NHS
Sheffield
Clinical Commissioning Group

Unadopted Minutes of the meeting of NHS Sheffield Clinical Commissioning Group Governing Body held in public on 6 September 2018 in the Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU

A

Present:
Mr Phil Taylor, Lay Member, CCG Deputy Chair (Chair)
Dr Nikki Bates, GP Elected City-wide Representative
Mrs Nicki Doherty, Director of Delivery - Care Outside of Hospital
Ms Amanda Forrest, Lay Member
Professor Mark Gamsu, Lay Member
Dr Kirsty Gillgrass, GP Locality Representative, Hallam and South
Dr Terry Hudsen, GP Elected City-wide Representative
Mr Brian Hughes, Director of Commissioning and Performance
Dr Jennie Joyce, GP Locality Representative, North
Dr Annie Majoka, GP Elected City-wide Representative
Ms Julia Newton, Director of Finance
Ms Chris Nield, Lay Member
Ms Mandy Philbin, Chief Nurse
Mrs Maddy Ruff, Accountable Officer.
Dr Chris Whale, Secondary Care Doctor

In Attendance:
Mrs Rachel Dillon, Locality Manager, West (from item 122/18)
Ms Lucy Ettridge, Deputy Director of Communications, Engagement and Equality
Mr Greg Fell, Director of Public Health, Sheffield City Council
Mrs Carol Henderson, Committee Secretary / PA to Director of Finance
Mr Phil Holmes, Director of Adult Services, Sheffield City Council
Mr Nicky Normington, Locality Manager, North
Mrs Judy Robinson, Chair, Healthwatch Sheffield
Professor Chris Welsh, Independent Director, Hospital Services Review (for item 116/18)

Members of the public:
There were eight 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 Finance.

ACTION

111/18 Welcome

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

112/18 Apologies for Absence

Apologies for absence had been received from Dr Zak McMurray, Medical Director, Dr Tim Moorhead, CCG Chair, GP Locality Representative, West, and Dr Marion Sloan, GP Elected City-wide Representative.

The Director of Finance advised members that Dr Gasan Chetty, GP

Locality Representative, Central Locality, had resigned from Governing Body with effect from 27 July 2018. She advised that the process for electing a replacement for Dr Chetty on Governing Body had been approved by the CCG's Remuneration Committee earlier in the day. and would start the following week.

Apologies for absence from those who were normally in attendance had been received from Mrs Katrina Cleary, Programme Director Primary Care, Dr Mark Durling, Vice Chair, Sheffield Local Medical Committee, Mr Gordon Osborne, Locality Manager, Hallam and South, Mr Paul Wike, Locality Manager, Central

The Chair declared the meeting was quorate**.**

113/18 Declarations of Interest

The Chair reminded Governing Body members of their obligation to declare any interest they may have on matters arising at Governing Body meetings which might conflict with the business of NHS Sheffield Clinical Commissioning Group (CCG). He also reminded members that, in future, not only would any conflicts of interests need to be noted but there would also need to be a note of action taken to manage this. The Chair reminded members that they had been asked to declare any conflicts of interest in agenda items for discussion at today's meeting in advance of the meeting

Declarations made by members of the Governing Body are listed in the CCG's Register of Interests. The Register is available either via the secretary to the Governing Body or the CCG website at the following link:
http://www.sheffieldccg.nhs.uk/about-us/declarations-of-interest.htm

The Chair declared an indirect conflict of interest in item 10: The Talbot Trusts – Appointment of Nominated Trustees, in his role as Chair of Sheffield Hospitals Charity. It was agreed that this did not preclude the Chair from being involved in discussions on this item.

There were no further declarations of interest from items to be discussed at today's meeting.

The Accountable Officer reported that she was now working two days per week as Chief Executive System Lead for Population Health and Primary Care, Integrated Care System (ICS) and would complete a revised individual Declaration of Interest form in this respect. **MR**

114/18 Chair's Opening Remarks

The Chair had no further issues he wished to draw to Governing Body's attention at this stage, except to advise that, in his role as CCG Deputy Chair, he was chairing his first meeting of Governing Body in the absence of Dr Moorhead, CCG Chair.

115/18 Questions from Members of the Public

Members of the public had submitted questions before and at the meeting. The CCG's responses to these are attached at Appendix A.

Governing Body was asked to note that a member of the public had also submitted several questions relating to the Walk in Centre and urgent care centres under the Freedom of Information Act, with the deadline for responses to these being 18 September 2018.

116/18 Independent Hospital Services Review

Professor Chris Welsh, Independent Director, Hospital Services Review, was in attendance for this item, presented this report that sought Governing Body's approval to formally approve the draft Strategic Outline Case (SoC) (the system's statement of intent around how it would take forward the recommendations of the HSR), and agree to its publication. He gave a presentation that reminded members of the process undertaken so far, provided a summary of the responses to the review, and outlined next steps.

Professor Welsh reminded Governing Body that the review had been set up to ensure that people across South Yorkshire and Bassetlaw (SYB), Mid Yorkshire and North Derbyshire (SYBMYND), continued to receive excellent hospital services now and in the future, and to ensure they were as sustainable as possible. He advised that Boards, Governing Bodies and members of the public had all now given their feedback on the recommendations in the report. He reminded Governing Body that the three main principles of the review, which were also the main principles of the SoC, were set out in slide 4, namely:

1. That there will continue to be a hospital in every Place: we are not closing any District General Hospitals;
2. Most patients will receive most of their hospital-based care at their local DGH;
3. We need the staff we have – we do not expect that the work of the Review will lead to any redundancies, although we may need to work differently.

The three main workstreams: shared working, transformation and reconfiguration set out in the SoC, were outlined in slide 5. A summary of responses to the review and how comments had been addressed was set out at slide 9, and included that transport had been a key issue from public feedback. Slide 10 set out next steps and timescales, and included that October 2019 would be the very earliest implementation date that could be considered.

Professor Gamsu asked what it was that we were hoping the public using these services would see as different to current provision, and what the level of clinical variation was now and what might it be reduced

to in three or four years' time.

Professor Welsh explained that the biggest challenge was the shortage of workforce across South Yorkshire and Bassetlaw (SYB), with feedback from the workforce being that this was related to a number of issues including failure to retain the workforce across SYB as we were not making the offers to them here that were satisfactory. There were also different clinical protocols across SYB, which made training difficult. We needed to say that we would have a unified system and job description and say we were going to deliver that service without hesitation. Retaining the workforce was a very large part of that working together.

The Director of Delivery – Care Outside of Hospital fully supported the SoC and its recommendations. She commented that it was about how we would take the opportunity to improve the outcomes for people across South Yorkshire and Bassetlaw, which were included but had not come out strongly enough.

The Secondary Care Doctor expressed surprise about the variation in standards across the health community. He commented that we really needed to be working on prevention, which was part of the whole picture, particularly the transformation agenda.

Ms Forrest, Lay Member, asked if we were building on the work done on collaboration in previous years, and where there were already excellent hosted networks in the system. Her thoughts were that getting a host of the networks would be a really important step forward. Ms Forrest also suggested that we needed to find a proper way of making use of the third / voluntary sector, including the unpaid elements of that, as part of the workforce. She also commented that the Social Care Institute needed to look really broadly at the workforce element of this review, as there was an opportunity for them to encourage those young people not in education or training that health and caring was a worthwhile profession to go into.

The Director of Commissioning and Performance asked if the Clinical Working Groups (CWGs) could now be expanded to ensure they could help with the complexities of developing hosted networks and expanding the transformation.

The Governing Body :

- Approved the Strategic Outline Case
- Agreed to its publication, in line with their statutory responsibilities in relation to leadership of service change as described in NHS England's Guidance on Planning, Assuring and Delivering Service Change for Patients (2018).

117/18 Minutes of the CCG Governing Body Meeting held in Public on 5 July 2018

The minutes of the Governing Body meeting held in public on

5 July 2018 were agreed as a true and correct record and were signed by the Chair, subject to the following amendments:

a) Independent Hospital Services Review (minute 100/18 refers)

Additional eighth paragraph to be included as follows:

Governing Body reiterated the importance of taking the opportunity of improving the health outcomes for these services across the region, highlighting that for the majority of the services there is well established outcomes data that currently demonstrates a variation across the region.

b) Quarterly Update on NHS Sheffield CCG 2018/19 Governing Body Assurance Framework and Risk Register (minute 102/18 refers)

Final sentence of final paragraph to read as follows:

The Director of Delivery – Care Outside of Hospital advised that there was a plan to close this gap by bringing regular updates to the Governing Body; this would be incorporated into the forward planner to ensure that there were regular updates, therefore this gap would be closed in the next quarterly update received.

118/18 Matters Arising

a) Urgent Care Winter Review (minutes 82/18 and 94/18(c) refer)

The Director of Commissioning and Performance advised Governing Body that he would give an update on the system wide plan that was being developed in line with national expectations for the 2018/19 winter period to the next meeting. **BH**

b) Quarterly Update on NHS Sheffield CCG 2018/19 Governing Body Assurance Framework (GBAF) and Risk Register (minute 102/18 refers)

The Director of Finance advised members that an update would be given to the CCG's Audit and Integrated Governance Committee (AIGC) the following week on the outcome of the CCG's Senior Management Team (SMT) review of the GBAFs facilitated by Mersey Internal Audit Agency, the report from which provided a comparison across 53 CCGs and highlighted some of the key risks which were included in GBAFs across the board. **JN**

The Deputy Director of Communications, Engagement and Equality advised Governing Body that communication and engagement with patients and the public on CCG priorities and service developments was being considered as part of the CCG's priorities for next year, as part of the programme management process.

c) Update on Month 2 2018/19 NHS Sheffield CCG Quality, Innovation, Productivity and Prevention (QIPP) Plan (minute 104/18 refers)

The Director of Commissioning and Performance advised Governing Body that he would provide an oral update on the outcome of discussions at the QIPP workshop that had taken place with the other South Yorkshire and Bassetlaw CCGs and Deloittes that had taken place in July under minute 124/18, and would also be providing an update to Governing Body in public November. **BH**

d) Performance, Quality and Outcomes Report: Position Statement Yorkshire Ambulance Service NHS Trust (YAS) (minute 105/18(i) refers)

The Director of Commissioning and Performance advised Governing Body that he would provide an oral update on the new ambulance standards, and on the review into Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) action plan for A&E performance improvement under minute 125/18(a), and present a full report to Governing Body in public in November. **BH**

119/18 Proposed Schedule of Governing Body Meetings 2019/20

The Director of Finance presented this report which sought Governing Body's approval on the proposed schedule of Governing Body meetings and strategic development sessions to be held in 2019/20, a similar programme to that of previous years.

The Governing Body:

- Approved the proposed dates of Governing Body meetings to be held in public in 2019/20.
- Approved the strategic development sessions for 2019/20.

120/18 The Talbot Trusts – Appointment of Nominated Trustees

The Director of Finance asked Governing Body to confirm the appointment of Mr Mark Wilde as a CCG nominated trustee to the Talbot Trusts for the period of 6 December 2018 to 5 December 2022. She drew members' attention to section 5 which outlined Mr Wilde's experience and advised that hence he was a suitable person for Governing Body to be recommending as a Talbot Trustee.

The Governing Body confirmed the appointment of Mr Mark Wilde as a CCG nominated trustee to the Talbot Trusts for the period 6 December 2018 to 5 December 2022.

121/18 NHS Sheffield CCG Emergency Preparedness, Resilience and Response (EPRR) Assurance 2018/19

The Director of Commissioning and Performance presented this report and advised members that this was a robust piece of work to ensure the CCG was able to provide assurance to NHS England of its readiness to respond to emergency situations, but had to be presented to Governing Body for approval instead of being delegated elsewhere. He reminded members that it was an annual process that we were required to do as part of our framework that we prepared in event of any emergency.

He explained that, as CCGs were Category 2 responders and had a duty to co-operate to an incident, it meant that some of our standards were slightly different to those of our acute trusts. He advised that there were 43 core standards this year but, as they were slightly different this year, he could not provide a direct comparison with previous years. As in previous years, we had collaborated significantly with the other South Yorkshire and Bassetlaw Category 2 responders, and agreed a common policy for emergency preparedness and business continuity that would be presented to our respective Governing Bodies for approval. He advised that our proposed level of compliance was '**Substantial'**.

He advised members that this year's 'deep dive' had focused on mandatory 'Command and Control' arrangements, against which we had assessed ourselves and would be developing action plans. He explained that, as a Category 2 responder, it would be unlikely that an incident control centre would be set up within the CCG's demise

Ms Nield, Lay Member, who would be supporting the CCG's emergency planning role, commended the Director of Commissioning and Performance, and the Corporate Services Risk and Governance Manager for the work they had undertaken to enable the organisation to get to this position, and also the real time, ongoing learning that had been, and still was, taking place.

The Governing Body:

- Noted the self-assessment and the actions identified.
- Approved the proposed overall assessment of Substantially Compliant.

Mrs Rachel Dillon, Locality Manager, West, joined the meeting at this stage.

122/18 2018/19 CCG Priorities

The Director of Commissioning and Performance presented this report which sought Governing Body's approval on nine proposed priorities for the CCG for 2018/19. He advised members that the proposed priority areas (as set out at table 1 of page 4) had been developed to align to the work we were doing as an organisation, how they fitted with the organisation's ambition, and to reflect the work ongoing across the

Accountable Care Partnership (ACP) and Integrated Care system (ICS).

The Accountable Officer commented that this report set the tone of the third of the CCG's five priority aims was to work with Sheffield City Council to continue to reduce health inequalities in Sheffield. Professor Gamsu commented that there was no mention of inequality and the voluntary care sector (VCS) and carers in the report which, for consistency and to tell the story, could not be left out. The Chair of Healthwatch Sheffield asked if something about patient and citizen engagement could be included as a priority. With regard to patient pathways, the Lay Members commented that this priority read as though the pathway started with the acute referral and it needed to acknowledge the role of the voluntary sector and what happens in communities. **BH** **BH** **BH**

Dr Hudsen commented that there were more core areas that could be independent of each other, but there were some more longitudinal things, for example prevention, and it was a case of how this was presented.

The Director of Delivery – Care Outside of Hospital advised members that the CCG's Director of Communications had been tasked to bring all of this into the CCG's 'story', having the confidence that they were all there without having to have an exhaustive list.

The Director of Public Health advised that he would welcome more coverage on multi-morbidity, and also questioned as to why cancer had been afforded more specialness than other areas. The Director of Commissioning and Performance explained that cancer had been included as it was a national priority, and that some of the pathways for what were suggested as areas of particular concentration, ie prostate, colorectal, breast and neck and cancer cancers had already been developed. He would also ensure that delivery in 2018/19 and what was actually going to change in the priorities would be made clear. He assured Sheffield City Council (SCC) colleagues that the CCG had excellent programme management plans in place and a very clear delivery plan for all of this. **BH**

He advised Governing Body that all the above comments and observations would be taken back to the workstreams to make sure the narrative was referenced and amended in terms of wording, and to then use that as a basic set of principles. **BH**

The Governing Body:

- Approved the presented list of priorities for the CCG for 2018/19.
- Approved the next steps in the development of future priorities.

123/18 Month 4 Finance Report

The Director of Finance presented this report which provided information on the CCG's financial position at Month 4, together with an assessment of the risks and existing mitigations available to deliver the CCG's control total of in-year break even (cumulative year end surplus of £18m). She

advised Governing Body that overall the CCG was broadly “on track” to meet the required in year breakeven position but that she had RAG rated the delivery as AMBER as further work was required to ensure all in year risks were mitigated particularly over the winter period.

She advised Governing Body that key risks remained delivery against the QIPP plan (which would be discussed in detail under item 124/18), volatility on national pricing arrangements for drugs within the GP prescribing remit and hospital activity. She noted that the CCG was currently undertaking the assessment of the Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) contract Quarter 1 freeze data, although no major issues with coding had been identified at this stage. The main problem continued to be the delays to full coding of each month’s data by the trust due primarily to staff vacancies. This was presenting difficulties for both the trust and the CCG to use the most up to date data for analysis and forecasting purposes. The CCG was monitoring implementation of a recovery action plan on coding with the trust.

The Director of Finance reported that three months of prescribing data was now available. The prices of Category M drugs had reduced in July but increased in August and September by 17p per item, but no intelligence was available at this stage as to pricing from October onwards. She reported that she had made some assumptions on the year end forecast outturn which she had based on current pricing and that if prices remained as they were now, we would underspend on this budget. She also advised Governing Body that work was ongoing with the CCG’s Medicines Management Team (MMT) on cost effective prescribing.

The Governing Body considered the risk assessment and existing mitigations to manage the risks to deliver the CCG’s year end control total of a £18m surplus as outlined in section 2.

124/18 Update on Month 4 Quality, Innovation, Productivity and Prevention (QIPP) Plan

The Director of Commissioning and Performance presented an update on progress with the QIPP Plan for 2018/19, which included an assessment of the current risks to the plan and the processes in place to ensure the plan was achieved. The planned QIPP was £18.5m (2.2% of the CCG’s total allocation), which included £752k of unidentified QIPP, reduced from £2.4m previously reported, as noted above. He drew members’ attention to the key issues.

At Month 4 there was a shortfall against the plan of £752k due to a number of the schemes not commencing on time, with five schemes risk rated as Red in addition to the areas with unidentified schemes. NHSE was providing support to the CCG through Deloittes who were reviewing the high risk schemes, and looking at what we were doing as an organisation with a view to seeing if any schemes could be accelerated. The Director of Commissioning and Performance advised Governing Body

that Deloittes have congratulated the process the CCG had in terms of the programmes that could be delivered.

The Director of Finance advised Governing Body that a QIPP workshop with the other South Yorkshire and Bassetlaw CCGs and Deloittes would be taking place later in the month, a report from which would be presented to Governing Body in November. **BH**

The Governing Body considered the current risks and issues identified and the actions being taken to reduce unidentified QIPP within the plan.

Section 3 highlighted three proposed new schemes which we felt were at the stage that we could work up for early implementation and would realise total savings of £1.05m if delivered: SYB-wide implementation of an integrated lower Gastro-Intestinal pathway; reduce unwarranted variation in GP referral rates, volumes and quality from primary to secondary care within all specialties across all localities and neighbourhoods in Sheffield and; to develop a new follow-up programme to align follow up ratios with contractually agreed ratios by establish a collective and collaborative approach with STHFT through a transitionary period by developing new reduction in variation of clinical approach in the acute provider.

With regard to the scheme to reduce unwarranted variation in GP referral rates, the Director of Commissioning and Performance advised Governing Body that the CCG would be taking this forward with the locality leads / managers in each of the four areas, and that a practice variation group had been established which would meet shortly. Governing Body noted that discussions had taken place within the Hallam and South (HAS) and North localities in relation to this scheme, and how this complemented work already underway, and a realism about what actual levels of improvement could be realised.

The GPs welcomed the follow-up programme to align follow up ratios with contractually agreed ratios and suggested that it might be worthwhile looking at the data and canvassing opinions on this from other clinicians. The Director of Commissioning and Performance advised members that negotiations were taking place with STHFT in relation to the trust not filling the existing follow up appointments with other patients.

Members agreed that the integrated lower Gastro-Intestinal pathway scheme needed to be implemented rapidly, and requested further detail on this might work particularly around the faecal immunochemical testing (FIT), the rule out test for colorectal cancer. The Director of Finance agreed to take this forward with the CCG's Clinical Director for Elective Care, who had been instrumental in working up this proposal. **JN**

With regard to the additional programme that had been developed where the CCG was working with partners to discharge patients with learning disabilities and autism into less restrictive environments, Ms Forrest, Lay Member, asked that the CCG bear in mind that there was a limited choice of residential facilities and had heard that some patients had been placed

outside of the city.

With regard to the current QIPP plan, in summary, the Chair advised members that a review would be undertaken on those schemes where activity was above plan, that a number of schemes had been taken out of the plan or reduced to zero as it had been realised that they would not deliver, and that additional schemes had been identified this year. He commended the ongoing work being undertaken by the CCG's QIPP Working Group. QIPP was about quality, not just cost savings.

The Governing Body:

- Considered the reported Month 4 QIPP position and the revised year end forecast position.
- Approves the commencement of the additional proposed schemes as discussed in section 3 and summarised in the table on Appendix 1, in order to reduce the unidentified gap against the £18.5m target savings.

125/18 Performance, Quality and Outcomes Report: Position Statement

The Director of Commissioning and Performance presented this report which reflected the CCG's statutory responsibilities. He drew members' attention to the following key issues, as detailed on the first two pages of the report.

a) A&E 4 Hour Waits: Performance at STHFT remained consistently below the 95% national standard, however, ongoing work was taking place between the trust and the CCG to try and improve the position. The Director of Commissioning and Performance advised that he proposed to present further information in public in November on A&E and the state of readiness and the wider context around emergency care. **BH**

b) Diagnostic Waits: STHFT had made significant progress on improving waiting times for Dexa and echocardiography scanning. However, there had been delays in waiting times for physiology and peripheral neurology scanning over the summer months, with action plans now in place to try and improve the position.

c) Ambulance Response Times: The Yorkshire Ambulance Service NHS Trust (YAS)'s performance still did not meet the new Ambulance Response Programme (ARP) standards, although it was starting to adapt its resource to deal with that capacity and demand.

d) Elective Waiting Times (Referral to Treatment): The CCG continued to perform exceptionally well against the 18 week waiting time national target.

e) Air Quality and Health Impacts: Governing Body noted the work that was ongoing in relation to a small working group being convened to look at the findings of mapping air quality in Sheffield against areas of deprivation and investigating potential links between areas of poor air quality and hospital admissions.

f) Quality

The Chief Nurse advised Governing Body of the following:

i) Clostridium Difficile: There had been 11 reported cases in June and July at STHFT, four over the monthly ceiling of seven cases, one case in July for Sheffield Children's NHS Foundation Trust (SCHFT), and 17 for the CCG. The CCG would be reviewing the Root Cause Analysis (RCAs) of the cases at STHFT, and a deep clean of one of the wards affected was taking place. A deep dive as to the nature of the community cases was taking place, with an evaluation of this to be included in the next review report.

ii) Never Events: One Never Event had occurred in the ENT which had taken place, with a further one to be reported to Governing Body in the next report. The CCG was also working with Sheffield Children's NHS Foundation Trust (SCHFT) in terms of risk management.

g) Other Issues

i) Cancer Waiting Times – 62 Day Waits: Governing Body noted the 22 breaches of the standard for the two week symptomatic breast pathway, 17 of which had been due to patients cancelling their booked appointments and five to delays due to patient choice. They noted that high reporting of patients choosing to cancel appointments had been an issue for a long time.

ii) Transfer of Patients: The Director of Commissioning and Performance advised members that STHFT and YAS invested significant time and effort to improve the effective transfer of patients, including members of STHFT's senior team visiting Hull A&E to see what could be learned from how that trust used electronic systems to support handover.

iii) Care Quality Commission (CQC) Inspections: The Chief Nurse advised Governing Body that the report from the CQC inspection of Dr I A McKenzie's practice would be included in the next report.

The Director of Adult Services, Sheffield City Council (SCC) advised Governing Body that Orchard House, which had had bad CQC ratings, had now closed, with its patients moved to more appropriate settings.

iv) Early Intervention in Psychosis (EIP): Governing Body noted the continued improvement and achievement of the waiting time target.

v) Mental Health Measures Performance Dashboard: Governing Body commended performance against the targets, which were all above the national standards.

vi 2017/18 Improvement and Assessment Framework (IAF): Governing Body noted the 'Good' Improvement and Assessment Framework (IAF) rating for the CCG for 2017/18.

The Governing Body:

- Noted Sheffield performance on delivery of the NHS Constitution Rights and Pledges.
- Noted the key issues relating to Quality, Safety and Patient Experience.

126/18 Petitions Presented to the CCG Relating to the Urgent Care Consultation

The Director of Finance presented this report which asked Governing Body to note and consider a petition received by the CCG in respect of Making Urgent Care Work Better in Sheffield. She reminded members that it was a formal requirement of the CCG's Constitution to make Governing Body aware of the petitions that had been received by the CCG and advised that page 3 of the report confirmed the actions the CCG was undertaking as a result of having received this petition. Governing Body noted that the petition had been presented after the formal consultation had been completed, therefore, the petition would not formally be included as part of the feedback.

The Governing Body:

- Noted the petition received.
- Noted the total number of signatures for the petition.
- Noted that the petition was available on request for viewing by Governing Body members.

127/18 Accountable Care Partnership (ACP) / Integrated Care System (ICS) Update

The Accountable Officer gave an oral update. She reminded members that they had received a number of supporting papers circulated to them for noting which, she advised, she had asked the ACP Programme Director to produce on a regular basis. She drew their attention to the following key issues.

The ICS had been fairly quiet over the past few months as the focus had been on the hospital services review. The ICS Executive Team would be meeting for the first time the following week. The Chief Executives had met the previous week, and a report from their discussion on whether they were focusing on the right things would be provided in the next update to Governing Body.

The Director of Finance advised that several members of Governing Body had attended the third and final South Yorkshire and Bassetlaw workshop on the future of commissioning that had taken place the previous day. A report from the workshops would be reviewed by the ACP in October, with discussions focusing on system-wide commissioning and the architecture around that.

Finally, members agreed that, whilst the update reports were useful, it would be helpful if executive summaries of lengthy documents, and of minutes of meetings could be provided

The Governing Body noted the update.

128/18 Reports Circulated in Advance for Noting

The Governing Body formally noted the following reports:

a) Accountable Care Partnership (ACP) / Integrated Care System (ICS) Papers (*to support main agenda item 17 (oral update)*
   i) ACP Programme Director's Report
   ii) ICS Briefing
   iii) Minutes of the ICS Meeting held on 8 June 2018

b) Chair's Report

c) Accountable Officer's Report

d) Annual Audit Letter 2017/18

e) Quarterly Complaints and MP Enquiries Update

f) Quarter Serious Incidents Update

g) Report from the Joint Clinical Commissioning Committee of CCGs (JCCCG)

h) Report from the Primary Care Commissioning Committee (PCCC)

i) Report from the Strategic Patient Engagement, Experience, Equality Committee (SPEEEC)

129/18 Any Other Business

There was no further business to discuss this month.

130/18 Summary of Meeting: Three Key Messages from the Chair

- The presentation from Professor Chris Welsh relating to the hospital services review and the SoC, which had demonstrated the progress that had been made and that everyone's comments been taken into account during preparation of the final report

- The useful discussion around the CCG's priorities that would help to guide us both in 2018/19 and in the development of future priorities.

- The commendable work that had been undertaken over the summer on the QIPP programme, which would hopefully help us deliver on all the schemes, and the reminder that QIPP was about quality, not just cost savings.

131/18 Date and Time of Next Meeting

The next full meeting in public will take place on Thursday 1 November 2018, 2.00 pm – 5.00 pm, Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU

Appendix A

Questions from Members of the Public to the CCG Governing Body 6 September 2018

Question 1 (Rita Brookes): Would the CCG please explain how they will meet the arbitrary savings targets for CHC required by NHS England? The savings required cannot be met through administrative savings.

Whilst we know that over the last two years the number of people from whom CHC has been withdrawn on reassessment has increased markedly, we would like to know whether you will be raising the threshold of those assessed as eligible to CHC entitlement even further or will you be limiting the care packages available? Either way patient safety will be put at risk. How will you ensure that the most vulnerable people in Sheffield are protected from unjustifiable cuts?

CCG response: *Thank you for taking the time to write to us with your question.*

The CCG has a statutory duty to comply with the CHC Framework.

We want to reassure you that NHS England has not set the specific financial targets in relation to CHC. All CCGs have a statutory requirement to deliver financial balance. This requires CCGs to critically assess the level of funding required for each of our areas of expenditure and hence we have a rigorous financial planning and budget setting process each year. As part of this, the CCG has maintained its budget for CHC for 2018/19 compared to 2017/18.

The level of spend compared to the number of patients in receipt of CHC will vary year on year depending on the length of time each patient receives care and also the 'case mix' of patients. The cost of an individual package can vary very significantly from those with very complex needs needing bespoke complex packages of care to other patients for whom we pay standard rates per week to a wide range of nursing homes across the city. The spend by the CCG can also vary depending on how many packages of care are jointly funded with Sheffield City Council where this is relevant within legal frameworks, such as for mental health patients in receipt of Section 117 care packages.

It is important to highlight that each year we look to set a budget which takes account of a number of factors including demographic trends, likely inflationary or price pressures and our service transformation plans. As you may be aware, through our care outside of hospital strategy we are looking with our health and social care partners in the city, to reduce the number of people needing to be admitted to hospital and their length of stay, where appropriate, and so potentially reducing the number of people requiring long term care and / or the level of care they require because they are able to continue to live independently in their own home.

We are not limiting the thresholds available or the packages of care.

Question 2 (Sue Harding): The public accounts committee published a report in January about the state of CHC in the country. They said: "Stakeholders told us that some CCGs have introduced arbitrary additional local rules which are not set out in the formal assessment tools, and the Equality and Human Rights Commission is

concerned that the way some CCGs are applying CHC policies may be unlawful. Too often assessors in multidisciplinary teams are inadequately trained, have never met the person they are assessing and do not involve the patient or their family in the assessment. Furthermore, a report by the Continuing Healthcare Alliance found that around 60% of healthcare professionals are assessing people without sufficient specialist knowledge of the medical condition that they are looking at. Whilst there are examples of good practice, these are not being systematically identified and replicated across the country"

Are you absolutely sure that this is not happening here in Sheffield? We would maintain that it is and you have a case to answer.

***CCG response:**. Thank you for taking the time to write to us about your concerns.*

Please be assured that Sheffield CCG is acting lawfully by following Government guidance and ensuring that we are applying the CHC framework appropriately and that no local arbitrary rules have been put in place.

We have recently had our processes and policies reviewed by NHS England and have had positive feedback in many areas and also that there is room for improvement as we believe it is the same in many areas of the country. We are striving to improve our service and are engaging with the public in many areas of our processes.

The Sheffield CHC team employs highly qualified nurses with a wide range of professional experience. The initial assessment is carried out by a assess coordinator who would not know the individual but they engage the individual's wider multi-disciplinary team as part of the process to get a full understanding of their needs. They also use reports and other documentation in the completion of the assessment.

Question 3 (Peter Selby): Relatives in Birch Avenue and Woodland View Nursing homes and this CCG Governing Body have been told repeatedly that CHC assessments are being conducted correctly by the Sheffield CHC team.

Would the CCG please explain why three residents in BA/WV died within weeks of receiving notification that they no longer had a primary healthcare need? One of these was Julia, my wife. Another resident was ill during the DST process which was held and postponed twice and he sadly died before the third assessment could take place.

Does this sound like a team that knows what it's doing and which has the health and welfare of the individual at the heart of what they do? This is not a question about individuals so please don't refuse to answer on that basis. This is a matter of principle.

And just how ill does a person have to be to have a primary healthcare need in Sheffield?

***CCG response**: Thank you for taking the time to write to us about your concerns.*

We are so sorry to hear about your wife and the residents who recently passed away, this must be a very difficult time for you all.

There is the full recognition that while people receive CHC funding or Funded Nursing Care this is to pay for the care in relation to their primary health needs. However, it is important to note that at any point an individual may become acutely unwell this may be an in relation to their initial diagnosis where their health has significantly deteriorated or it may be that another acute problem has arisen. Either of which may require medical intervention from a GP or hospital. These would not affect the short term support identified within the eligibility criteria, unless these became so problematic that it would trigger another review of a Decision Support Tool or Fast Tract assessment (this is used when a patient is deemed to need intensive health and care support as part of the end of life care).

We cannot emphasise greatly enough that Sheffield CCG employs highly qualified CHC nurses with a wide range of professional experience , who are able to provide appropriate assessments to identify a primary health need,. The CHC team also comprises a specialist team who are able to concentrate on assessments in relation to Fast Tract assessments

Question 4 (Dorothy Dimberline): Could you please explain why the CCG refuses to acknowledge or speak to the people whom relatives of residents at Woodland View and Birch Avenue Dementia Homes have delegated as their representatives, namely Woodland View Dementia Support Group represented by Phil, Frances, Sue and Rita.

Many of us don't understand the intricacies of your systems and procedures and there is a national issue with ordinary people understanding the complicated process of Continuing Healthcare. We need someone who we trust to help us and to act on our collective behalf to ensure that all communication is consistent and accurate and not delivered piecemeal.

Also, many people lack the confidence to speak out and find dealing with large organisations very daunting. This is particularly true of relatives who are experiencing the sadness and stress of dealing with their loved one's dementia.

Also, is it true that the CCG have refused a request from MP Clive Betts to hold a meeting with relatives at Woodland View? If that is the case can you explain how this sits with the following quote from your website: "As a patient/carer and citizen of Sheffield, your voice will always be at the heart of the decisions we make. The only way we will get it right is by listening, hearing and acting upon your suggestions, experience and feedback and we are committed to supporting every person in this city to have their say".

***CCG response**: Thank you for taking the time to write to us about your concerns and we are sorry to hear that you think we aren't listening to families and residents. We want to reassure you that we are listening.*

Meetings have taken place with the families, relatives and members of the Support Groups in relation to Birch Avenue and Woodland View. This initially had been to gain a greater understanding for the level of opportunity to review the service delivery model at these homes due to the notice served from the provider organisations. On reflection, this approach had been limited to just two care homes rather than the wider appreciation of the requirements and opportunities with all the care homes in Sheffield

Over time, the CCG has been able to develop a greater understanding of the need to work collaboratively with the partners across Sheffield to be able to optimise how improvements in Dementia care can be made. The CCG and partners have taken the approach that a much wider engagement across Sheffield would be beneficial to deepen the understanding of what people with Dementia need and want and therefore help design future dementia care for people at home, hospital and care homes. It might be an ideal opportunity for a member of the support group to be involved in the shaping and evaluation of the engagement work and would be welcomed onto the Dementia Steering Board.

The CCG, Age UK, and Alzheimer's Society, have met previously with the support groups, families and cares from both Birch Avenue and Woodland View last summer in order to offer assurance regarding the management of CHC assessments. It became apparent at these meetings that some individuals remained confused and concerned regarding the CHC process and therefore imperative that the CHC assessment nurses, and advocates from Age UK and Alzheimer's, offered support and explanations at the time of need.

The CCG continues to offer its support and listen to issues in relation to CHC and has welcomed the independent role of Healthwatch to be able to interview relatives and members of the support group to be able to guide the CCG on any particular actions that CCG may need to take in relation to improving communication and expectations.

Question 5 (Rita Brookes): A person with severe neurological disease such as Parkinson's, Alzheimer's, etc, is so disabled that require nursing in bed. This person can't speak, needs feeding, needs their hydration regulating, needs turning regularly to maintain skin integrity, is doubly incontinent, etc, etc. Do you think this person has any health needs?

CCG response: *Thank you for taking the time to write to us about your concerns*

Unfortunately, it would be impossible to give a precise answer from the information provided. We do know that individuals can present with similar issues but present different concerns or problems and these can be at varying degrees. This is the reason why CHC assessments are based on using the robust Decision Support Tool. This framework provides the platform to take into consideration any area of health or social care need at that time and would not be based on a clinical diagnosis.

Through the roles and experiences of our nurses and social worker, a joint decision would be reached based on the eligibility and care intervention that would meet the individual's needs.

Question 6 (Ruth Milsom): What realistic analysis and forecasting underpin your assumptions that 12% of cases currently seen in hospital can be diverted to community healthcare?

CCG response: *The assumption in the modelling that around 12% of cases being diverted to primary or community care is based on a strong national and international evidence, as well as clinical and commissioner input around a realistic scenario for South Yorkshire and Bassetlaw. It is confirmed by the most recent 2018 NHS Improvement guidance:*

- *There is strong evidence that at any given time a significant proportion of the patients in a hospital could receive care in another setting:*

- *The National Audit Office in 2015 found that older patients who no longer needed acute treatment were spending a total of 2.7m days in NHS hospitals per year (https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital-Summary.pdf).*
- *Most recently, NHS Improvement guidance published in 2018 refers to extensive use of audit tools which has shown that 20% to 25% of admissions and 50% of bed days do not require an acute hospital bed as these patients' medical needs could be met at a more appropriate, usually lower, level of care. (https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf)*
- *The NHS Improvement guidance also states that 39% of people delayed being discharged from hospital could have been discharged into different, usually lower dependency, services more suited to meeting their needs.*

- *There is also strong evidence that for many patients receiving care in a setting other than hospital (for example, in a dedicated rehabilitation setting, or being back in their own home with the appropriate support) would be more appropriate and would improve health outcomes. Particularly for frail elderly patients, being in hospital can lead to rapid loss of independence and physical condition. See for example*
  - *The National Audit Office which cites a 5% loss of muscle strength for each day an elderly person stays in hospital (NAO, Discharging Older Patients from Hospital, 2015 https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital-Summary.pdf);*
  - *NHS Improvement guidance states that 35% of 70-year-old patients experience functional decline during hospital admission, for people over 90 this increases to 65%. (https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf)*
  - *These reports draw on a wide body of academic research which is in the public domain.*

The evidence around alternative places to deliver care does not only apply to older people. In maternity services for example some patients can choose to give birth at home. In paediatrics, some treatments that would once have required a child to attend hospital (such as receiving intravenous antibiotics) can now be delivered at home. For working age adults, similarly, treatments such as dialysis and some kinds of chemotherapy can now be delivered by neighbourhood teams closer to, or in, patients' own homes.

Based on this national evidence, there is a significant opportunity to provide care for patients outside hospital. 12% was agreed by clinicians and commissioners in the system at the time of the STP as being a reasonable and realistic assumption to make based on an assessment of capacity and infrastructure, and well within the level of opportunity identified in national and international evidence.

Question 7 (Ruth Milsom): Furthermore, what is the realistic case for doubling this to 24%? The latter appears to be a stab in the dark attempting to massage the feasibility outlook of the proposed reconfiguration scenarios.

CCG response: *As explained above, is well within the limits identified in the NHS Improvement guidance 2018, of 50% of bed days not requiring an 'acute' hospital bed as these patients' medical needs could be met at a more appropriate, usually lower, level of care.*

Question 8 (Ruth Milsom): Have figures been published to support the above assumptions that either 12% or 24% reduction in hospital usage can be achieved in the areas covered by the HSR?

CCG response: *The assumptions in the HSR (and earlier, in the STP) are based on a substantial national and international body of evidence which is in the public domain.*

With regard to how far South Yorkshire and Bassetlaw will be able to deliver this, the work is being taken forward through partnerships between the different health and social care services in each place (Accountable Care Partnerships). Each Place has produced a Place Plan, and Place Plans are published online. They lay out the current proposals in each Place that are intended to begin to deliver the shift of activity out of hospital. Primary and community care will continue to work together and with other partners to ensure that patients are receiving care as close to home as is appropriate for them.

Question 9 (Ruth Milsom): The HSR demonstrates unequivocally that the problem faced across the board is staffing. Section 3.3 of the Executive Summary (Paper A, p.10) states:

"Workforce – As is the case across the country, SYBMYND has a significant shortfall in the number of substantive staff in the system, with problems in both the recruitment and retention staff. The remaining workforce is therefore overstretched and there is a significant reliance on costly agency staff. Gaps in the workforce mean that staffing levels can fall below those required to provide a safe service for patients."

In the 'SYBMYND Strategic Outline Case Annex B: Case For Change' (no page numbers in this section), Tables 1 and 2 show that all areas under review are suffering from shortages of nursing and clinical staff, with the exception of consultants in maternity.

It appears that almost all case scenarios put forward in terms of reconfiguring - Options 1 to 3 projecting closure of 1, 2 or 3 units - result in significant requirements for capital expenditure, even accounting for a highly optimistic 24% diversion of hospital cases to community healthcare.

My question is: what realistic projections have come out of these studies and assumptions to suggest that reconfiguring can save money more effectively than simply employing more NHS clinicians and nurses to deal with the understaffing problems? Furthermore, would investing to solve understaffing not be the obvious way forward in terms of patient safety and future-proofing?

CCG response: *We want to reassure you that we are doing this. One of the main aims of the proposals in the Hospital Services Review is to enable our region attract and retain more staff. The proposals include the development of Hosted Networks and a Health and Care Institute, which aim to develop shared approaches to recruitment, promote training and development, and work together to attract new staff through avenues such as apprenticeship schemes.*

However, there are limits to how far we think we will be able to solve workforce shortages even through better working together and better use of our existing workforce and due to a national shortage of clinical staff. A number of reasons, including falling numbers of

applicants for some specialties, mean that there are likely to be shortages of staff across the country at least in the short term.

The HSR looked at reconfiguration of services for other reasons in addition to workforce numbers. There is evidence across the UK that focusing specialist activity in a smaller number of specialised units can improve quality of care given. We anticipate that the majority of services will continue to be delivered in local hospitals but for areas where patients are at higher risk and need more specialist care, providing care in specialist units with a higher level of consultant presence can improve health outcomes. In some cases this can also lead to savings as staff rotas can be consolidated and reliance on locums can be reduced.

Question 10 (Ruth Milsom): Referring to UTCs, the Key Assumptions detailed on p.82 (Appendix) state (point 1) that "each of the Urgent Treatment Centres (UTCs) are staffed by 6 GPs each... The range provided by the trusts was 4 to 8." What is the basis for assuming 6 GPs per UTC, when usage figures differ vastly from Place to Place as analysed in the scenarios on p.83?

CCG response: *The modelling assumptions used the mid point of the range provided by the Trusts (mid-way between 4 and 8). This is a standard way of developing assumptions for use in modelling.*

Question 11 (Deborah Cobbett): Thank you for including full responses from members of the public and the Sheffield Save Our NHS survey raw data. Please accept a report about this survey highlighting people's appreciation and concerns about hospitals going beyond the five services and your proposals about an Innovation Hub and/or Health and Care Institute. There is praise for staff dedication and the quality of the process of care, not your focus on outcomes; there is pride in our *National* Health Service, as opposed to its fragmentation into footprints and so-called ICSs.

In the light of this, will you and Healthwatch please publicise these current NHS consultations:

- **Evidence based Interventions [Closes 28 September]** **https://www.engage.england.nhs.uk/consultation/evidence-based-interventions/**
- **Developing the Long Term Plan for the NHS [Closes 30 September]** **https://www.engage.england.nhs.uk/consultation/developing-the-long-term-plan-for-the-nhs/**
- **Contracting arrangements for Integrated Care Providers (ICPs) [Closes 26 October]**
- **https://www.engage.england.nhs.uk/consultation/proposed-contracting-arrangements-for-icps/**

Whilst NHS England are responsible for publicising their national consultations, we are happy to publicise relevant national consultations on our website and will add the relevant ones that you have highlighted.

Can you explain why you are so impatient to implement rapid change at pace when there are such consultations still going on?

CCG response: *There are immediate and pressing challenges facing our services, so our primary objective is to address these challenges. In ensuring it is carried out effectively, legally and in the best interests of our population, transformation work takes time, even when there is a pressing need. The work we are undertaking now will not be completed before the findings of the national consultations are reported and we will consider our next steps should they provide any reason for us to change our approach.*

The Department of Health and NHS England have made it clear that the direction of shared working that is laid out for the ICSs is the national direction.

Question 12 (Deborah Cobbett): We welcome the creation of a group to work on transport issues.

- **Given our community contacts and knowledge of local travel issues, will you invite us to join this group?**
- **Will you improve on recent public events where you simply asked participants to rank criteria of your own choosing?**
- **Will you recognise the expertise of different groups, such as public transport users?**

CCG response: *You would be very welcome to put forward members to join the patient/ public transport advisory group. Please contact Tom Read at volunteering@syha.co.uk*

The group will represent a diverse range of the population, including public transport users, car park users, people from rural communities where transport links are poorer, representatives from communities most likely to use public transport. We also hope to have some current or recent hospital patients on the group to share their experiences.

At each stage of the review we have engaged with patients/ public in the most appropriate way to incorporate the public/ patient feedback into the review. This engagement has included open discussion and posing open ended questions which allow for free-text responses, as well as the evaluation criteria ranking exercise (which was the same exercise used to gain the opinions of NHS managers and clinicians) and was therefore the best way to give the public / patient opinion equality of weighting.

The patient / public transport advisory group will feed in their views on a range of transport and access related issues in a range of ways.

Question 13 (Deborah Cobbett): On geographical boundaries, in addition to transport worries, will the ICSs create bureaucratic and financial barriers to 'patient flow' between different footprints and institutions? How will this differ from arrangements under our *N*HS?

CCG response: *There are currently significant barriers to patient flow between trusts, and different geographical footprints. This was raised by our clinical working groups (CWGs) as one of the main problems facing the current system. The CWGs identified barriers in the current system including different patient transfer protocols, a lack of formal agreements between organisations around transferring patients between organisations, different availability of out of hospital services in different areas, and barriers to sharing patient information, all of which make it difficult for patients to move between different footprints and institutions.*

The aim of the Integrated Care System, and of the Hospital Services programme, is to reduce barriers between the trusts. We are aiming, for example, to use the Hosted Networks to agree standardised transfer protocols between Trusts so that patients can be transferred more easily, and to standardise care pathways, based on best practice, so that patients receive similar care whichever hospital they are in.

Question 14 (Deborah Cobbett): On governance, your responses show what a legal minefield it is, and yet you are pushing ahead with changes we fear will undermine our NHS through cuts, closures, privatisation and management by targets and checklists which can so easily distort efforts and 'take the clinical out of commissioning' to quote one of your members.

- **Would you agree that this is linked to the decline in staff morale and difficulties in recruitment and retention, except perhaps among careerist managers?**
- **What is the environment you report that you are working in? Would neoliberal be a suitable adjective? Do you think you are part of a strategy to underfund public services, demoralise the staff and then produce privatisation as the answer?**
- **When you argue that rapid change is necessary and that you will improve outcomes, what is the evidence base?**
- **Are you attempting to agree new standards of care for SYB? If so, what is wrong with national standards?**

CCG response: *The aim of the Integrated Care System is to support the NHS through enabling NHS and social care organisations to work more effectively together. The long term future of the NHS depends on us being able to work together to make the best use of the resources that we have, and to support staff to build a career within the NHS.*

We recognise that whilst the ICS aims to make patient flow more straight-forward within the SYB footprint, we also have patients who flow outside of the SYB geographical boundary. We therefore work very closely with neighbouring organisations and partnerships (such as North Derbyshire where some South Sheffield patients flow and Mid Yorkshire where some North Barnsley patients flow).

The need for rapid change is laid out in the Section 1A and 1B reports of the Hospital Services Review, which describe the challenges currently facing the system. Annex B of the Hospital Services Strategic Outline Case provides some updated figures on these. It says for example that since Quarter 1 of 2016/17, only one trust has consistently met the target for 95 per cent of patients who attend Type 1 A&E to be discharged, admitted or transferred within four hours of arrival.

The proposals that we have laid out in the Hospital Services Review are those which our clinicians advised would help them to improve outcomes for patients, largely by supporting the workforce and making it more robust. For example a key objective is to reduce reliance on locum staff, and to strengthen our permanent workforce, which will improve the quality of care.

On standards of care, SYB will follow national standards where these are prescribed. In areas of workforce, where there are guidelines rather than standards, the modelling so far has been based on Royal College guidelines. However Royal College guidelines have traditionally focused on a workforce that is largely based on traditional divisions between consultants, junior doctors and nurses. Some of the Royal Colleges are already beginning to look at how alternative roles, such as nurse endoscopists or physicians' associates can

support the traditional workforce. SYB will work with Health Education England, the Clinical Senate, and the Royal Colleges where relevant to help develop work in this direction.

Question 15 (Deborah Cobbett): We regret the lack of responses except from Rotherham Council. How will you ensure better involvement of local authorities in the future?

CCG response: *All the Local Authorities in South Yorkshire and Bassetlaw, and North Derbyshire, are members of the Collaborative Partnership Board. We will continue to engage with them and encourage their involvement.*

We are also engaging with the Joint Health Overview and Scrutiny Committee (JHOSC) which has agreed to be the group which oversees the Hospital Services programme. Local authorities are able to exercise their powers of oversight through the JHOSC, as they are currently doing.

Question 16 (Deborah Cobbett): Will you do more to involve staff and address the concerns raised in the People's Review, such as these?

"Give admin staff time to look up and smile when I go into reception; Nurses and professionals try hard but it is hard – no pay rises, not valued. It's all about computers rather than care; Take care to employ the cleaning staff in-house to improve everyone's chances; Staff are over stretched. The "good service" provided is because they work over and beyond their contracts - which puts pressure on them and their health; reintroduce training bursaries better pay and shift arrangements for clinical staff; 1 nurse able to administer a particular treatment for over 7 wards. Grossly under-supported; Look after our staff!

You must reduce staff stress which causes massive amounts of sickness and loss of valuable and experienced staff. It also leads people to retire at the earliest opportunity. Never mind bursaries, student nurses should be paid like they used to be. I worked on a ward where the majority of the nursing staff were mature entrants. How can these people get in now? In my NHS years 1972- 2000, I didn't know of one person being sacked but 2000- 2013, I saw dozens being sacked. A little more human understanding would reduce a climate of management intimidation. Please don't bleat about staffing issues unless you are prepared to treat your workers properly.

In the light of those comments, what makes you think that improving health and wellbeing of staff will be effective?

CCG response: *The proposals in the Hospital Services Review aim to address some of the systemic issues which underlie pressures on staff, such as competition between trusts for the same staff, over-reliance on locum staff, and working with schools and universities to attract staff from non-traditional routes. The proposals emerged from the Clinical Working Groups, which were made up of groups of staff from all of the Trusts, and were identified by them as the issues which organisations could most usefully work together on in addressing workforce problems.*

Question 17 (Deborah Cobbett): Were your 5 'core' services chosen on the grounds of 'unsustainability'? It seems that they are not the most unsustainable, according to your own table. Why is this?

CCG response: *The basis on which the 5 core services were selected is laid out in the Strategic Outline Case, as well as in the Stage 1A report of the HSR. The SOC says the following:*

The HSR spent the first three months of the Review assessing performance across all acute specialties in SYBMYND.
The findings of the assessment are published in the Stage 1A Report of the HSR, available at:
https://www.healthandcaretogethersyb.co.uk/application/files/7515/0903/4254/Hospital_Services_1a_Report.pdf
The HSR found that a number of acute services across SYBMYND were facing significant sustainability challenges. The HSR undertook a methodical prioritisation process to identify those services which were facing the most acute challenges, and from these it selected five significantly challenged services as the focus of the Review.

Details of how the services were identified are laid out in the 1A Report which is available on the website. In summary, the HSR considered a range of published metrics to provide an independent analysis; worked with Trusts to identify the services that they thought most unsustainable; and identified the level of interdependencies with other services.

The below table identifies the acute services identified as the most unsustainable. A high score indicates that not only was the service of high concern to individual Trusts across the system, but that this assessment was backed up by evidence, and that the service was critically interdependent in maintaining other hospital services.

Table 1: Assessment of service sustainability. Services taken forward for inclusion in the Hospital Services Review are highlighted

Service	Independent analysis	Trust self assessment	Degree of clinical co dependencies	Sustainability Score
Emergency Medicine	13.6	16.0	16.0	15.2
Gastroenterology	10.8	13.0	15.0	12.9
Urology	13.5	12.0	13.0	12.8
Stroke - HASU	10.8	16.0	11.0	12.6
Critical Care	13.0	12.0	12.0	12.3
ENT	11.9	12.0	13.0	12.3
Cardiology	14.3	11.0	11.0	12.1
Radiology	11.8	12.0	12.0	11.9
Acute Medicine	11.2	11.0	12.0	11.4
Dermatology	14.3	18.0	0.0	10.8
Paediatric Medicine	9.4	11.0	11.0	10.5
Orthopaedics	14.3	8.0	8.0	10.1
Endoscopy	6.7	10.0	12.0	9.6
Ophthalmology	14.4	14.0	0.0	9.5
Neonatology	7.6	10.0	10.0	9.2

In order to agree which of these very challenged services the Review should focus on, the HSR team invited input from the HSR Steering Group (including Medical Directors of all the trusts); patients and the public; and national organisations such as NHS England.

From the Steering Group, the following five services were identified for Review:

- *Urgent and Emergency Care*
- *Acute Paediatrics (Care of the Acutely Ill Child)*
- *Maternity*
- *Stroke (the acute pathway, supporting HASU)*
- *Gastroenterology and Endoscopy*

Four of these scored in the top fifteen most unsustainable services in SYBMYND (highlighted in orange in the table above). The fifth, maternity, was added because its interdependencies with paediatrics make it difficult to consider paediatrics in isolation, as well as its significance considering the role of the District General Hospital (which was part of the HSR's terms of reference).

Question 18 (Deborah Cobbett): What are the implications of the CQC reports on services requiring improvement? Will they be supported with resources to address local needs or closed or what?

CCG response: *Individual trusts are working with the CQC to address immediate issues raised in the CQC reports. The HSR is focusing on the longer term sustainability of services.*

Question 19 (Deborah Cobbett): In addition to sustainability, how safe are local services? How long will it be until there is a case in South Yorkshire of a young doctor having to fight for her job after being scapegoated for the lack of resources?

CCG response: *Ensuring sustainable safe hospital services is one of the key aims of this work.*

Question 20 (Deborah Cobbett): Why in your next steps do you plan public consultation "if necessary" before implementing reconfigurations by December 2020 when you plan to launch the new networks as early as April 2019? Is there not a danger that the networks will affect everything else making closures more likely?

CCG response: *Public consultation will take place if the system has agreed, following detailed modelling and consideration of all of the options, that reconfiguration is the most appropriate option for any services. The HSR final report said:*

> *The HSR has recommended reconfiguration only when clinical engagement and modelling has suggested either that services are so unsustainable that they cannot be maintained through transformation alone; or that they are inextricably linked to another unsustainable service. The HSR recognises that while reconfiguration can have positive outcomes, it also carries risks, and so recommends reconfiguration only as a last resort.*

The aim of the Hosted Networks and the work of the Clinical Working Groups would thus be to find alternatives to reconfiguration. We will continue to seek alternatives to reconfiguration, through developing the mechanisms for shared working and transforming the workforce across the system, while developing the modelling of the reconfiguration options. We are committed to continuing to engage with patients and the public in the period leading up to any public consultations that are required to take place.