themselves, which can be very difficult on very young children. Additionally there is better access to primary care services than nationally so children having a possible need for the service are more likely to be identified. Waiting lists for the services vary by provider from two weeks to over 18 weeks.*

The variations in waiting times, high levels of activity and concerns around service quality led to a recent review of the services by the local dental professional network and a working group is currently exploring how the quality of the services can be improved.

In Sheffield the service is high quality and delivered to national standards for children's general anaesthesia for dental extractions. Those children who can be redirected to alternative services to avoid the need for a GA are. Work has been undertaken in the community with certain groups with high referral rates, for example Roma Slovak children. Work has also been undertaken to reduce repeat GAs for example through audit and through cross specialty training between paediatric dentistry and oral and maxillofacial surgery to ensure treatment plans are appropriate to avoid the need for repeat GAs. There is also pre-assessment by a specialist paediatric dentist to ensure only those children needing a GA get it, that is some may be treated without recourse to GA.

The Sheffield oral health improvement strategy focuses on children to reduce decay rates and the public health outcomes framework indicator has shown a small improvement in the last four years but prevalence and severity still remain higher than nationally.