Minutes of the meeting of NHS Sheffield Clinical Commissioning Group Governing Body held in public on 7 July 2016 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
Dr Nikki Bates, GP Elected City-wide Representative
Mr John Boyington, CBE, Lay Member
Mr Kevin Clifford, Chief Nurse,
Dr Devaka Fernando, Secondary Care Doctor
Ms Amanda Forrest, Lay Member
Professor Mark Gamsu, Lay Member
Dr Anil Gill, GP Elected City-wide Representative
Mr Idris Griffiths, Director of Health Reform and Transformation
Ms Julia Newton, Director of Finance
Mrs Maddy Ruff, Accountable Officer
Dr Marion Sloan, GP Elected City-wide Representative.
Dr Ted Turner, GP Elected City-wide Representative.
Mr Phil Taylor, Lay Member

In Attendance:
Ms Sarah Baygot, Communications and Engagement (on behalf of the Head of Communications)
Mrs Katrina Cleary, CCG Programme Director Primary Care
Mr Will Cleary-Gray, Programme Director Commissioners Working Together (for items 92/16 to 95/16)
Mrs Rachel Dillon, Locality Manager, West
Dr Mark Durling, Chair, Sheffield Local Medical Committee
Mr Greg Fell, Sheffield Director of Public Health
Mrs Rachel Gillott, Deputy Director of Delivery and Performance (for items 99/16 and 100/16)
Ms Carol Henderson, Committee Administrator / PA to Director of Finance
Mr Simon Kirby, Locality Manager, North
Mrs Kate Laurance, Head of Commissioning, Children, Young People and Maternity (for items 90/16 and 92/16 to 93/16)
Dr StJohn Livesey, Clinical Director Urgent Care (on behalf of the Medical Director)
Mr Jim Millns, Assistant Director of Contracting (for item 90/16)
Mr Peter Moore, Director of Integrated Commissioning
Ms Judy Robinson, Chair, Healthwatch Sheffield
Mr Eugene Sullivan, Interim QIPP Director (for item 98/16)
Ms Michelle Wilde, Joint Locality Manager, Central

Members of the public:
There were seven 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 Delivery.

ACTION

80/16 Welcome

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

81/16 Apologies for Absence

Apologies for absence had been received from Dr Amir Afzal, GP Locality Representative, Central, Mr Tim Furness, Director of Delivery, Dr Zak McMurray, Medical Director, and Dr Leigh Sorsbie, GP Locality Representative, North.

Apologies for absence from those who were normally in attendance had been received from Ms Katy Davison, Communications and Engagement Lead, Mr Phil Holmes, Director of Adult Services, Sheffield City Council, Mr Gordon Osborne, Interim Locality Manager, Hallam and South, and Mr Paul Wike, Joint Locality Manager, Central.

82/16 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

83/16 Chair's Opening Remarks

The Chair thanked the Chief Nurse, who was attending his last meeting of the Governing Body due to his retirement from the CCG at the end of August, for his contribution to the Governing Body over the past few years.

He had no further comments to make in addition to his report appended at item 22a.

84/16 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.

85/16 Minutes of the CCG Governing Body meeting held in public on 5 May 2016

The minutes of the Governing Body meeting held in public on 5 May 2016 were agreed as a true and correct record and were signed by the Chair.

86/16 Minutes of the CCG Governing Body meeting held in public on 26 May 2016

The minutes of the Governing Body meeting held in public on

26 May 2016 were agreed as a true and correct record and were signed by the Chair.

87/16 Matters Arising

a) Public Health Quarterly Update (minute 64/16(c) refers

The Director of Public Health advised members that he would email the Committee Administrator with clarification as to what the definitions homelessness were. **GF**

Post meeting note:

Legal Definition

Homelessness Code of Guidance for Local Authorities

Under the legislation (Part 7 of the Housing Act 1996), certain categories of household, such as families with children and households that include someone who is vulnerable, for example because of pregnancy, old age, or physical or mental disability, have a priority need for accommodation. Housing authorities must ensure that suitable accommodation is available for people who have priority need, if they are eligible for assistance and unintentionally homeless (certain categories of persons from abroad are ineligible.) This is known as the main homelessness duty. The housing authority can provide accommodation in their own stock or arrange for it to be provided by another landlord, for example, a housing association or a landlord in the private rented sector.

Prevention and Access to Supported Accommodation

As a Council we also provide advice, help and support to people who are homeless, or are threatened with homelessness . The Council can help to prevent homeless and support people to remain in their home or when this is not possible, to access affordable and sustainable accommodation. The Council can also help people who are homeless to find a suitable property in the private rented sector.

The Council will also facilitate those who are homeless with support needs into a suitable placement – this may be self-contained accommodation with floating support, or a refuge or hostel. Some schemes are long-term designed for people who need support to live independently, other are short-term, designed to help people acquire the emotional and practical skills needed to move on into more mainstream housing.

Sheffield City Council Definition (we used for the Homeless Health Needs Audit (which is included on the Sheffield Health and Wellbeing Board Website) is:

Section 1: Purpose of the Homeless Health Needs Audit:
This audit is a snapshot of the needs of a sample of homeless people in Sheffield. For the purpose of this audit, the definition of “homeless” is that

used in the national framework used by Homeless Link. That is, single homeless people, generally understood to be those who do not have a secure or suitable place to live but do not meet the priority need criteria.

b) Unadopted Minutes of the Primary Care Commissioning Committee Meeting held on 1 April 2016 (minutes 29/16, 55/16(c), 65/16 refer)

The Programme Director Primary Care advised Governing Body that she would be pulling together high level reports for Governing Body on the key issues discussed at Primary Care Commissioning Committee meetings. **KaC**

c) Proposed Changes to the NHS Sheffield CCG Constitution (minute 76/16 refers)

The Accountable Officer advised Governing Body that Member practices had approved the proposed changes to the Constitution, with the final result showing that 53 out of 86 practices (58%) had cast a vote. Of these 53 votes, 50 were yes votes, two were no votes and one was incorrectly completed. Therefore, 94% of the votes cast were in agreement to the proposed changes

The proposed changes would now be submitted to NHS England for final approval.

88/16 Update on Care Outside of Hospital

The Director of Health Reform and Transformation gave a presentation that updated Governing Body on progress with the development of Care Outside of Hospital, including the Primary Care Strategy, Urgent Care Strategy, Active Support and Recovery, and Developing Neighbourhoods.

He reminded members that there were three key elements of care outside of hospital.

The first element was around primary care and working proactively to link this to person-centred care, which was something that could be applied to every profession. He advised that the primary care strategy recognised the ever increasing pressures that practices were working under, and this had also been recognised as part of NHS England's "*Five Year Forward View".* The CCG would be working with practices to work 'at scale', especially at neighbourhood level, and supporting their plans for sustainability.

The second element was around the urgent care strategy, for which there were elements already being implemented, including looking to relocate the GP Collaborative in association with Sheffield Teaching Hospitals NHS Foundation Trust (STHFT), and also the possibility of co-location of an urgent primary care centre, which it was hoped could be done before the end of the year.

The third element was around Active Support and Recovery and

developing neighbourhoods. The Director of Health Reform and Transformation advised Governing Body that we were very actively involving the voluntary sector in the neighbourhood care model.

He advised that 10 neighbourhoods were now identified and in a few weeks time hoped to be able to identify the ones that cover the whole of the city. He reported that each of the neighbourhoods were being launched by a 'big tent' event; four of which had already been launched and well attended. Each one of those events would have then come up with the areas of care they thought they could most improve. Initial themes from the events were summarised at slide 10.

He advised Governing Body that it was already implementing change on the ground and really gathering pace, and was being linked to the work of People Keeping Well. They were developing a comprehensive social prescribing service that would be launched this summer, and this service was fundamentally about allowing professionals to refer a patient to a part of the system that was not part of formal care. This would support local based services in a practice, for example Darnall Wellbeing which is located in Darnall Primary Care Centre, but health professionals would also be able to refer a patient to a city-centre service and it would then direct according to the individual patient's needs. He advised Governing Body that feedback from People Keeping Well and referral to community support workers had been really good, for example relating to the referral of people to the Benefits Advice Service.

Professor Gamsu welcomed this approach and that it was hopeful given the integration with the Local Authority which was different to what it was a few years ago. With regard to social prescribing, we needed to be thinking about how we do that with a co-ordinated approach, and have to recognise there is a problem there that, as a CCG we have to address.

Professor Gamsu also commented that with regard to the People Keeping Well approach, one of the precious things we have was some key anchor organisations that were very much part of delivery, and part of our solution would be to think about our overarching relationship with them. The Director of Health Reform and Transformation responded that one of the benefits of the new model was that we could design services around particular areas and work with the voluntary groups within that, which was a critical part of the model. We were also working with Sheffield City Council, particularly around community partnerships and how they could be best used. He also advised that he had met with Voluntary Action Sheffield (VAS) and Sheffield City Council in relation to developing a model to expand access to social prescribing.

With regard to how to get more resource into neighbourhoods, the Director of Health Reform and Transformation advised that we would be supporting services to be effective to be able to take some of those savings and put them back into the services. .He would come back to Governing Body with a model on how that might be achieved. **IG**

Ms Forrest commented that it was a fantastic vision, and that it was very

positive that people were turning up for the ‘big tent’ events. She reported that her experience as a carer was that people do not see carers as part of an organisation or a system so they tend to work in silos. She commented that the CCG needed to know that STHFT also own that picture as they run a lot of the community services. She also raised the issue of how information on patients is shared and managed and reported that she had seen different professionals having their own approach to record keeping, which was not helpful in trying to look at this in a holistic way, but she would be interested in finding out more about this.

The Director of Health Reform and Transformation reminded members that they had agreed an information sharing model at Governing Body so there was a process in place but needed to get the infrastructure in place to support that. There needed to be more shared records, and we would build on that with a system that would allow that technically as part of the digital road map.

The Locality Manager, West, advised members that there had been so much energy and enthusiasm from the people that had attended the ‘big tent’ events, with fantastic ideas being generated. However, the next step would be to prioritise and implement those ideas.

The Chair raised the issue of leadership as, if people operated in silos, then there would need to be someone in a leadership role to manage that. He commented that developing the leadership in the groups would be huge, as would the organisational development (OD) requirement.

The Locality Manager, North commented that there was something about how decisions were made if working in neighbourhoods and what would happen if it didn’t go as smoothly as people envisaged. We needed our practices to lead on supporting neighbourhood development, and not just focus on what they want to get out of it.

The Joint Locality Manager, Central, advised members that two events had taken place in Central Locality, which was the starting point that would enable them to do things differently, and was very encouraging.

The Chair advised members that it was apparent from the City-wide Locality Group that the practices were ready for change and adopting what the CCG had asked them to. However, the change of pace issue could be a challenge and so we needed to be ready to support our practices. This arrangement needed to mature quite quickly and we needed to make that investment so that our system was viable as, if we did not manage the pace of change or investment it would be a credibility problem for the CCG.

The Secondary Care Doctor commented that ‘tribes’ of professionals, for example geriatricians, tended to work within their own competencies so there was a workforce change and skills transfer that had to go strategically with neighbourhood working. The Clinical Director Urgent Care advised that Nottingham had done a lot of work on this, including looking at going down the route of having generic workers.

The Accountable Officer advised Governing Body that, as a CCG, we were currently looking at our structures which would support these developments. This would include creating an out of hospital delivery team to support primary care, which the whole focus of the CCG has to change to support. She also commented that leaders would emerge and the CCG's role was to support and give them the right development.

The Accountable Officer also advised Governing Body that the Primary Care Strategy had been launched at a recent Protected Learning Initiative (PLI) event that had been well attended by practices. She reported that some workshop sessions in the localities would be arranged as part of a whole raft of practical things the CCG needs to be doing to general practices, some of which would naturally be supported through the neighbourhoods.

The Director of Health Reform and Transformation advised Governing Body that Active Support and Recovery was gathering pace, A draft Memorandum of Understanding (MoU) was been developed across all of our providers, which included comments and feedback from the voluntary sector. He advised that the Governing Body would need to consider if the MoU would be sufficient to move us forward at the pace we wanted to move or if we would need to procure from other parts of the city. He commented that we have a real opportunity to create that integrated services across the city and that we were on a journey of evolution but needed the formal structures in terms of making this happen.

The Accountable Officer requested that, for the next meeting, Governing Body receive an update on the general practice element and what the CCG was doing to support general practice. **KaC/IG**

The Governing Body received and noted the presentation.

89/16 Proposal for the Extension of the Tenure of Elected Governing Body GPs

The Director of Health Reform and Transformation presented this report. He explained that the tenure of three of the four city-wide (elected) Governing Body GPs was due to conclude on 30 September 2016 and the fourth on 1 January 2017, which coincided with a number of internal reviews being undertaken in relation to the roles and responsibilities of the Governing Body GPs, the outcomes from the CCG's stakeholder survey 2016, and reorganisation of the executive team. As it was important during this time to maintain a level of continuity and stability, the report recommended an extension of the tenure for the city-wide (elected) Governing Body GPs rather than opening it back out to election. This could be undertaken within the CCG's Constitution by enacting SO3.9 (Suspension of Standing Orders, provided that at least two-thirds of the whole number of the members of the Governing Body were present (including at least one member who was an Officer Member of the CCG and one member who was not) and that at least two-thirds of those members present signified their agreement to such suspension) and

suspending Standing Order (SO) 2.2.4 (Elected GP Representatives), pending the above internal review process.

The Director of Health Reform and Transformation advised members that when the timeframe had been agreed, following completion of all the processes, a communication would be sent out. In the meantime, a meeting had been arranged for 4 August for the Governing Body GPs to meet with the Chair. **TM**

The Governing Body agreed to Enact Standing Order 3.9 (Suspension of Standing Orders) and suspend Standing Order 2.2.4 (Elected GP Representatives), pending the conclusion of the internal review process.

90/16 Children and Young Peoples and Mental Health Services: Integrating Commissioning Between NHS Sheffield CCG and Sheffield City Council

Mrs Kate Laurance, Head of Commissioning, Children, Young People and Maternity and Mr Jim Millns, Assistant Director of Contracting, were in attendance for this item.

Mr Millns presented this report which provided Governing Body with an overview of the work to date between the CCG and Sheffield City Council (SCC) regarding the establishment of joint commissioning arrangements, specifically relating to children and young people and mental health services and sought their approval to continue with this work.

Mrs Laurance advised Governing Body that there had been a number of national drivers that had pushed our joint work together and brought it together from a planning perspective, which had enabled us to work more effectively around planning service reviews and contract management, etc, but it was worth noting that this did come with challenges. She also advised that there were a lot of national and local agendas that were pushing this to support and enable delivery of some key health improvement and was something that we should be considering as an organisation.

The Chair commented that he agreed with the approach. However, he felt that the funding streams were fragmented and did not see much in the paper as to how we deal with cost shifting, etc, and this had to be a risk.

The Director of Integrated Commissioning advised Governing Body that there were absolutely excellent relationships between SCC and the CCG, which were robust enough to manage fairly difficult problems. It needed to set the tone for where we are. There were areas where we have joint budgets, for example equipment. We need to forget the individual organisation and understand it from a more holistic perception the organisational objectives.

The Director of Public Health commented that the relationships between the individuals in each organisation were really good and the problems were more structural. He questioned how close we were to having purely

joint budgets and commented that there could be more about upstream interventions for the mental health joint budget.

Mr Millns commented that this was the beginning of our journey. It had taken a lot of time and effort to build up that trust, to recognise what the pressure points are, the benefits to be gained by doing it through integrated commissioning outweighs the negatives, and there was a degree of jointness about addressing the ongoing problems. Mrs Laurance commented that it was about ownership of each other's business and getting joint ownership of that. It was about SCC and CCG owning the access targets and jointly supporting the new resources across.

The Accountable Officer advised that, as a Governing Body, they had not had a paper to update them on the work done on the direction of travel for joint commissioning with SCC, which she requested for the September meeting. She commented that the report was a position statement for children's services and personally felt that it was the right direction for children and young people's services. She advised Governing Body that, under the CCG's new structure, children's services would come under the remit of the Director of Integrated Commissioning. Governing Body needed to understand what the joint budgets would be and the financial risks. The Director of Integrated Commissioning would discuss this with the Director of Finance outside of the meeting. **PM/JN**

The Governing Body:

- Noted the work that has been undertaken to date between NHS Sheffield CCG and Sheffield City Council regarding the establishment of joint commissioning arrangements.
- Approved the continuation of this work, so that genuine integrated commissioning arrangements are fully established around Children and Young People's and Mental Health services.

91/16 CCG Procurement Strategy

The Director of Finance presented the refreshed Procurement Strategy that had been updated to reflect changes to the Public Contract Regulations (2015), a paper on which had been presented to Governing Body on 5 May 2016.

The Accountable Officer commented that she could not see any mention of commissioning for social value in the strategy. The Director of Finance explained that the review had only been undertaken at this stage on technical issues but that this, and other issues, would all be addressed in the next iteration of the Strategy.

Professor Gamsu questioned who the written reports that had to be produced for any contract entered into would be aimed at. The Director of Finance explained that they should be put into the public domain for any contracts we award.

The Director of Integrated Commissioning commented that, where we

would probably need some help, would be with how we procure outside of the procurement process.

The Governing Body approved the revised version of the CCG's Procurement Strategy, noting that a further iteration, subject to further amendments being made as noted above, would be presented to Governing Body for approval in due course. **JN**

92/16 Commissioners Working Together Communications and Engagement Report: Pre-consultations for Children's Surgery and Anaesthesia and Hyper Acute Stroke Services and Draft Strategy for Consultation

Mr Will Cleary-Gray, Programme Director Commissioners Working Together, and Mrs Kate Laurance, Head of Commissioning, Children, Young People and Maternity, were in attendance for this item.

Mr Cleary-Gray presented this report and drew Governing Body's attention to the key highlights. He advised that it was very much about improving quality, and reported that an open pre-consultation had been held, with a lot of time spent trying to reach as many people as possible about some of the potential opportunities there were to improve services.

Review of Children's Surgery and Anaesthesia

A summary of the issues people had fed back mattered most to them was included at section 2.4, with the most important factors being safety, quality of care, access to specialist care, and care closer to home. There was also a strong theme around communication between all the services and for the patient being seen as soon as possible.

Hyper Acute Stroke Services

Being seen quickly and accessing appropriate specialist care was predominant in the pre-consultation themes as was travel time, good access to rehabilitation services and making sure they were absolutely connected to those services.

Mr Cleary-Gray also drew Governing Body's attention to the draft strategy for consultation and advised that we would have to consult formally on the potential changes. The consultation period would run from 3 October 2016, to the 17th January. He advised that it would be helpful to get as much feedback as possible from Governing Body to develop the strategy.

Professor Gamsu commented that he was surprised that the Equality Impact Assessment (EIA) for the data for hyper acute stroke services had been based on 2011/12 services, some of which were now out of date, and was concerned that we could be more robust in how we look at these to challenge ourselves more. He also commented that there was an inequalities dimension in terms of transport. The director of Public Health explained that once a stroke patient was in the system they were equitably treated. Mr Cleary-Gray noted this and informed the Governing Body that

the EIA would be updated at a number of stages including before consultation.

The Chair commented that he felt taking steps to improve services for the better had been waiting for a while due to the NHS reorganisations and this was a key milestone.

Ms Forrest commented that it was really important to get the consultation absolutely right and really straightforward on the issues we were consulting on, be very clear on the reasons why we were consulting.

Mr Boyington commented that there was a danger that this would be reported as cuts to services rather than improving care, so the way the argument was presented would be very important.

Finally, Governing Body members were asked to feedback any further comments on the draft strategy to the CCG's communications and engagement team (sophiejones25@nhs.net) as soon as possible.

The Chair reminded members that the supporting documentation for this report was available for Governing Body members in the 7 July 2016 Governing Body papers at: http://www.sheffieldccg.nhs.uk/about-us/GB-meetings.htm

The Governing Body noted the pre-consultation report into children's surgery and anaesthesia and hyper acute stroke services.

93/16 Commissioners Working Together: Children's Services – Surgery and Anaesthesia Options Appraisal

Mr Will Cleary-Gray, Programme Director Commissioners Working Together, and Mrs Kate Laurance, Head of Commissioning, Children, Young People and Maternity, were in attendance for this item.

Mrs Laurance presented this report which provided Governing Body with an update on the work undertaken to date in reviewing children's surgery and anaesthesia services across South Yorkshire, Bassetlaw and North Derbyshire. She advised Governing Body that lots of work had been undertaken and engagement with all communities to develop the service specification and in developing the options outlined in the proposals.

The feedback from patients and their parents / carers was really important in developing the proposals. One of the key elements of the proposed model was that it brings the system together in a networked approach children's surgery and anaesthesia.

The Chair commented that it was about quality across the whole system, and about the overall sustainability of service.

The Chair reminded members that the supporting documentation for this report was available for Governing Body members in the 7 July 2016 Governing Body papers at: http://www.sheffieldccg.nhs.uk/about-us/GB-

meetings.htm

The Governing Body:
- Noted the work to date.
- Approved the options appraisal, emerging model and plans for public consultation.
- Supported the next phase of development of the full business case, and to receive a full business case for approval in the New Year.

94/16 Commissioners Working Together: Hyper Acute Stroke Services (HAS) Options Appraisal

Mr Will Cleary-Gray, Programme Director Commissioners Working Together, was in attendance for this item and presented this report which provided Governing Body with an update on the work undertaken to date in reviewing Hyper Acute Stroke Services (HAS) across South Yorkshire, Bassetlaw and North Derbyshire. He advised Governing Body that the focus of the proposals were about improving quality for all our local populations across South Yorkshire and Bassetlaw. The proposed approach would also lead to a much more networked approach to stoke care. The options were very clearly laid out in terms of model of provision and would be made very clear in the consultation the quality improvements that would result.

The Director of Public Health asked what would happen if Chesterfield (which was one of the three preferred units to provide hyper acute stroke services for South Yorkshire, Bassetlaw and North Derbyshire) was not the preferred site to provide services for East Midlands following their review. Mr Cleary-Gray responded that they had factored in that there could be a potential change in that they may or may not provide these services in the future and the proposals had taken that into consideration..

The Chair of Healthwatch Sheffield asked about the Equality Impact Assessment (EIA), in particular transport and travel time and if there was a wider view about the possible impact on patients and their visitors / carers of access to services. Mr Cleary-Gray responded that this was part of the key issues for consideration and had been part of the pre-consultation and they would be trying to tease this out further in the next stages. Travel time was a key metric assessed in all of the available options and a travel time had been maximum travel time had been factored in. He also advised that there would be a repatriation policy agree as part of any future changes that would ensure patients can get back to their own local hospital or home.

The Chair reminded members that the supporting documentation for this report was available for Governing Body members in the 7 July 2016 Governing Body papers at: http://www.sheffieldccg.nhs.uk/about-us/GB-meetings.htm

The Governing Body:
- Noted progress of the work.
- Approved the options appraisal, supported the preferred option, to

move from a five hyper acute stroke unit's model to a three unit model in the first stage and plans for public consultation.
- Agreed to receiving the full business case with recommendation for change for final Governing Body approval following formal consultation in the New Year..

95/16 Commissioners Working Together: Chemotherapy Delivery Model Case for Change

Mr Will Cleary-Gray, Programme Director Commissioners Working Together, was in attendance for this item and presented this report which requested Governing Body to consider the Case for Change for delivering Chemotherapy across South Yorkshire and Bassetlaw. He advised members that they had been asked as a group of CCGs to review chemotherapy outreach services The current model of provide was not equitable and therefore required a review and it had become very difficult to continue with and sustain the current model and the report gave a full precis of the outreach services

He drew Governing Body's attention to the three options that had been identified following the review:

1. Do nothing as the services are not sustainable.
2. Retain current model, implementing best practice across all outreach localities.
3. Assess and review the needs of South Yorkshire, Bassetlaw and North East Derbyshire to inform and implement a new model.

He advised that the report was asking Governing Body to support the next phase of the work (Option 3) – one that would be sustainable, given that both more and more people were being diagnosed with cancer and were living through cancer.

The Secondary Care Doctor asked if workforce reconfiguration in secondary care would be reviewed, as that needed to be part of the next stage of work, and that it would need to be part of the strategy to engage with consumers that this would not be a cut in services. The Chair commented that the workforce would need to be different to be able to deliver the new model as we could not expect them to carry on delivering services the way they were currently doing. Mr Cleary-Gray advised that they had not talked about how these would fit with the wider Sustainability and Transformation Plan (STP), would be picking up what the future workforce looks like, and the out of hours model would also be looking at that.

The Chair reminded members that the supporting documentation for this report was available for Governing Body members in the 7 July 2016 Governing Body papers at: http://www.sheffieldccg.nhs.uk/about-us/GB-meetings.htm

The Governing Body:
- Noted the work to date.

- Assessed and reviewed the needs of South Yorkshire, Bassetlaw and North East Derbyshire to inform and implement a new model" following the initial case for change contained in the detailed report.
- Approved the recommendation to progress option 3.

96/16 Commissioning for Value – Decision Making and Prioritisation Framework

The Accountable Officer presented this report which proposed a formalisation of the CCG's decision making processes to ensure transparency, consistency and fairness in its commissioning decisions and how we do that as an organisation. She asked if members' felt that this was the right process, which could be amended and brought back for further discussion if not.

Professor Gamsu asked if it would be worth including something that stated that part of the process would be to make sure that Healthwatch was aware of what we were doing in terms of public and patient engagement. The Chair suggested that section iii of Appendix 1 (page 16) be expanded to reflect this.

The Director of Public Health questioned how increasing the emphasis on cost effectiveness and affordability would get factored in to the process.

The Chair of Healthwatch asked if there would be any provision for grant making so that smaller groups / organisations that would not bid for contracts could be part of that. The Accountable Officer explained that, whilst this was not included within this process, it was a very important part of it that would be picked up by the Director of Finance and her procurement team as part of procurement and commissioning for social value.

With regard to the integrated commissioning of children's and mental health services, the Accountable Officer advised members that this would be reviewed as part of the next stage of the process.

The Governing Body:
- Approved the Commissioning for Value Decision Making and Prioritisation Framework, subject to final amendments as noted above.
- Agreed to the CCG working within the framework at all times.

97/16 2016/17 Finance Report

The Director of Finance presented this report which provided Governing Body with the Month 2 results and the key risks and challenges to deliver the planned year end surplus of £3.5m (0.5%). She advised Governing Body that, at this early stage in the year, the main issue related to the level of risk particularly in relation to delivery of the CCG's ambitious QIPP plan. She advised that Governing Body would discuss a paper in the private session on the recovery plan requested by NHS England.

Mr Taylor commented that at Month 2 it was very difficult to tell anything

due to the lack of information available, however, as we were in a very tight financial situation this financial year, would suggest paying extra attention to the risks. He asked why the case mix (cost per patient) at Sheffield Children's NHS Foundation Trust (SCHFT) had increased by 15% compared to the first two months in 2015/16. The Director of Finance responded that the activity was being sense checked, but the increase could be due to a handful of patients with complex requirements, which would mean the numbers could be skewed.

Mr Taylor also asked about commissioned and activity costs for Sheffield Teaching Hospitals NHS Foundation Trust (STHFT), especially with regard to the number of excess beds days (XBDs) which were 69.1% over target for electives and 41.6% over target for non electives. The Director of Finance explained that this could well be due to the data as just a few patients with very long stays in hospital could skew the figures.

With regard to delayed transfers of care (DTOCs), the Director of Integrated Commissioning advised Governing Body that there had been a huge step change in the numbers of patient's discharge reported as being delayed, with some waiting up to 10 weeks for discharge from hospital, whilst supporting services were arranged.

The Chair asked if the continuing lack of data due to the problems with implementation of STHFT's Lorenzo IT system was a material risk, and if there was anything Governing Body could usefully do in terms of escalation if necessary. The Director of Integrated Commissioning advised that, the A&E attendance and admission reports were much improved, and the whole management of the hospital was now on the electronic system. However, we still needed to understand what was in the service development of the contract, so at this stage there was not much Governing Body could do. The Director of Finance reported that STHFT had advised at the Contract Management Board (CMB) meeting held earlier in the day that they were still trying to work through the issues. She explained that the CCG did not pay the trust until we were assured that the contracted activity had actually happened.

The Governing Body considered the risks and challenges to delivery of the planned 9.5% surplus identified at this early stage of the financial year, as noted above.

98/16 Quality, Innovation, Productivity and Prevention (QIPP) Plan for 2016/17

Mr Eugene Sullivan, Interim QIPP Director, was in attendance for this item and presented an update on progress with implementation of the CCG's Quality, Innovation, Productivity and Prevention (QIPP) Plan for 2016/17.

He advised that his role was to make sure he could report to the CCG's Executive Team and the Governing Body what he regarded was assurance of the programme, including where the programme is, where the commissioning is, and where we are around risk. He also advised that he would be doing this in partnership with one to ones with Executive and

Scheme Directors, two of which had already taken place and gone well.

He advised that the Governing Body was very prudent to want to start to monitor the QIPP this early in the year. He reported that there was no room for slippage, and part of what they were doing at the moment included trying to implement in-year schemes, looking at Right Care, and undertaking 'deep dives' into the expenditure areas in the saving schemes, two of which had already been undertaken.

He advised Governing Body that the directors had already re-forecast progress on their programmes and advised this was now telling us that the initial £19.5m gross savings target had been reduced to £16.2m and it was prudent to think there would be more slippage. He reported that, collectively we would need to think about having a 24 month £35m QIPP savings strategy (which was included in the financial recovery plan) and, in this respect, would be working to bring forward 2017/18 and may possibly mitigate 2016/17 risks to be able to get the maximum benefit this year for next year. He also advised Governing Body that they were reviewing carefully and making balanced decisions on Procedures of Limited Clinical Value (PLCV). He also commented that, as the CCG did not have a history of delivering QIPP, this financial challenge would continue into the next few years

Professor Gamsu suggested that it would be helpful for him, Ms Forrest, and the CCG's engagement team to meet with the Interim QIPP Director to get a quick understanding of the programme and where best to focus on engagement with the public.

The Interim QIPP Director commented that the CCG's QIPP would mean a loss of income for some of our provider organisations, which made a lot of the QIPP very difficult to do. The Director of Finance explained that most of this related to the contracts with our main providers, which been discussed with them through our contract negotiations. She also advised that Equality Impact Assessments (EIAs) relating to the impact on patients were undertaken as part of every one of our QIPP schemes.

Mr Taylor commented that the paper stated that QIPP and transformation were likely to be permanent features and in this respect asked how much of the Interim QIPP Director's time he envisaged would be spent with people advising and helping them to deliver the schemes. The Interim QIPP Director responded that a lot of his time would be spent with the integrated teams, and Executive and Scheme Directors to get the assurance about what they were delivering but would do whatever the challenge required him to do and what was necessary, in conjunction with colleagues. Lunchtime learning sessions with staff to get their feedback and views had also been arranged.

The Chair asked how much of the detail and granularity Governing Body needed to see. The Director of Integrated Commissioning commented that, as there was a lot of detail and there were a lot of schemes, to give more assurance to Governing Body it would be helpful to have lay member support.

Dr Bates advised that she was involved very closely with the children's portfolio and it would be useful if an update on each of the children's QIPP areas could be included in future report, and from time to time include more detail on a particular QIPP area. Ms Forrest suggested that the latter could include the areas that were deviating most, and to have a summary for each of the higher risk areas.

The Clinical Director Urgent Care asked how much information Governing Body needed for assurance on the leadership of each scheme. Dr Gill commented that if we had to provide scrutiny to our Member practices then Governing Body needed to have access to all information available.

The Accountable Officer suggested that, given the scale of the CCG's financial challenge, and the QIPP programme as part of that, to create a small sub group of the Governing Body, with a mix of clinicians, officers and lay members, to undertake further scrutiny of the plan. She also advised Governing Body that she had asked the Interim QIPP Director and members of the Executive Team to go out to the localities and have discussions with our Membership about our whole approach, as we had not had sufficient discussions at locality level about the whole QIPP issues, we needed to get ownership from them, and it could be that they may have some solutions.

The Interim QIPP Director welcomed the scrutiny approach. He advised that for future updates he would look at including additional appendices and a Red / Amber / Green (RAG) rating for each scheme.

The Governing Body:

- Noted the total QIPP programme for 2016/17.
- Noted the current Month 2 position.
- Considered the plans to mitigate the current forecast shortfall, as noted above.

99/16 Quality and Outcomes Report

Mrs Rachel Gillott, Deputy Director of Delivery and Performance was in attendance for this item.

The Director of Integrated Commissioning presented this report which reflected the CCG's statutory responsibilities and drew members' attention to the following key issues.

a) <u>Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)</u>

As noted under minute 97/16, the information relating to the number of A&E attendances and admissions was now being reported. However, as performance was still very variable, the CCG had issued a contract performance notice. He advised Governing Body that the trust had presented an improvement plan which had been considered at the CMB meeting held earlier in the day along with their governance approaches around that.

With regard to pathways, we were challenging the trust on their performance against the cancer pathways, which had now been escalated to the point that a contract performance notice would be issued later this month.

The Director of Integrated Commissioning reminded Governing Body that ambulance handovers had always been a significant problem for the trust, however, they had now changed their process which had resulted in a much improved position with no patient waiting over an hour for handover in April.

Ms Forrest commented that she was heartened about the breakthrough in ambulance handovers, but this had got to be sustained. The Deputy Director of Delivery and Performance advised that most of the change had actually been done by the trust rather than the ambulance service, a lot of which related to completion of building work near to A&E which had previously severely restricted the amount of handovers and that the process was now nurse-led.

b) Quality Premium

The Director of Integrated Commissioning advised Governing Body that a huge amount of work was taking place to populate this information, which we would start to share with our providers as some of it was very dependent on their performance. He also advised that, nationally, providers had been asked to submit improved trajectories for some of their most challenged areas on the Sustainability Transformation Plan (STP) which, he advised, was very much part of the operational planning process for 2016/17. He reminded members that if they did not succeed and hit their targets then they would not get paid.

c) Quality

The Chief Nurse advised members of the following:

Previously Unassessed Periods of Care (PUPOCs)

He advised Governing Body that it was now a requirement from NHS England for CCGs to publish progress on PUPOCs, and drew their attention to the background information at Appendix 12 that advised that, historically, all CCGs received requests from patients or their representatives for a 'retrospective' assessment, for eligibility for continuing healthcare (CHC). This meant the CCG had to look at whether the patient should have been eligible for CHC for a period in the past and if so, reimburse the patient for the cost of their care. In 2012, NHS England had introduced a programme of cut-off dates for making such requests.

No further requests could now be made for such PUPOCs, for care that occurred before March 2013 unless there were exceptional circumstances. He clarified that it did not include patients who were receiving care now, but if we should have been funding the care of a

patient for a period in the past and, following assessment, if it determined that they should have been eligible for CHC, should reimburse them for the cost of their care.

He advised Governing Body that the CCG's intent was to complete every PUPOC within the proposed timescale.

d) Other Issues

The Chair commented that it was helpful for Governing Body to have sight of the actions being taken against the NHS Constitution Rights and Pledges for 2016/17. The Accountable Officer advised this these had been included at her request and would appreciate having the time to discuss them properly.

Professor Gamsu commented that the action box enabled the CCG to put out a message about the things we produce and pulling it out from here would be a good thing to do. The Accountable Officer suggested that we could include actions that involved support from our localities and asked the Deputy Director of Delivery and Performance to take this forward in this respect. **RG**

Dr Anumba asked about Appendix B (page A6): mental health trust performance measures and specifically about Improving Access to Psychological Therapies (IAPT). She noted that the report stated that the IAPT service has an inclusive approach, however she reflected that her own historical experience had been that they did not accept some referrals. She also commented that there did not seem to be a recognisable way of improving access to the service.

The Deputy Director of Delivery and Performance advised that this had been raised through with the trust and that there was a difference between local service criteria and the what the national measure reports on.. She commented that it would be helpful to receive specific examples of where referrals had been refused, for her to take forward with the trust. **GPs**

Professor Gamsu commented that IAPT was part of our physical health QIPP, and the service was a key mechanism for enabling people to take control of their own lives and in terms of addressing our physical health agenda. Dr Bates advised Governing Body that members of the community mental health teams had not attended at least three of the ‘big tent’ events that had taken place.

The Deputy Director of Delivery and Performance advised Governing Body that an Integrated Performance and Delivery Group had been in place since December 2015. The group was still evolving but was trying to triangulate issues where there have been concerns about quality and performance etc, and would asked them to consider how to take these issues forward including the impact they would have on QIPP. **RG**

Ms Forrest commented that the QIPP sub group might be the place to explore this and test it out, and it could be part of the ‘deep dives’ being

undertaken by the Interim QIPP Director. The Deputy Director of Delivery and Performance agreed to take this forward. **RG**

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.

100/16 CCG Improvement Framework Assessment (IFA)

Mrs Rachel Gillott, Deputy Director of Delivery and Performance, was in attendance for this item.

The Director of Integrated Commissioning presented this report which updated Governing Body on the process for CCG Assurance during 2016/17, provided an initial assessment of the CCG position against the new framework, and sought Governing Body endorsement of the proposed process for management of CCG and provider / partner performance against the framework.

The Deputy Director of Delivery and Performance advised members what the CCG was being assessed on, and that the emphasis had changed. These , are significant changes, and that there would be Ofsted type ratings for organisations published in July.

She advised that the CCG would now be assessed against 60 indicators across four domains and six clinical priority areas, and our assessment would be done through an independent iterative assessment process. She advised that, of the 60 indicators, our own assessment was that we were above the national average on 11, below on 35, but data was not yet available.

She advised that the CCG would receive its baseline assessment and rating for 2015/16 on 15 July, which would be published in the public domain but there were no plans for the outcome of our assessment to be shared with us before it went live. However, we were working with NHS England to manage communications about this.

Ms Forrest raised concerns about the amount of work being asked of the organisation at the moment, and especially for CCG staff as there was a limit as to how much work could be done.

The Director of Health Reform and Transformation commented that it was a really helpful report as the assessment process was very complicated. He drew members' attention to page 6 of Appendix C which detailed our own assessment for 2016/17. He advised members that the indicators were not of equal weight and there were one or two areas where we could 'fall down'.

The Deputy Director of Performance and Delivery advised Governing Body that the indicators were really wide ranging, with linkages into all aspects of the CCG, for example on the digital road map. She advised that a further report would be presented on the areas where the CCG was thought to be most at risk (based on information available). **RG**

The Governing Body endorsed the following actions:

- CCG IAF indicators would be incorporated into CCG delivery and assurance processes e.g. via Integrated Performance and Delivery Group, Contract Management discussions, and potentially Health and Wellbeing Board / associated delivery groups.
- For each CCG IAF indicator/ group of indicators, relevant leads have been identified to oversee and report on progress and any mitigating action if required, in line with CCG delivery and assurance processes.
- Reporting on progress and any required mitigating action, will be included in the Governing Body Quality and Outcomes report and in CCG Portfolio packs.
- Delivery and assurance processes for the elements not directly within CCG control are being established through discussion with relevant CCG portfolio leads and system partners, specifically Sheffield City Council, Public Health colleagues and Transforming Sheffield programme leads.

101/16 Report from the Primary Care Commissioning Committee meeting held on 4 May 2016

Mr Boyington, Chair of the Primary Care Commissioning Committee (PCCC) presented this report and advised members that the minutes of the meeting had now been adopted at the PCCC meeting held on 29 June 2016.

Members asked that a short high level summary, with the key decisions that had been made, be appended to the front of the minutes in future. **KaC**

The Governing received and noted the minutes.

102/16 Communications, Engagement, and Equality and Diversity Update

The Director of Health Reform and Transformation presented which updated Governing Body on the priority areas of work the communications, engagement and equality and diversity team had been working on and their alignment to the CCG's corporate objectives. The report also asked or Governing Body's thoughts about future communications and engagement.

The Communications Lead advised Governing Body that awareness raising within the CCG was included in the report, broken down into self care, neighbourhoods, campaigns that had been undertaken, and feedback from local communities. She advised Governing Body that Appendix A report on the progress within the team.

Professor Gamsu reminded Governing Body that they had had previous

helpful discussions about neighbourhoods and a further meeting had been arranged with engagement leads to discuss their work, so it was beginning to feel like the CCG had systematic engagement. He also advised Governing Body that a meeting with Patient Reference Groups across the city would be taking place on 27 July, which was very welcomed as it was about connecting in a key way with our how the CCG Membership engages within the city. In this respect, the Locality Manager, West, asked if locality engagement could be captured in future reports. **IG(SB)**

Ms Forrest commended Governing Body members read the Healthwatch report that was included in the report.

The Governing Body considered and noted the priorities and actions of the communications, engagement and equality and diversity team.

103/16 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
- Locality Executive Group reports
- Update on Serious Incidents
- Quarterly Safeguarding Update
- Complaints and MP Enquiries Annual Report 2015/16
- Unadopted Minutes of the Quality Assurance Committee meeting held on 6 May 2016
- Unadopted Minutes of the Audit and Integrated Governance Committee meeting held on 26 May 2016
- Commissioners Working Together Board Minutes
- Update on Special Educational Needs and Disability (SEND *)* Reforms
- Emotional Health and Wellbeing and Mental Health Transformation Strategy for Children and Young People in Sheffield

104/16 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.

105/16 Any Other Business

a) Sheffield's Green Commitment

Dr Sloan advised members that the Sheffield's Green Commitment report, the final report of the Green Commission, had now been published and was available at: www.sheffield.gov.uk/your-city-council/policy--performance/green-commission.html

b) Chemist and Drug National Awards

Dr Sloan advised members that Community Pharmacy Sheffield had won the GP Partnership of the Year award at the 2016 Chemists and Druggists National Awards held in Cardiff.

This ambitious, city-wide project had been launched in October 2015 and had seized upon the challenge of breaking down the traditional barriers between GPs and community pharmacists. It was the largest programme of its kind in the UK, with 57 pharmacists working closely alongside local GPs for up to two sessions each week. Further details were available at: http://www.chemistanddruggist.co.uk/awards/winners

c) CCG Annual Public Meeting and Members' Council Meeting

The Accountable Officer asked Governing Body members if they would be interested on working with her to plan the CCG's Annual Public meeting taking place on the afternoon of Tuesday 13 September 2016 and the Member Practice Council meeting taking place on the evening of 28 September 2016.

d) Test Beds (Digital Technology)

The Accountable Officer suggested that it would be helpful for members to receive an update on Test Beds (digital technology) at the next meeting. **IG (VMcR)**

106/16 Date and Time of Next Meeting

Please note there will not be a Governing Body meeting in August unless there are exceptional circumstances.

The next full meeting in public will take place on Thursday 6 October 2016, 2.00 pm – 5.00 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 7 July 2016

Question 1 Assuming the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) was submitted at the 30th June 'checkpoint', what was its status and by whom was it ratified? At what point will the details or even the outline of the STP be opened for public consideration - particularly with regard to those matters which are identified as being ones for quick decision? Is it the intention of the CCG to use the September special meeting to consider the STP in whatever stage it is at then?

CCG response: *The South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) submission was submitted to NHS England on 30 June 2016. The plan, which brings together health, council and voluntary sector organisations from across South Yorkshire and Bassetlaw, is in the very early stages of looking at how we can bring about joined up health and social care that gives everyone a great start in life, supporting them to stay healthy and live longer. Its status is work in progress and we are awaiting national guidance on next stages.*

As our submission is in very early stages, over the summer we will start to develop the ideas further with all the partners and we also expect to be having conversations with the public and our staff as soon as possible, so that they can help shape the plan. When we have national guidance, we will have more clarity on when public conversations will start to take place

Question 2 Is the dynamic of the STP that CCGs prepare local place plans and which are then negotiated within the STP to produce a version (ideally) of maximum collective benefit or does the STP Board set parameters within which place plans are developed locally?

CCG response: *The STP is an overarching plan for South Yorkshire and Bassetlaw, and is a great opportunity to come together as one community to really address the challenges facing our health and care services and improve the health and wellbeing of our population. Each of the five localities involved (Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield) are all working on local place plans which are aligned to the STP.*

Question 3 The Agenda Paper J on Commissioning for Value represents a helpful clarification of process but makes no specific mention either of social value or of considerations relating to workforce wellbeing, planning and sustainability except in relation to decommissioning. Is this intentional?

CCG response: *It was not intentional that we didn't make reference to social value or of considerations relating to workforce wellbeing, planning and sustainability in Paper J on Commissioning for Value. These are important elements that will be addressed in work regarding commissioning for value and the minutes of the Governing Body will reflect that these elements should have been included.*

Thank you for raising this question and providing the opportunity for us to clarify this point.