Item 20f

Joint Committee of Clinical Commissioning Groups

Public Meeting held 27 June 2018, 3:30 – 4pm, at NHS Sheffield CCG

Action Summary for CCG Boards

75/18	**Matters Arising** **Public questions Joint Committee of Clinical Commissioning Groups** The Chair thanked the Associate Director of Communications and Engagement and requested that the protocol statement regarding public questions to the JCCCG should be published on the website so members of the public are aware of our commitment to them (**www.healthandcaretogethersyb.co.uk**).	**Associate Director of Communications and Engagement**
76/18	**Independent Hospital Services Review Report** All feedback on the HSR will be made available to all the organisations involved in SYB ICS. Will Cleary-Gray confirmed that the ICS will receive feedback on the HSR and will share this with commissioners and providers, the JCCCG, Committees in Common. He added that Alexandra Norrish and her team will distill the information and provide a report back.	**A Norrish** **A Norrish**
77/18	**Questions from the public** The Chair informed members that questions had been received from Deborah Cobbett this afternoon therefore the JCCCG was unable to answer them at this meeting. However, the Chair did give Deborah Cobbett the opportunity to raise her questions to the JCCCG and they would be responded to according to the JCCCGs protocol.	**JCCCG**

Public Minutes of the meeting of the

Joint Committee of the Clinical Commissioning Group Meeting

Public Meeting held 27 June 2018, 4- 5:30pm, at NHS Sheffield CCG

Present:
Dr Tim Moorhead, Clinical Chair, NHS Sheffield CCG (Chair)
Dr David Crichton, Clinical Chair, NHS Doncaster CCG
Dr Richard Cullen, Clinical Chair, NHS Rotherham CCG
Chris Edwards, Accountable Officer, NHS Rotherham CCG
Andrew Goodall, Healthwatch Representative
Idris Griffiths, Accountable Officer, NHS Bassetlaw CCG
Dr Eric Kelly, Clinical Chair, NHS Bassetlaw CCG
Alison Knowles, Locality Director – North, NHS England
Priscilla McGuire, Lay Member
Dr Ben Milton, Clinical Chair, NHS North Derbyshire CCG
Philip Moss, Lay Member
Julia Newton, Director of Finance, NHS Sheffield CCG
Jackie Pederson, Accountable Officer, NHS Doncaster CCG
Maddy Ruff, Accountable Officer, NHS Sheffield CCG
Lesley Smith, Accountable Officer, NHS Barnsley CCG
Will Cleary-Gray, Chief Operating Officer, SYB ICS

Apologies:
Dr Nick Balac, Clinical Chair, NHS Barnsley CCG
Sir Andrew Cash, Lead, South Yorkshire and Bassetlaw ICS
Dr Chris Clayton, Chief Executive Officer, NHS Derbyshire CCG
Dr Phillip Earnshaw, Clinical Chair, NHS Wakefield CCG
Pat Keane, Chief Operating Officer, NHS Wakefield CCG (Deputy for Jo Webster, Accountable Officer)
Dr Steven Lloyd, Clinical Chair, NHS Hardwick CCG
Jo Webster, Chief Officer, NHS Wakefield CCG

In attendance:
Jane Anthony, Corporate Committee Clerk, Exec Pa Business Manager, SYB ICS
Lisa Kell, Director of Commissioning Reform, SYB ICS
Alexandra Norrish, Programme Director, Hospital Services Review, SYB ICS
Helen Stevens, Associate Director of Communications and Engagement, Commissioners Working Together, SYB ICS
Dr Lisa Wilkins, Consultant in Public Health Medicine

Members of the Public
Elaine Borthwick, Pfizer
Katy Cherry, GSK
Deborah Cobbett, SSONHS
Ken Dolan, SYBNAG
Nora Everett, SYBNAG
Steve Merryman, SYBNAG

Minute reference	Item	ACTION
71/18	**Welcome and introductions** The Chair welcomed members and the public to the meeting.	
72/18	**Apologies** Apologies were received and noted.	
73/18	**Declarations of Interest** There were no declarations of interest.	
74/18	**Previous minutes of the meeting** The minutes of the meeting held on 28 March 2018 were accepted as a true and accurate record and are published on the website **www.healthandcaretogethersyb.co.uk**	
75/18	**Matters Arising** The Chair invited the Associate Director of Communications and Engagement to update members regarding the process for public questions put to the Joint Committee of Clinical Commissioning Groups (JCCCG). The Associate Director of Communications and Engagement tabled a draft document outlining the JCCCGs promise to the public regarding their questions. She informed members that she had progressed conversations with individual CCGs, Joint Commissioning Committees and Joint Health Overview and Scrutiny Committee (JOSC) to understand their process and to inform a clear process for the JCCCG concerning public questions. Members added: • It would be difficult for the public to send in questions 5 working days in advance when the papers are published 5 working days in advance of the meeting. • The JCCCG should respond to questions raised by the public within 3 working days. The Chair added that the JCCCG will answer questions pertinent to its own business, however, it does not undertake to answer general questions relating to the NHS as there are other relevant organisations that undertake the duty to answer general questions. The JCCCG approved the following protocol in respect of public questions put to them:	

	Public questions Joint Committee of Clinical Commissioning Groups Involving people and communities in the design and delivery of health services, as well as decision making, is fundamental to the work of the Joint Committee of Clinical Commissioning Group. We welcome people attending our Joint Committee meetings held in public. We promise you: • We will publish agendas and papers on our website, seven days (5 working days) before the meeting. • Paper copies of the agenda will be available at each meeting. • We will allow 10 minutes before the start of each meeting for you to make a statement or ask a question about items on that day's agenda. • We will invite written questions on the items on our agenda. Please submit your question up to three working days before the meeting. You can do this by submitting a question to jane.anthony1@nhs.net. • Where possible and if time permits, we will answer written questions as part of the relevant agenda item at the meeting. In any event, we will respond to your written question within three working days. • We will also post your question and our answer on our website. Because there are eight CCGs within the JCCCG, it is not administratively possible for questions submitted less than three working days before the meeting to be considered at the meeting. We aim to make fair, transparent and well-informed decisions. Please remember that Joint Committee meetings are business meetings which we hold in public, not 'public meetings'. The Chair thanked the Associate Director of Communications and Engagement and requested that the above statement should be published on the website so members of the public are aware of our commitment to them (**www.healthandcaretogethersyb.co.uk**). There were no other matters arising.	**Associate Director of Comms & Engagement**
76/18	**Independent Hospital Services Review Report** The Chair welcomed Alexandra Norrish to the meeting to give her presentation on the Independent Hospital Services Review Report. Alexandra Norrish confirmed that all feedback regarding the Hospital Services Review Report should be received by 12th July 2018. The feedback will be collated and discussed at the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) Executive Steering Group meeting on 17th July 2018 and this discussion will be used to inform the strategic outline case. All feedback on the HSR will be made available	**A Norrish**

	to all the organisations involved in SYB ICS. It was noted that the individual CCGs have a different responsibility and to that of the collective JCCCG. Members comments were responded to as follows: • Children will be transferred according to the level of care they need e.g. at home, in the community or in hospital. In a normal healthy child a chest infection can be treated at home, however, a chest infection in a child with cystic fibrosis would lead to the child being very unwell and therefore the child may require a stay in hospital for treatment. • Levels of hospitalization vary across specialties, the vast majority of patients are seen and treated at the place they present and then go home. • 24/7 care does not mean a consultant presence throughout a 24 hour period, it will be open 24 hours and there will be cover in accordance with national guidance. The Associate Director of Communications and Engagement informed members that there has been robust networking put in place in order to gather information and feedback on the HSR report e.g. conversations with the public via CCGs, discussion at Joint Health Overview Scrutiny Committee, leafletting in pharmacies, libraries and GP practices. The Chair confirmed that the Independent Hospital Services Review report was work in progress and no decisions regarding the report have been made, the report is presented to the JCCCG for members information only. The Joint Committee of Clinical Commissioning Groups: • Received the Independent Hospital Services Review report and noted the contents of the paper. • Await the Review feedback from Boards and Governing Bodies and consider the requirements and work of the Joint Committee in collectively taking forward the next steps of the Hospital Services Review including any decisions required on behalf of the members of the Joint Committee of Clinical Commissioning Groups. Will Cleary-Gray confirmed that the ICS will receive feedback on the HSR and will share this with commissioners and providers, the JCCCG, Committees in Common. He added that Alexandra Norrish and her team will distill the information and provide a report back. The Chair thanked Alexandra Norrish for her update to members.	**A Norrish**
77/17	**Questions from the public** The Chair informed members that questions had been received from Deborah Cobbett this afternoon therefore the JCCCG was unable to answer them at this meeting. However, the Chair did give Deborah	

	Cobbett the opportunity to raise her questions to the JCCCG and they would be responded to according to the JCCCGs protocol.	**JCCCG**

Deborah Cobbett put forward the following questions:

1. On governance

We have asked before about the geographical borders of the HSR: SYB or SYBMYND and the issues this raises for democratic accountability.

- Would you comment on the issue of accountability in the light of this quotation?

Current governance arrangements do not go far enough to *give the system the level of control required* to effect change. Any future model will require all organisations to cede some sovereignty to the system – this will be difficult, particularly without legislative change and while the end-state clinical model is not yet fully defined. (page 160) [my italics].

2. On staffing issues

- Given widespread evidence that staff are leaving our NHS in droves, sometimes immediately after qualifying, what grounds do you have for this optimistic outlook quoted below?

By working together, the acute trusts will strengthen their workforce, building on existing expertise to improve quality of care for patients, enhancing the reputation of our hospitals. We will work creatively with schools and universities to attract new entrants to healthcare professions, as well as those who wish to return to clinical practice. We will become a leading innovative system, identifying and adopting new approaches to healthcare to solve some of our most complex challenges. We will make SYB(MYND) into a place where people want to come and work.

- What impact have frontline staff (as opposed to clinical leads and managers) had on the HSR? How will you resolve the concerns we hear about stress, unpredictability of end of shift times and failures to listen to staff requests for flexible working times?
- What response did you get by leaving paper based surveys in "areas convenient for staff"? (see page 16 of the report)
- How often does the Staff Partnership Forum meet and where do you publish its minutes? (This was mentioned only very briefly in one of the FAQ lists)

3. On meeting patients' needs

Sheffield Director of Public Health, Greg Fell, in his 2017 report stated: Demand for health and social care in England is currently increasing by about 4% per year, faster than the ageing population. Moreover, there is now consistent evidence from a macro perspective that the key drivers

	of cost growth are: disease incidence (prevention); lack of attention to primary care, high cost technology (manufacturer pressure & patient expectation)' and over diagnosis (clinical culture and system pressure). • In view of this, when will you drop the propaganda about the ageing population with complex needs burdening our NHS and admit that our NHS is exploited by private firms through Big Pharma and management and IT consultancies? • Why do you ignore the impact of austerity cuts in all public services, government policies which increase child poverty and mental ill-health, and other causes of ill health? • How does your review address the needs of each town, as presented in the section of the first annex, entitled *Place Definitions*? • Why do these needs not appear in a more central position in the review? The Chair thanked Deborah Cobbett for her questions. The Chair responded to a comment from the public requesting clarification of who is able to ask questions at the meetings by saying that questions pertinent to JCCCG business made through the public questions protocol may be asked by any member of the public. Nora Everett asked a question regarding a conversation that happened last year as part of the STP conversations between Barnsley Save Our NHS and the Associate Communications Director, and this conversation was not recorded in the report to the Collaborative Partnership Board. The Associate Director of Communications supplied the following post meeting note that the conversation was recorded and is on page 3 (under point 3) of the report that went to the Collaborative Partnership Board which mentions the discussion and the comments being included in the analysis. http://www.healthandcaretogethersyb.co.uk/application/files/9615/0305/4207/Summary_paper_to_the_collaborative_partnership_board.pdf There were no other questions from the public. Post meeting note – Deborah Cobbett's questions and the JCCCGs answers are attached at the end of these minutes.	
78/17	**To consider any other business** There was no other business brought before the meeting.	
79/17	**Date and Time of Next Meeting** The Chair informed the meeting that the next meeting will take place on 22 August 2018 in The Boardroom, NHS Sheffield CCG, 722 Prince of Wales Road, Sheffield, S9 4EU.	

Response to questions to JCCCG

1) Geographical borders

We have asked before about the geographical borders of the HSR: SYB or SYBMYND and the issues this raises for democratic accountability.

The different geographies referenced in the report reflect the fact that different local health economies are involved in different recommendations for the Review. What this means for hospital trusts and services is explained in the Report (page 25). In summary:

- **South Yorkshire and Bassetlaw**: the organisations in the Sustainability and Transformation Partnership (STP) for South Yorkshire and Bassetlaw (SYB) are now members of the Integrated Care System (ICS). For CCGs, this is Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. For acute hospitals, it is the Foundation Trusts of Barnsley, Doncaster and Bassetlaw, Rotherham, Sheffield Children's, and Sheffield Teaching. For mental health organisations it is the Foundation Trusts of Rotherham, Doncaster and South Humber and Sheffield Health and Social Care.

- **South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire**. This refers to the geography of the organisations in the Joint Committee of Clinical Commissioning Groups (JCCCG) which has seven members. These are Barnsley, Bassetlaw, Doncaster, North Derbyshire, Rotherham, Sheffield and Wakefield. Hardwick CCG is not a member of the Joint Committee but has taken decisions in parallel with the JCCCG.

- Working in parallel to the JCCCG, there is the Provider Working Together partnership, which is made up of seven acute hospital trusts. These are Barnsley Hospital NHS Foundation Trust, Chesterfield Royal NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Mid Yorkshire Hospitals NHS Trust, The Rotherham NHS Foundation Trust, Sheffield Children's Hospital NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust. These seven trusts are included within the scope of recommendations on the hosted network, ie they will be building on their collaborative history to develop shared working on clinical services.

- **South Yorkshire and Bassetlaw and North Derbyshire**: these are the organisations above, minus Mid Yorkshire Hospitals NHS Trust and Wakefield CCG. The acute hospitals within the area are included within scope for potential reconfiguration options.

	Mid Yorkshire has already been through a reconfiguration so is not included in reconfiguration options. Statutory accountability and decision making for all of these organisations remains with their respective NHS Foundation Trust Board or NHS Clinical Commissioning Group Governing Body. The various organisations come together for joint discussion through a number of different joint groups but none of these joint groups have any formal decision making authority about the Hospital Services Review, so the accountable organisations and decision making remain with their Boards and Governing Bodies. **Would you comment on the issue of accountability in the light of this quotation?** Current governance arrangements do not go far enough to *give the system the level of control required* to effect change. Any future model will require all organisations to cede some sovereignty to the system – this will be difficult, particularly without legislative change and while the end-state clinical model is not yet fully defined. (Hospital Services Review page 160) The legislative framework of the 2012 Act means that the organisations in the system which have statutory authority are the Boards and Governing Bodies of the NHS providers and Clinical Commissioning Groups. This means that at the moment, discussions can happen in the governance groups of the Integrated Care System, but decisions are taken by Boards and Governing Bodies. The Integrated Care System cannot itself make binding decisions. As we develop the governance of the Integrated Care System, we are developing ways for organisations to work more closely together, while respecting the existing statutory structures. One way is through the existing legal vehicles such as a Joint Committee of Clinical Commissioning Groups for CCGs, and Committees in Common for providers. Both of these exist but they do not currently have delegated powers around the recommendations of the Hospital Services Review. The HSR suggests that, going forward, the partners needs to continue to explore these approaches and develop ways, within the existing statutory framework, to allow organisations to work together when needed to deliver high quality, safe services for patients. The HSR also suggests that the current legislative framework makes collaborative working more difficult. There is a recognition at national level that the current legislative framework is not suited to delivering the level of collaboration between organisation that is the basis of shared working going forward. The Health Select Committee into integrated care (published 11 June 2018, https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/6	

50.pdf) recognised this, saying

> The existing legal context does not necessarily enable the collaborative relationships local leaders are building, and in places adds significant complexities for them to grapple with. (p.75)

The committee concluded that

> The law will need to change to fully realise the move to more integrated, collaborative, place-based care. … The purpose of legislative change should be to address problems which have been identified at a local level which act as barriers to integration in the best interest of patients. We wish to stress again that proposals should be led by the health and care community. (p. 78)

2) Staffing issues

Given widespread evidence that staff are leaving our NHS in droves, sometimes immediately after qualifying, what grounds do you have for this optimistic outlook quoted below?

> "By working together, the acute trusts will strengthen their workforce, building on existing expertise to improve quality of care for patients, enhancing the reputation of our hospitals. We will work creatively with schools and universities to attract new entrants to healthcare professions, as well as those who wish to return to clinical practice. We will become a leading innovative system, identifying and adopting new approaches to healthcare to solve some of our most complex challenges. We will make SYB(MYND) into a place where people want to come and work."

Work with our Clinical Working Groups explored the reasons why SYBMYND is facing such significant challenges around workforce. The reasons identified were complex and are laid out in the notes of the Clinical Working Groups, available on our website.

The proposals laid out in the HSR are designed to present solutions to many of the most significant concerns around workforce, for example

- **Recruitment**: we do not currently attract as many potential recruits to the NHS as we could. The HSR proposes a workforce Institute which could include universities and working closely with schools, to encourage students to enter careers in healthcare, while also taking into account any national NHS responses to the national workforce issue.

  An issue raised by a number of attendees at the public events was concerns around limited opportunities for young people who were interested in careers in healthcare, but were not coming through the traditional routes. A workforce Institute could look at developing apprenticeship schemes and other entry routes for potential trainees.

	• **Retention**: The CWGs identified a number of reasons why staff are leaving the NHS. Some sites and specialties said that staff have limited opportunities for career progression or training; the HSR Report proposes that Hosted Networks could build opportunities for staff to develop their careers through rotations and secondments between sites. Staff in other specialties said that the main reason that people were leaving was because existing vacancies and a reliance on locums mean extra pressure on substantive staff. The Report proposes that Hosted Networks would focus on strengthening recruitment and reducing reliance on locums, and the reconfiguration proposals within the Report are aimed at ensuring the right number of staff in those services which are currently most overstretched. **What impact have frontline staff (as opposed to clinical leads and managers) had on the HSR?** The main way that we have engaged with staff has been through the Clinical Working Groups, which engaged clinicians from across the specialties. Each trust was asked to nominate clinicians and other staff (such as nurses and midwives) as members of the Clinical Working Groups. These members were asked to engage with their colleagues across their home trusts. After each meeting, the HSR team provided a short summary of the points that had been made (these are available on our website). The CWG members were asked to discuss these points with colleagues, and to bring back feedback from the wider staff groups to a session at the beginning of the following meeting. In addition to this, the HSR team engaged directly with some frontline staff. The team spoke, for example, to groups of nurses in the trusts, and a number of staff attended the SYB-wide events and responded to the online surveys. Trusts were also provided with regular updates on the HSR, which they were asked to share with staff across the organisation. **How will you resolve the concerns we hear about stress, unpredictability of end of shift times and failures to listen to staff requests for flexible working times?** Issues around how staff are managed in an individual trust are for individual trusts and managers to address rather than being a matter for the HSR. However the proposals around Hosted Networks aim to develop a shared approach to some aspects of HR such as a shared policy around flexible working. **What response did you get by leaving paper based surveys in**	

"areas convenient for staff"? (see page 16 of the report)

The ICS communications team attended a number of events at healthcare sites across the footprints. Some of the hospitals invited members of the team to set up a stall in their reception areas, and the team also attended some GP surgeries. This gave an opportunity to talk directly with both patients and staff at the sites, and to distribute surveys to get their views on the issues. Copies of the survey were left at the sites for any staff who were interested and had not been able to attend. A number of staff were also interviewed in the telephone surveys. Staff briefings, as well as ICS organised nurse forums, were also held in many sites, and staff communications with links to the online survey shared through all partners' regular communications mechanisms.

We do not know how many responses were from leaving surveys in staff areas as the survey did not ask people where they had heard about it. Of the 545 paper-based and online survey responses completed, 150 respondents indicated they were NHS employees (28%).

How often does the Staff Partnership Forum meet and where do you publish its minutes? (This was mentioned only very briefly in one of the FAQ lists)

The Staff Partnership Forum is a meeting between the ICS and regional trade union representatives. It is not a meeting held in public and therefore the notes from the meeting are not published in public. It meets bi-monthly.

3) Meeting patients' needs:

Sheffield Director of Public Health, Greg Fell, in his 2017 report stated:

> Demand for health and social care in England is currently increasing by about 4% per year, faster than the ageing population. Moreover, there is now consistent evidence from a macro perspective that the key drivers of cost growth are: disease incidence (prevention); lack of attention to primary care, high cost technology (manufacturer pressure & patient expectation)' and over diagnosis (clinical culture and system pressure).

In view of this, when will you drop the propaganda about the ageing population with complex needs burdening our NHS and admit that our NHS is exploited by private firms through Big Pharma and management and IT consultancies?

A recent report by the Health Foundation and the Institute of Fiscal Studies factors (https://www.ifs.org.uk/uploads/R143.pdf) looked at the pressures on NHS spending from a wide range of factors. It stated that:

> Over time, all aspects of NHS spending have risen. The biggest element is spending on staff – doctors, nurses and others. Over

	the last 20 years, there has been an increase of more than 70% in the number of hospital doctors, and of more than 10% in the number of nurses, health visitors and midwives, per 1,000 population. (p.iii) Looking forward, health spending is likely to continue to rise. Simply continuing to provide the services we currently expect will become more expensive as the population grows and ages, prevalence of chronic conditions increases, and the prices of inputs, including the costs of drugs and the wages of doctors and nurses, go up. Central estimates suggest that by 2033−34 there will be 4.4 million more people in the UK aged 65 and over. The number aged over 85 is likely to rise by 1.3 million – that's almost as much as the increase in the entire under-65 population. The burden of disease is also increasing. The number of people living with a single chronic condition has grown by 4% a year while the number living with multiple chronic conditions grew by 8% a year between 2003−04 and 2015−16. Looking forward, more of the UK's population will be living with a chronic disease and very many with multiple conditions. This is because while life expectancy has been increasing, healthy life expectancy has not kept pace and the period of people's lives spent in poor health has increased; particularly for the poorest. As a result, without major progress on the vision set out in the Five Year Forward View, over the next 15 years spending in acute hospitals to treat people with chronic disease is expected to more than double. (p.v) **Why do you ignore the impact of austerity cuts in all public services, government policies which increase child poverty and mental ill-health, and other causes of ill health?** The Hospital Services Review looked at the sustainability of acute services, focusing on how acute services could be made fit to meet the future needs of the population. Issues around mental health, prevention and public health are being addressed in other workstreams of the Integrated Care System and were not the focus of the Report. 4) Places **How does your review address the needs of each town, as presented in the section of the first annex, entitled *Place Definitions*? Why do these needs not appear in a more central position in the review?** The HSR aimed to develop a more equitable access to acute health services for patients across South Yorkshire and Bassetlaw. However it did not make site-specific proposals: this was to ensure that the public and stakeholders could comment in principle on the proposed approach for services. In due course, Boards and Governing Bodies will agree any	

	next steps, having taken account of public and stakeholder feedback. This could include a more detailed analysis of the impact on specific communities and places to develop a site-specific analysis. If this happened, the evidence collated in the Place Profiles would help to inform the analysis going forward.	