NHS
Sheffield Clinical Commissioning Group

Minutes of the meeting of NHS Sheffield Clinical Commissioning Group Governing Body held in public on 8 January 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 (up to item 12/15(b)
Ian Atkinson, Accountable Officer
Dr Nikki Bates, GP Elected City-wide Representative
Kevin Clifford, Chief Nurse
Dr Richard Davidson, Secondary Care Doctor
Amanda Forrest, Lay Member
Tim Furness, Director of Business Planning and Partnerships
Professor Mark Gamsu, Lay Member
Idris Griffiths, Chief Operating Officer
Dr Andrew McGinty, GP Locality Representative, Hallam and South (from item 13/15 onwards)
Dr Zak McMurray, Clinical Director
Julia Newton, Director of Finance
Dr Marion Sloan, GP Elected City-wide Representative
Dr Leigh Sorsbie, GP Locality Representative, North
Dr Ted Turner, GP Elected City-wide Representative

In Attendance:
Dr Maggie Campbell, Chair, Healthwatch Sheffield
Helen Cawthorne, Local Manager, Hallam and South
Katrina Cleary, CCG Programme Director Primary Care
Rachel Dillon, Locality Manager, West
Carol Henderson, Committee Administrator
Dr Susan Hird, Consultant in Public Health, Sheffield City Council (for item 13/15)
Professor Jeremy Wight, Sheffield Director of Public Health
Moira Wilson, Director of Care and Support, Sheffield City Council

Members of the public:
Four 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

01/15 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.

The Chair welcomed Dr Maggie Campbell, Chair, Healthwatch Sheffield, to her first Governing Body meeting.

02/15 Apologies for Absence

Apologies for absence had been received from John Boyington, CBE, Lay Member, and Dr Anil Gill, GP Elected City-wide Representative.

Apologies for absence from those who were normally in attendance had been received from Dr Mark Durling, Chairman, Sheffield Local Medical Committee, Simon Kirby, Locality Manager, North, and Paul Wike, Locality Manager, Central.

03/15 Declarations of Interest

Professor Gamsu declared a conflict of interest in the following item:

- The CCG's Contribution to Reducing Health Inequalities (paper H)

It was agreed that Professor Gamsu's interest, as Trustee of the Citizen's Advice Bureau (CAB), should not prevent him from participating in the discussion.

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

04/15 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 14a on the agenda.

05/15 Questions from the Public

A member of the public asked a question at the meeting. The CCG's response to this is attached at Appendix A.

06/15 Minutes of the CCG Governing Body meeting held in public on 4 December 2014

The minutes of the Governing Body meeting held in public on 4 December 2014 were agreed as a true and correct record and were signed by the Chair, subject to the following amendments:

a) Declarations of Interest (minute 182/14 refers)

Second paragraph to read as follows:

It was agreed that Ms Forrest's interest, as the former Chief Executive of the lead organisation that had led the development of the bid for Best Start Sheffield - Big Lottery Fund Fulfilling Lives a Better Start in January 2014, should not prevent her from participating in the

discussion.

b) Month 7 Quality and Outcomes Report: Other Issues (minute 191/14(f)(ii) refers)

Minute to read as follows:

Public Health: The Director of Public Health advised members that the public health element of this report had already been changed to include a quarterly narrative report on the work of the public health team.

The Chair drew members' attention to Appendix A, detailing questions that had been submitted before the meeting and the CCG's responses to these, which had been emailed following the meeting.

07/15 Matters arising from the minutes of the meeting held in public on 4 December 2014

a) Climate Change and Health Director of Public Health Report for Sheffield 2014 (minute 189/14 refers)

The Director of Public Health advised Governing Body that he would be discussing with his public health colleagues about how to take the recommendations in the report forward.

b) Month 7 Quality and Outcomes Report: Reduction in Infant Mortality (minute 191/14(e)(v) refers)

The Chief Nurse advised Governing Body why infant mortality rates have changed from red to green, because of small numbers there was an issue regarding child deaths as just one death could significantly change the rating. He reported that every single child death in the city gets reviewed by the Child Death Overview Panel.

c) Five Year Forward View (minute 192/15 refers)

The Director of Business Planning and Partnerships confirmed that Sheffield City Council would be a partner in the engagement exercise workshop along with our providers.

d) Co-Commissioning Primary Care Services (minute 194/14 refers)

The CCG Programme Director Primary Care advised Governing Body that, at this stage, she had arranged to meet with three of the four localities to discuss their views, and reported that the locality meeting she had attended earlier in the day had been supportive of Level 1 co-commissioning.

e) Remuneration of GPs Undertaking Commissioning Work for the CCG (minute 196/14)

The Director of Finance clarified that for those GPs who were offered a

contract of employment with the CCG, the effective start date for continuity of service issues would be the day they started working with the CCG.

08/15 Managing Conflicts of Interest

The Director of Business Planning and Partnerships presented this report. He reminded Governing Body that it had been prompted in part by the opportunity for the CCG to co-commission with NHS England, although the extent of new conflicts of interest would be dependent on what level of co-commissioning we adopt, but that the paper is also a reminder of definitions of what conflicts of interest are and how they should be managed. He drew members' attention to section 2 and the helpful definition and reminder of what a conflict of interest is.

He advised Governing Body that the guidance requires us to create a decision making committee for the purpose of primary care co-commissioning when we move to sharing decision making responsibility, which must have a lay and executive majority and a lay chair. He suggested that it was not necessary to form such a committee in advance of us taking on that responsibility.

The CCG Programme Director Primary Care advised Governing Body that there would be a 'sharing and learning' network across South Yorkshire and Bassetlaw where learning from those CCGs that are taking on co-commissioning above level 1 would be shared.

The Governing Body:

- Noted the legislation and guidance with regard to managing conflicts of interest and the further work to be undertaken to update the CCG's current protocol for the management of conflicts of interest.
- Considered what this means for Governing Body and Commissioning Executive Team (CET) members and member practices.
- Agreed to abide by the principles and processes outlined.

09/15 Update on Governing Body Assurance Framework (GBAF) and Risk Register (RR)

The Director of Business Planning and Partnerships presented the Quarter 2 update and a snapshot of Quarter 3. He reminded members that the Assurance Framework (AF) listed the potential barriers to us achieving our key objectives, detailed what we are doing to address or mitigate the risk, and the assurance Governing Body receives on this. He drew members' attention to the spreadsheet attached to the report which summarised where risk owners have indicated that controls or assurance of control is not yet sufficient.

The Chair of Healthwatch Sheffield asked about the frequency of assessing risks. The Director of Business Planning and Partnerships explained that the key objectives and key risks were reviewed and amended as appropriate at the start of every year, and that during the year each key individual risk is reviewed every quarter as a minimum. It was noted that unfortunately the date of the last review had not been

changed for some risks. He would ensure that future reports were fully completed and accurate in this regard.

The Governing Body:

- Noted the position with regard to the Governing Body Assurance Framework and the arrangements in place for managing high level risks during Quarter 2.
- Reviewed the outstanding gaps in control and assurance
- Noted the actions of both the Governance Sub Committee and Audit and Integrated Governance Committee and the assurance that operational risks are being effectively managed by officers.
- Agreed that the current reporting schedule from the Governance Sub Committee and Audit and Integrated Governance Committee should remain.

10/15 2015/16 Commissioning Intentions (CIs) Refresh

The Director of Planning and Partnerships presented this report and advised Governing Body that it was a refresh of the 2014/16 plan we agreed last year, rather than a new plan, and now included plans on a page for each of our portfolios, which had not been included before.

He advised Governing Body that the report will need to be updated to reflect the actions from the Health Inequalities Plan, and the 2015/16 planning guidance that had been received after the report was written. The key new requirement is that we must demonstrate that we are investing in mental health services. It also highlighted a number of new projects we have for next year, which would include the development of a Respiratory Strategy.

He advised Governing Body that we were using our Involve Me network to seek comments on the CIs and he was personally speaking to the CCG's localities and member practices about our plans. **TF**

The Director of Finance drew Governing Body's attention to section 3: financial allocations, plan and efficiency, which set out how the additional funding allocations for front line NHS services for next year had been split nationally. She highlighted that because NHS England's Board had decided that virtually all of the extra £1.1bn for CCGs should go to "under target" CCGs, Sheffield as an "over target" CCG only benefited from the decision to make tranche 1 of the 2014/15 systems resilience funding recurrent (£3.7m for Sheffield). She also highlighted that NHS England has decided to tie the general uplift to the national Gross Domestic Product (GDP) deflator and not to NHS inflation. She explained that this meant because the GDP deflator had reduced from 1.7% to 1.4% since indicative allocations were announced in December 2013, Sheffield CCG would get £2m less money than we had been planning for. It was agreed that it was not appropriate for this to result in an increase to the QIPP plan as the £6m current plan was considered challenging, but instead would need to be accommodated by reducing reserves for pressures / discretionary investment. It would make the contract negotiations for 2015/16 more challenging.

The Chair commented that we could not carry on simply 'squeezing' the system and urgently needed to pursue the transformational service changes in the Commissioning Intentions but the reduction in resources to support to change made it more challenging. He suggested that it was important for the CCG to have a communications plan to share with the public, and to start some debate and discussion to inform our decision making. The Director of Public Health agreed that the CCG needed to make the public aware of the general financial position, plus some targeted briefing of MPs and the Health and Wellbeing Board would also be helpful.

The Governing Body:

- Noted the progress to date in refreshing the CCG's Commissioning Intentions.
- Considered and agreed the next steps and actions to be taken, as noted above, before publication of the plan.
- Agreed to receive an update at the March meeting. **TF**

11/15 2014/15 Finance Report

The Director of Finance presented this paper confirming the financial position to the end of November 2014 and the risks and challenges for managing the delivery of the CCG's overall planned 1% surplus for 2014/15. She advised Governing Body that the CCG remained on track to deliver its planned surplus, with the RAG ratings remaining as per last month as there had been no material changes to the forecast spend. She highlighted that the impact of recent pressures on A&E and urgent care services were not yet factored into the reported position at this time but envisaged that they could be managed within the CCG's winter contingency reserves.

The Governing Body received and noted the report.

12/15 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) <u>Urgent Care / Acute Pressures</u>: The current national situation was very challenging for all health and social care. In Sheffield, we were seeing an increase in the numbers of people going through to A&E, and an increase in the frequency in the number of times when A&E attendances were particularly high, with a large number of these resulting in admissions, and a snapshot of the number of patients admitted during December indicated a 15% increase in certain specialties. He reported that there were a significant range of initiatives that had been taken in Sheffield that he had described in previous months, the latest of which was a CCG communications bulletin: 'Helping You to Help Yourself this Winter' sent out widely in the last few days. He advised Governing Body that the position as at 7 January was that the number of patients waiting more than four hours

at A&E was 93% year to date at Sheffield Teaching Hospitals NHS Foundation Trust (STHFT), and 97.8% at Sheffield Children's NHS Foundation Trust (SCHFT), which was one of the performing trusts in the country. This equated to a combined score of 94.7% so we were fairing better than most cities in the country. He also reported that we were increasing capacity in primary care over the winter period which included an additional 30,000 appointments for the rest of this financial year which, he reported, were being actively taken up by patients and utilised.

He also advised Governing Body we were also seeing similar pressures within the ambulance service, which at times had peaked to being quite severe and we were actively working with them to address this, along with the other CCGs as our co-commissioners. He also reported that there were a high number of patients now turning up at A&E by ambulance, which some days had been as high as 40-50% of the total numbers that day.

He advised that there was an association with the urgent care pressures on elective activity and a recent increase in cancelled operations. However, the handful of patients who had been waiting over 52 weeks for treatment had been seen and although there were some complexities around people waiting over 18 weeks this position was now improving.

He advised Governing Body that we were closely monitoring the acute pressures, especially where patients are urgent cases, ie we continue to keep very good performance on patients waiting for treatment for cancer. However, there were some specialties that would take a considerable amount of time to resolve which could, in some cases, be several months, but the general picture was that most specialties were continuing to maintain good performance. We were seeking additional private capacity for NHS patients in the short term and asking patients if they would like to do this, especially for those waiting for orthopaedic and some routine cardiac surgery procedures.

The Chief Operating Officer advised that he would be approaching the acute trusts to see if there was any early indication that the acute pressures in the system had resulted in increased mortality rates, and commented that due to the volumes and acuity of patients it would unfortunately be surprising if it did not show an increase from last year. **IG**

Dr Sorsbie asked why more people were being admitted if there had not been the same increase in the population, and she asked how many of these would only be overnight admissions. The Chief Operating Officer explained that it was not just the numbers of people attending A&E but the acuity of those patients leading to having to be admitted. A relatively small percentage change in this could have a 'tipping point' affect , but there was a high degree of complexity around this.

The Chair of Healthwatch Sheffield asked about the studies

undertaken that show that people could be dealt with elsewhere than A&E and asked why we were not creating that 'elsewhere'. The Chief Operating Officer advised that greater levels of intermediate care services had been created but deeper changes to the system would be required. The Chief Nurse commented that there was clear national evidence that between 15-20% of patients could be treated outside of A&E if the right alternatives were in place. However, going elsewhere was behavioural it was our challenge as commissioners to address that.

The Director of Finance suggested that we use our Systems Resilience Group to review the impact of the winter monies and that the evaluation would be an important part of the planning process.

Dr Sorsbie commented that some of the data she had looked at did not reflect that patients were not being admitted unnecessarily, and the challenge to Governing Body in terms of risk was what we do, as we need to do something very different by working with our providers to deliver what is best for the patient.

Ms Forrest commented that it currently felt very confusing, both for people who work in the NHS and for members of the public, as to where they should go to for urgent care.

The Chief Operating Officer would provide a further update at the February meeting. **IG**

Dr Afzal left the meeting at this stage.

b) Quality

The Chief Nurse advised members of the following:

(i) Clostridium Difficile (C.Diff): As reported to Governing Body in December, the number of cases continued to significantly drop, with only one reported case at STHFT, who were now only one case above trajectory.

(ii) Influenza: We had seen a small number of cases of Influenza A reported at STHFT, which had fortunately been relatively short lived.

(iii) Friends and Family Test (FFT): The Chief Nurse drew members' attention to the graph at page 12 and reported that this directly mirrored what was going on in terms of STHFT's performance and they continued to score very highly in terms of patient perceptions.

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

Dr McGinty joined the meeting at this stage.

13/15 The CCG's Contribution to Reducing Health Inequalities

Susan Hird, Consultant in Public Health, Sheffield City Council, attended for this item.

The Director of Business Planning and Partnerships introduced the report. He advised Governing Body that the proposals had been discussed at our Commissioning Executive Team (CET) and with each of our clinical portfolios, and were being led by Ms Hird on behalf of the CCG.

Ms Hird advised Governing Body that the CCG was already doing good work around reducing health inequalities and the paper formalised that work and proposed new initiatives, focussing on what would have the biggest impact. Most of the work would be led by the clinical portfolios. The Director of Business Planning and Partnerships advised that they had not sought in this paper to identify individually all the groups of people that might suffer from a lower life expectancy than the average.

Professor Gamsu welcomed the paper and commented that it was useful to start to formalise our approach more. We need to recognise the good work we are doing on mental health and continue to do that. With regard to the final action at table 1, he advised Governing Body that work was commencing with the community and voluntary sector to discuss how to improve access to services and to develop coherent plans for addressing inequalities at a local level and we need to continue to support that work over the next year.

The Director of Public Health welcomed the plan and asked how we were how going to make sure all the actions actually happen, how we were going to measure progress, and what the timelines would be. The Director of Business Planning and Partnerships responded that these were all practical and feasible things that could be done and the plan was to include them within our Commissioning Intentions for next year as we would not want to have a health inequalities plan that was separate to the rest of our activity. The Director of Public Health also commented that there was clearly a role for health champions and health trainers, and the plan would form part of the feedback to the Health and Wellbeing Board.

Ms Forrest felt that there was another action that should be included to systematically use the expertise, insight and experience of people in the community and voluntary sector.

The Chair of Healthwatch Sheffield advised that reducing health inequalities had been discussed at the Health and Wellbeing Board and reported that everyone has the intention to do something about it and asked if we should be focusing on asking those community and voluntary sector people the questions as to what should happen. The Chair responded that that intelligence was really valuable and would be

delighted if Healthwatch wanted to take over that discussion with the public.

The Governing Body:

- Approved the contents of the report.
- Supported the inclusion of the health inequalities actions in the CCG Commissioning Intentions for 2015/16.

14/15 Information Sharing for Direct Care

Dr McGinty, Sheffield CCG Caldicott Guardian, presented this report which proposed the next steps in order to achieve appropriate record sharing across the Sheffield system that supports best care from the patient / client perspective as there was currently a lack of sharing information about patients. He drew Governing Body's attention to section 3.1 that outlined the conclusions from the Sheffield CCG Select Committee Inquiry into Patient Data Sharing that had been set up to investigate how the sharing of the primary care record could be enhanced. He advised that it would become more important in terms of how we manage our patients and the services we commission and how we manage that data sharing with our GP members. At the moment there was a lack of sharing of information between professionals about patients, however, it was thought that patients assume that all health care workers are 'talking' to each other already.

The Chief Operating Officer advised Governing Body that the inquiry had involved extensively patients and patient experts, particularly in the area of information governance and reported that all the select committee information was available on the CCG's public website.

The Chair commented that the report did not mention that GPs have a certain number of legal obligations about sharing data, which was an important factor in slowing down the sharing of data. The Chief Operating Officer responded that the interpretation of the law around this had not helped and there were overriding principles in terms of affecting the care of the patient which are set out in the latest Caldicott guidance.

The Director of Care and Support, Sheffield City Council, commented that it was very timely and suggested taking it through the Integrated Commissioning Programme Board to raise its profile and to look at it from a Local Authority perspective.

The Accountable Officer commented that it was a good paper and the process undertaken in Sheffield was excellent, we need to be really clear about the public message and the national messages about direct and indirect use of patient identifiable data, and there needs to be a separate discussion with regard to how we share information about secondary uses.

Dr Sorsbie asked if the patient had to give consent to share their records. The Chief Operating Officer confirmed that consent of the individual would be sought at the point when access to their records was needed (with the exception of urgent or safeguarding situations).

The Governing Body:

- Confirmed agreement with the conclusion (section 5).
- Recognised that the work regarding integrating out of hospital care under the Integrated Commissioning Programme can only succeed with record sharing along the lines as described in this paper.
- Agreed a CCG position statement regarding the sharing of records for direct care, as proposed in section 7.1.
- Agreed the Principles for a good sharing process as arrived at following the Patient Select Committee work (as shown in Appendix B)
- Supported the encouragement and influencing of practices in making the transition from current arrangements to one where the primary care record is routinely shared in support of holistic person centred care.

15/15 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
- Updates on Serious Incidents
- Quarterly Update on Safeguarding
- Quarterly Update on Compliments, Complaints and MP Enquiries
- Locality Executive Group reports
- Unadopted Minutes of the Quality Assurance Committee (QAC) meeting held on 28 November 2014
  Ms Forrest, Chair of the QAC, drew Governing Body's attention to the key points which included the committee not being assured by the service currently being provided by the Yorkshire Ambulance Service NHS Trust but they were assured by the process in hand to address these. They had also discussed the Care Quality Commission (CQC) ratings of general practice and noted that their prioritisations of risk had been withdrawn from the public domain, and received assurance on all our systems that dealt with specific issues at the two acute trusts.

The Governing Body formally noted the following reports

- Unadopted Minutes of the Audit and Integrated Committee meeting held on 11 December 2014
- NHS Sheffield CCG – A Review of Localities and their Clinical Decision Making at the Heart of our CCG
  Dr McGinty advised Governing Body that the City-wide Localties' Group current plan was to meet fortnightly, not monthly as stated under section 2.2(c).

16/15 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, section (2) Public Bodies (Admission to Meetings) Act 1960.

17/15 Any Other Business

There was no further business to discuss this month.

18/15 Date and time of Next Meeting

Thursday 5 February 2015, 4.00 pm Boardroom, 722 Prince of Wales Road, Sheffield, S9 4EU

Appendix A

Question from Mike Simpkin, Sheffield Save our NHS, to the CCG Governing Body 8 January 2015

Question: The CCG will be aware that the RCN says that nationally the number of District Nurses has almost halved over the last ten years. Whatever the advantages of commissioning for outcomes, how can commissioners make a considered assessment of service quality if you do not know how the service is being delivered?

***CCG Response*:** We do not specify staffing levels in our contracts as this is too restrictive on providers in designing and improving services over time. We do monitor activity, performance and quality, and community nursing forms part of the total contract management process of the services provided by Sheffield Teaching Hospitals NHS Foundation Trust.

Having said this, we have invested significantly in the last few years in community nursing as a whole. We have also protected the core funding of district nursing whilst expecting efficiency improvements. In 2012, STHFT undertook an external review by Professor Pat Cantrill. We also invested in key developments and these resulted in a reorganisation of district nursing which extended the service's core hours to 08:00 and 22:00, seven days a week, 365 days a year. At that stage, staffing levels increased from approximately 259 to 277.

So, whilst we don't specify staffing levels as a condition of the contract, we can reassure you that we have invested in district nursing in recent years and we have not seen the reduction in Sheffield that you refer to in your question. We continue to work with STHFT to improve district nursing services and, in particular, how to improve working as a wider community team alongside GPs and social care staff.