NHS
Sheffield Clinical Commissioning Group

Minutes of the meeting of NHS Sheffield Clinical Commissioning Group Governing Body held in public on 3 September 2015 in the Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU

A

Present:
Dr Tim Moorhead, CCG Chair, GP Locality Representative, West
Dr Ngozi Anumba, GP Locality Representative, Hallam and South
Kevin Clifford, Chief Nurse
Dr Devaka Fernando, Secondary Care Doctor
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
Julia Newton, Director of Finance
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
Katrina Cleary, CCG Programme Director Primary Care
Katy Davison, Head of Communications
Rachel Dillon, Locality Manager, West
Rachel Gillott, Deputy Chief Operating Officer (for item 156/15)
Carol Henderson, Committee Administrator / PA to Director of Finance
Susan Hird, Consultant in Public Health (on behalf of the Director of Public Health)
Phil Holmes, Director of Adult Services, Sheffield City Council
Simon Kirby, Locality Manager, North
Dr Andrew McGinty, Clinical Director / CCG Caldicott Guardian (for item 155/15)
Gordon Osborne, Interim Locality Manager, Hallam and South
Mark Wilkinson, Head of Informatics (for item 155/15)

Members of the public:
There were nine 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

146/15 Welcome

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

The Chair also welcomed Dr Devaka Fernando and Mrs Maddy Ruff to the meeting.

147/15 Apologies for Absence

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

Locality Representative, Central Dr Nikki Bates, GP Elected City-wide Representative, John Boyington, CBE, Lay Member, Dr Zak McMurray, Medical Director, and Dr Marion Sloan, GP Elected City-wide Representative. The Director of Business Planning and Partnerships confirmed that the meeting was quorate.

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

148/15 Declarations of Interest

The GPs and Locality Managers that were employed in general practice declared a potential conflict of interest in item 8: Sheffield Integrated Commissioning Programme: Active Support and Recovery, as the part of the discussion would be around how to procure services.

The GPs and Locality Managers that were employed in general practice also declared a potential conflict of interest in item 12: Oral Update on the Redistribution of Personal Medical Services (PMS) Premium Funding, however, this would be an update on the process and would not be asking Governing Body to make any decisions.

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

149/15 Chair's Opening Remarks

The Chair thanked Idris Griffiths, Chief Operating Officer, for his work over the past five months in the role of Interim Accountable Officer. It had been a really difficult task and he done a fantastic job. He recommended Mr Griffiths' final Interim Accountable Officer's report appended at item 13b to Governing Body and members of the public.

The Chair had no further comments to make in addition to his report appended at item 13a.

150/15 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.

151/15 Update on the Redistribution of Personal Medical Services (PMS) Premium Funding

The CCG Programme Director Primary Care gave an oral update on progress with the CCG's approach to enabling practices to demonstrate their special circumstances for consideration and how it affected the practices identified as losing substantial funding. She reminded members that the Extraordinary meeting of the Governing Body on

16 July had agreed two key aspects: to develop a locally commissioned service for all practices that already provided services over and above core general practice services and to establish a special circumstances process.

She advised Governing Body that a draft of a locally commissioned service was in its final stages of development, with just the refining of the services to be included to be determined, in discussion with the Local Medical Committee (LMC). A final proposal would be presented to the CCG's Commissioning Executive Team (CET) for approval on 15 September, with the intention to send it to practices week commencing 21 September to give them sufficient time until the 1 October deadline to decide if they wanted to sign up or not. This deadline would co-incide with the date when practices would start to see a reduction in their contract values from NHS England.

With regard to the special circumstances process, we had already agreed that the focus is on patient need that is not fully covered by the Carr-Hill formula and we would base this on the 'London' criteria and have localised that in partnership with the LMC. The criteria had been shared with practices shortly after the 16 July Governing Body meeting with requests for submissions to be received by 31 August. We had established a Special Advisory Group specifically to review and agree whether or not practices had a special case, and to have a means of moving forward for those practices that were deemed to have a special case.

She advised Governing Body that of the 14 submissions received five had been received from the 11 practices that would be losing £20 or more per weighted patient, five from those practices that would be losing between £10 and £20 per head, and one that would be losing less than that.

Professor Gamsu asked if she had a feeling whether those practices would be able to cope with the timeline given for the CCG to move to a decision and an action plan. The CCG Programme Director advised that she had no indication that practices felt that the process was taking too long, although they had flagged up as to what might happen if they were not successful with their application, and was sure that they would raise what they would have to consider doing if they were not successful.

The Chief Operating Officer advised Governing Body that the CCG could work with NHS England to request postponement of implementing their reduction in general practice contract values if it was felt that our process was going to take some time, but currently that did not seem necessary.

152/15 Minutes of the CCG Governing Body meeting held in public on 2 July 2015

The minutes of the Governing Body meeting held in public on 2 July 2015 were agreed as a true and correct record and were signed by the Chair, subject to the following amendment:

Questions from Members of the Public (minute 126/15 refers)

Second paragraph to read as follows:

The Chair of Healthwatch Sheffield advised Governing Body that Healthwatch had undertaken a mapping exercise to see where Patient Participation Groups (PPGs) were located across the city. They would be more than happy to look at requests from members of the public for advice and help, which would fit in with the work they had undertaken on looking at access to services for those people that found it difficult, the report from which would soon be published

153/15 Minutes of the CCG Governing Body meeting held in public on 16 July 2015

The minutes of the Governing Body meeting held in public on 16 July 2015 were agreed as a true and correct record and were signed by the Chair, subject to the following amendment:

Final sentence after the recommendations to be included as follows:

Although Option 3: Use the money to support addressing Health Inequalities in the city, was not supported by Governing, they agreed that it was important. Professor Gamsu reminded Governing Body that there were real issues around inequalities that needed to be addressed in primary care, with this option an indication that more funding needed to be provided.

154/15 Matters arising from the minutes of the meetings held in public on 2 July and 16 July 2015

a) Quality and Outcomes Report: NHS111 Performance Issues (minute 132/15(c) refers)

The Chief Operating Officer advised that clarification on the calls to NHS111 by disposition type and on undertaking an analysis to understand how people get into hospital was provided under the Quality and Outcomes Report (minute 159/15).

b) Patient, Carer and Engagement Report (minute 134/15 refers)

The Director of Business Planning and Partnerships advised Governing Body that the CCG's Patient Engagement Group has just completed a period of testing out a proposed policy for reimbursement of expenses for volunteers, both with those people that were likely to have an interest in getting involved with the work of the CCG and through the CCG's Involve Me network. He proposed that, because there would be public interest in this policy, to present it to Governing Body for consideration, even though the Governance Sub-Committee had delegated authority to approve the policy. **TF**

This was approved by Governing Body.

He also advised Governing Body that the Patient Engagement Group had started to revise the CCG's Engagement Plan and would come back to Governing Body with a proposed renewed action plan. **TF**

155/15 Sheffield Health and Social Care Records Sharing

Dr Andrew McGinty, CCG Clinical Director / Caldicott Guardian and Mark Wilkinson, Head of Informatics attended for this item.

Dr McGinty presented this report. He reminded Governing Body that they had approved the paper: *Information Sharing for Direct Care" on 8 January 2015* and this paper was a follow up paper about 'Making it Happen', and took into account national and local changes since January, was based on better knowledge, and was about care record sharing within the Sheffield region, but was not about secondary uses, or national care.data issues. It provided a description of the journey that had taken place since Governing Body had set the direction of travel, with a perspective developed that set out how we wanted to improve the quality and inequalities of patient care, whilst integrating health with social care.

He advised that the aim was to bring together the currently held separate patient records from the GP, secondary care and social care, ie using patient information for wherever the patient is in Sheffield, which would make a huge difference for the person reviewing the records, and make for more efficient treatment of, and a better experience for, the patient being treated. The Health and Social Care (Safety and Quality) Act 2015 says that we have a duty to share information in the provision of care, which conflicts with our complying with the requirements of the Data Protection Act 1998 and the Department of Health Code of Confidentiality. He commented that we were never going to get legislation that says it is all right to share.

He reported that he did not know how much money it would save in the city, but from a practical point of view it was the right direction of travel.

He advised that there was an incompatibility of all our computer systems 'talking' to each other, however, Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) had bought a new system, the Medical Interoperability Gateway (MIG), that would allow them to look at data on the EMIS and SystmOne systems used by general practice, but hold no data once the records had been reviewed and closed down. The piloting of this system was just about to start and we were asking the clinicians at STHFT how they use it and what it enables them to do.

Dr Sorsbie asked what information the MIG would be sharing. It was important to work out what was being extracted as there were some things that did not have a direct impact on health care (ie information from a third person). Dr McGinty explained that he was in discussions with consultants as to what they would find useful.

He advised that there would need to be a stakeholder understanding between the GP, patient and those providers we do business with but there was currently no formal framework about how we share. How we communicated this to the patients of Sheffield was going to be paramount of its success.

The Chair of Healthwatch commented that this was not just about communication but about engagement and re-engagement with us involving all the people that this applied to, and reconnecting that both in terms of direction of travel and the content.

Dr Gill asked about the mechanism for informing patients. Dr McGinty advised that once the engagement had been completed the specifics could be included into the communications plan (Appendix E). Dr Gill advised that there were a number of practices that think patient notes should not be shared outside the practice. Dr McGinty responded that discussions would be taking place with individual practices and at Locality Council meetings.

The Locality Manager, North, commented that there would be confusion from patients who had already been asked if they would consent to sharing their records. In order for it to be successful it had to be right from the start, with all the practice team, not just the GPs, requiring training in what they should / should not be doing.

Dr McGinty advised that, for patients that had previously declined the sharing of their records, their status would be unchanged, although would be asked if they would reconsider their decision.

He reminded Governing Body about the 2014 Patient Select Committee and advised that the feedback was that patients expected us to be sharing information in this way and there were benefits from doing this. The Chief Operating Officer reminded Governing Body that all the paperwork and findings from this were available on the Internet. He reported that there was very little international evidence available, although he was aware that Finland have done this and started to see evidence of the benefits of doing it.

The paper proposed that the CCG adopt the ‘implied consent to share, explicit consent to view’ model that had been adopted elsewhere, but would need to make clear as to how this was working in general practice and ensure we have all the governance controls in place. He believed this was the model that would get the patient record to be opened for them wherever they go.

Mr Wilkinson commented that this was a complex area and they had tried to go through it with a free mind and make it as simple as they could. There was a lot to be done around the patient engagement (which was still to be completed). He reported that they had shared some of this with other organisations and there was general support for the ideas behind it.

Professor Gamsu asked for reassurance that there were systems where

this approach had been taken forward and had led to a significant improvement in terms of system and service quality. He also asked if it was the intention to allow the patient to access their own records as the paper came across that it was for the professionals only.

Dr McGinty explained that it was not specifically about patients having direct access to their own medical records as they were held in primary care. There was a separate agenda around that that already existed, with a Government initiative to drive that forward.

Director of Adult Services, Sheffield City Council, supported the proposal and commented that the patient was the biggest 'counter' as it was about patient centred care.

The Secondary Care Doctor advised that there was evidence available that reported that doing what was proposed caused no harm to the patient.

Dr Sorsbie commented that, as a lot of people did not speak English so may not understand the implications of what they were being asked to do, the privacy statement should be provided in a number of different languages. Dr McGinty responded that they would be developing a city-wide website with easy to understand guidance and literature to accompany it.

The Governing Body approved the following recommendations:

- Endorsed the approach to help aid the city-wide discussions over the next few months, noting that there may be a further city-wide paper in due course asking for formal sign up on the following:
  1. To adopt the "Implied consent to share, explicit consent to view" model as adopted elsewhere.
  2. To establish a "Sheffield Shared Records Information Governance Steering Group".
  3. To develop a city wide Record Sharing Framework.
  4. To create a city wide full Privacy Notice.
  5. To create a city wide Shared Records website.
  6. To develop other materials - Public Leaflet, Easy Read Leaflet, FAQs, Letter for Patients, Advice Leaflet for Staff, Communications pack for GP Practices.
  7. To create a patient communication plan

The Governing Body approved the following recommendations:

8. To work jointly with the Prime Minister's Challenge Fund (PMCF) to agree city-wide materials, communications pack for GP practices and that the PMCF deliver the training / support to practices.
9. To encourage GP practices to revisit those patients who are currently recorded as having refused consent to reconsider sharing their records (as part of the above).
10. To ask all SystmOne practices to change their Organisational Preference system setting from the 'implied dissent' model to the

'implied consent' model.

11. To adopt the proposed approach to a single practice citywide MIG Data Sharing Agreement – ie practice signs once.
12. To ask each Sheffield practice to sign the city-wide MIG Data Sharing Agreement – thus enabling read only sharing with STHFT and the Yorkshire Ambulance Service (YAS) now.
13. To be the vehicle for approving any future city-wide changes to the MIG Data Sharing Agreement on behalf of all Sheffield practices.

It was agreed that recommendation 12 should be extended to include the future sharing of information between practices

156/15 Sheffield Integrated Commissioning Programme: Active Support and Recovery

Rachel Gillott, Deputy Chief Operating Officer attended for this item. She presented this report which sought Governing Body's approval to pursue a partnership approach with key local providers to collaboratively redesign active support and recovery services, which could ultimately lead to a direct award of contract to these providers as opposed to pursuing a competitive tendering approach. The paper also provided some background information on the work of the programme to date and next steps. She reminded Governing Body that it was a requirement of the Health Act imposed on CCGs to consider integrated care and the best mechanism to do this.

She advised Governing Body that the CCG's Commissioning Executive Team (CET) and executive colleagues at the Local Authority had been part of the conversations. The recommended direction of travel was new territory as not many people had gone down this path before us. It was also important to recognise that the current procurement regulations still existed and that flexibilities should be allowed. With this in mind, it was proposed that Option A: a non-competitive procurement approach as outlined in the paper, subject to a positive response from providers during September and a subsequent successful co-production of the service model, would secure the CCG the best possible outcome for patients. The CCG would lead the procurement, in liaison with the Local Authority.

The Chief Operating Officer commented that the information in here would lead us to justify why we would not go out to competitive procurement and use a non competitive process. However, we cannot guarantee a legal challenge would not be sought but our defence would be that we had complied with Monitor requirements. He reported that this was increasingly common with the integration of services for this type of procurement.

The Director of Adult Services, Sheffield City Council, supported the CCG around the Local Authority's involvement in this work, and Professor Gamsu's request for further detail and links to previous reports to enable members of the public to be made fully aware as to what was happening.

The Governing Body:

- Approved Option A: a non-competitive procurement approach as outlined in the paper, subject to a positive response from providers during September and a subsequent successful co-production of the service model.
- Noted that an update on the approach and if possible, proposals on scope and funding envelope would be presented to Governing Body in October for approval.

157/15 Governance Report

The Director of Business Planning and Partnerships presented this report which updated Governing Body on seven areas of governance:

1. The terms of office for members of the Governing Body.

   The paper re-confirmed the Chair's re-election from 1 November 2015 for a further three years. He drew members' attention to a slight amendment in that the tenure of Dr Nikki Bates had commenced from 2 January 2014 for three years, and not 30 September 2013 as stated in the report.

2. NHS England's approval of the CCG's revised Constitution.

3. The proposed transfer of Upperthorpe Medical Centre to the North Locality.

4. The process for establishment of a Primary Care Co-Commissioning Committee.

   He advised Governing Body that the purpose of this committee would be to take primary care commissioning decisions delegated by Governing Body due to conflicts of interests on Governing Body, and to take decisions delegated by NHS England, should the CCG apply for and be granted those delegated powers. He had recently circulated draft terms of reference, which were compatible with the national model, to members for comment. The key issue was that we needed to be able to make decisions about the special cases process as noted under minute 151/15, which meant establishing the committee so it could meet in October. If Governing Body was happy with the principles of the committee then, as per the requirement of the CCG Constitution, he would be writing to practices asking for their agreement to the proposed changes before formally requesting approval from NHS England. **TF**

5. The arrangements for the CCG's Annual Public Meeting.

   The Director of Business Planning and Partnerships advised that the meeting would take place at The Source, Meadowhall, which had good transport links and ample space for parking.

6. The process for planning the October Members' Council.

7. The proposed dates for Governing Body meetings for 2016/17.

The Governing Body:

- Noted the terms of office for members of the Governing Body.
- Noted NHS England's approval of the CCG's revised Constitution.
- Approved the proposed transfer of Upperthorpe Medical Centre to the North Locality.
- Approved the process for establishment of a Primary Care Co-Commissioning Committee.
- Noted the arrangements for the CCG's Annual Public Meeting.
- Noted the process for planning the October Members' Council.
- Approved the proposed dates for Governing Body meetings for 2016/17.

158/15 2015/16 Finance Report

The Director of Finance presented this report which provided Governing Body with information on the financial information for Month 4 and the key risks and challenges to deliver the planned year end surplus of £7.4m (1%). She advised Governing Body that the level of risk was quite high and that a number of clinical and managerial actions, as a result, are being considered and / or implemented to mitigate those risks.

She drew members' attention to Appendix A and the Memo Table: NHS England Presentation of CCG's financial position. She advised that this reporting had arisen to give greater clarity in the context of most CCGs declaring year end surpluses whilst many provider trusts were in deficit.

The report highlighted that the 1% surplus in 2015/16 was being achieved through the carry forward of resources from prior years. For 2015/16, the CCG was planning only to break even on its allocation for this year. This was the position for many CCGs and it was proving challenging to deliver, but we needed to achieve this due to the financial pressures ahead in 2016/17 and beyond. She reminded members that CCGs had no automatic 'right of access' to their historic surpluses, as 'draw down' of historic surpluses was a matter of negotiation between NHS England and the Department of Health / Treasury. Unlike trusts who will have 'cash in the bank' as a result of any historic surplus, the financial regime for CCGs is such that the cast sits with the Treasury.

The Chair advised that the Governing Body had discussed in the private session the CCG's financial position including a complete review of the risks and challenges set out in the paper and potential mitigating actions.

Finally, the Director of Finance asked Governing Body to approve, in line with the Better Care Fund (BCF) Section 75 Agreement, the changes to the budgets within the BCF as set out in section 4. She reassured Governing Body that these had been reviewed by the Executive Management Group who had recommended them to Governing Body for approval.

The Governing Body:

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

159/15 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) Overall Performance: There were some areas of improvement, especially in 18 weeks which was pleasing to see, however, there were still a limited number of specialties that were not meeting the 18 week target – orthopaedics and cardiology which we were pursuing with STHFT.

b) Maximum Four Wait in A&E: Performance had improved since the last report which was currently at 94.4% year to date for STHFT and overall at 94.52% for Quarter 2. Sheffield Children's NHS Foundation Trust (SCHFT) were the second best performing hospital in the country.

He advised that the number of patients that were directed to A&E by their GP was relatively low, but our overall attendance benchmarking-wise was relatively high. The proportion of people aged between 20-30 and above 85 attending A&E was proportionately high, with a significant number of those aged 20-30 discharged without any follow up. He reported that, on average, although we have about 310 A&E attendances a day, a significant number of hospital admissions were not made through A&E. Some were direct pathways, transfers from another department at A&E, or from intra hospital referrals.

Ms Forrest reported that the STHFT Governors' meeting she had attended earlier in the week had discussed A&E attendance. They had had concerns about the number of attendances, people being confused about what the options are for seeking out of hours care, and what roles people can take to manage their own conditions. The Chief Operating Officer advised that this was being taken forward by the urgent care review, which would be brought back to Governing Body in due course. The review would also address why our use of 111 was lower than the national and regional averages.

c) Ambulance Response Rates: Ambulance performance continued to remain one of our biggest challenges, which were taking up through the collaborative commissioning arrangements at Wakefield CCG.

d) CCG Assurance Process: He drew Governing Body's attention to the final two pages of his report which detailed this year's assurance process with NHS England and described the four levels of assurance. He advised that the Quarter 4 rating for 2014/15 had still not been received, due to the moderation exercise by NHS England across the

CCGs, which he would report as soon as it was available. **IG**

e) Quality

The Chief Nurse advised members of the following:

(i) Clostridium Difficile (C.Diff): Performance continued to improve, with the CCG and STHFT below our respective targets. SCHFT had already reached their target for the year which was only three. As reported previously, very low targets of less than 10 are acknowledged to be poor indicators of performance and quality and therefore the significance of this was limited

(ii) Patient Experience: This month's report focused on SCHFT. There continued to be an increased in the number of complaints, most of which related to the building work currently being carried out and to the lack of parking facilities.

The Chair of Healthwatch raised concerns about the Friends and Family Test and the decrease in the number of patients that would recommend Maternity touch point 3 (postnatal ward) at the Jessop Wing, and also reported on the recent negative activity on Patient Opinion around this. She asked for assurance that this would be reviewed. The Chief Nurse responded that every single report was picked up with the relevant provider and that, specifically in relation to Maternity, the number of "touch points" was acknowledged to be a problem and this may account for low response rate. In addition, he confirmed that we also seek assurance from providers and make comment, where appropriate, on Patient Opinion stories.

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

160/15 Reports circulated in advance of the meeting for noting:

The Governing Body formally noted the following report:

- Chair's Report
  Dr Sorsbie asked if the Chair had any further information about his national meeting with MPs. The Chair advised that he had been attending NHS Clinical Commissioners' meetings which was now a big part of the NHS Confederation. Part of the work done had been through the Core Cities (the big cities outside of London) activity, which had been valuable, and part of this had been around the development of Health and Wellbeing Boards and what the future of that might be. As part of that, he had attended a meeting chaired by Norman Lamb, Liberal Democrat MP for North Norfolk, to talk about how health and social care can work together more closely. People

were quite interested in what we might do next and it was an opportunity to influence some of their thinking.

The Governing Body formally noted the following reports:

- Interim Accountable Officer's Report
- Key Highlights from Commissioning Executive Team and CET Approvals Group meetings
  With regard to the proposals for spend for 2015/16 Research Capability Funding, the Chief Nurse advised that we have to get sign off for any work we do for the clinical research network and have to prepare a report each year on what we do and what we spend. He advised that we now have a part time research manager in post to help us to support primary care research, including its governance arrangements, and all of the research projects have to git with our Commissioning Intentions. He would circulate a copy of his paper to members. **KeC**

  He also advised Governing Body that the Care Quality Commission (CQC) had published reports for five of the six practices it had visited, which had all been rated in the Good category and had all received recommendations as to where they could improve. He would share with Governing Body the one page briefing he had presented to the Quality Assurance Committee meeting the previous week. **KeC**

The Governing Body formally noted the following reports:

- Update on Serious Incidents (SIs)
- Locality Executive Group (LEG) reports
- CCG Annual Audit Letter 2014/15
- Communications Quarterly Update

161/15 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.

162/15 Any Other Business

There was no further business to discuss this month.

163/15 Date and time of Next Meeting

The next meeting will take place on Thursday 1 October 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 3 September 2015

Question 1: **Devolution: Has the possible devolution of NHS services played any part in the planning of proposals of wider devolution for the Sheffield City Region? Has the CCG developed any view about the desirability and feasibility of such NHS devolution? If there are proposals relating to the NHS, does the CCG agree that there should be widespread public consultation before any commitments are made?**

CCG response*: Sheffield CCG has been involved in discussion around devolution in a very broad sense. At the moment we do not have any concrete plans around devolution.*

There are some interesting aspects of devolution that we might explore in the future. Devolution is not an end in itself, of course, it is just the means to an end. If it meant that we could focus Sheffield services on Sheffield people, as well as meeting national expectations, then that would be a good thing. We would need to understand what powers and freedoms we would need that we don't currently have to help us to do this. We would also need to understand what the risks are.

If the point of devolution is to focus on outcomes for the people of Sheffield, then the people of Sheffield should have a strong voice in determining which outcomes are the most important to them and how they might be achieved.

Question 2: Sheffield Walk-In Centre: Evidence from elsewhere suggests that the overall costs of walk-in centres are higher than those of GMS and probably many PMS services. How is the Sheffield GP walk in centre, run by One Medical Group under separate contract, affected by the GP income equalisation proposals? What measures has the CCG taken to ensure that other local GP services which are having income reductions are not competitively disadvantaged in relation to the Walk In Centre? How does the walk-in centre relate to the Satellite Hubs being instituted under the Prime Minister's Challenge Fund?

CCG response*: The facility at Broad Lane has two separate service elements: a walk-in service which is under contract to the CCG and which is not part of the General Practice equalisation process; and a general practice service for its registered list of patients. This is provided via an Alternative Personal Medical Services (APMS) contract with NHS England. It is envisaged that both elements will be re-procured over the next 12-18 months. The CCG continues to treat all practices equitably in the services we commission, eg Locally Commissioned Services, regardless of their contract status. The Satellite Units being developed via the Prime Minister's Challenge Fund are separate to the walk-in centre.*

Question 3: Sharing Personal and Medical Information: Paragraph 10 of Agenda Paper C refers to revisiting the 11% of "patients who are currently recorded as having refused consent to reconsider sharing their records". Presumably this high proportion includes the patients who opted out of the care data programme, although these opt-outs have apparently not yet been actioned by the Department of Health. Leeds is a pathfinder for the reactivation of the care data programme and the Leeds Care Record website states clearly that the care data programme is quite separate from the Care Record. Does Sheffield observe a similar distinction and if so, why have these opt-outs been referenced in this way? What safeguards are proposed a) to prevent the proposed sharing of records for integrated care being used to circumvent care data-opt outs thus potentially enabling patient data to be more widely shared, including for commercial purposes? and b) to prevent unauthorised access to personal medical records, particularly within non NHS agencies like the local authority and private sector care providers?

***CCG response**: This paper is about "care **record sharing within the Sheffield region** – it is not about secondary uses, or national care.data issues" (Section 1, Page 3, 4th para)*

There are specific, and different codes, to record opt out of each of the following:

- *risk stratification profiling,*
- *Summary Care Record,*
- *care.data*
- *or to opt out of SystmOne eDSM (SystmOne practices only) record sharing*

There has been confusion in the past about what patients are opting in/out of and we believe that the national care.data concerns has led some records to be opted out of sharing altogether (even for direct care purposes) rather than just exclusion from care.data

The question about commercial purposes relates to data extracts flowing to the Health and Social Care Information Centre (HSCIC) and their subsequent use. The sharing discussed in this paper is between live operational clinical systems for health and social care professionals and does not relate to data extracts to the HSCIC.

Appropriate access to records is governed by access controls within each operational system (eg NHS role based access smartcard for the NHS access to SystmOne).

The paper says "We need to start refining our record sharing plans to be more granular in terms of which data items are needed by, and shared with, which professionals, for what purposes. We also need to ensure that this is enabled so that the professionals have actual, easy, access in reality." (Section 2, Page 3, last para). We need to look at each of these on an organisation by organisation, system by system basis as we look to implement access, and reflect the security / access controls of each in the city wide Record Sharing Framework (Section 7.2)