NHS
Sheffield
Clinical Commissioning Group

Unadopted Minutes of the meeting of NHS Sheffield Clinical Commissioning Group Governing Body held in public on 1 November 2018 in the Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU

A

Present:
Dr Tim Moorhead, CCG Chair, GP Locality Representative, West (Chair)
Dr Amir Afzal, GP Locality Representative, Central
Dr Nikki Bates, GP Elected City-wide Representative
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 Annie Majoka, GP Elected City-wide Representative (from item 136/18(b))
Ms Julia Newton, Director of Finance
Ms Chris Nield, Lay Member
Mrs Maddy Ruff, Accountable Officer.
Dr Marion Sloan, GP Elected City-wide Representative (from item 133/18)
Mr Phil Taylor, Lay Member

In Attendance:
Mr Gary Barnfield, Head of Medicines Management (on behalf of the Chief Nurse)
Ms Sandie Buchan, Head of Information, Performance and Performance Management Office (PMO) (for item 141/18)
Dr Trish Edney, Healthwatch Sheffield Representative (on behalf of the Chair of Healthwatch)
Ms Lucy Ettridge, Deputy Director of Communications, Engagement and Equality
Ms Alison Hall, Continuing Health Care (CHC) Clinical Lead (for item 144/18)
Ms Jane Haywood, Independent Chair of the Sheffield Safeguarding Children's Board (SSCB) and Sheffield Adult Safeguarding Partnership (SASP) (for item 136/18)
Mrs Carol Henderson, Committee Secretary / PA to Director of Finance
Mr Paul Higginbottom, Senior Programme Manager Ongoing Care (for item 144/18)
Mrs Sue Laing, Corporate Services Risk and Governance Manager (for items 139/18 and 140/18)
Mr Gordon Osborne, Locality Manager, Hallam and South
Mr Paul Wike, Locality Manager, Central

Members of the public:
There was one member 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

132/18 Apologies for Absence

Apologies for absence had been received from Mrs Nicki Doherty, Director of Delivery - Care Outside of Hospital, Dr Jennie Joyce, GP

Locality Representative, North, Dr Zak McMurray, Medical Director, Ms Mandy Philbin, Chief Nurse, and Dr Chris Whale, Secondary Care Doctor.

Apologies for absence from those who were normally in attendance had been received from Dr Mark Durling, Vice Chair, Sheffield Local Medical Committee (LMC), Mr Greg Fell, Director of Public Health, Sheffield City Council (SCC), Mr Phil Holmes, Director of Adult Services, SCC, Mr Nicky Normington, Locality Manager, North, Mrs Judy Robinson, Chair, Healthwatch Sheffield, and Ms Lorraine Watson, Locality Manager, West.

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

Dr Sloan, GP Elected City-wide Representative, joined the meeting at this stage.

The Chair welcomed Dr Amir Afzal to his meeting of the Governing Body since his appointment to Governing Body as GP Locality Representative, Central.

On behalf of Governing Body, the Chair thanked Dr Jennie Joyce for her contribution to Governing Body during the time she had been providing cover to the role of GP Locality Representative, North, since March 2018 in the absence of Dr Leigh Sorsbie. He advised that it was anticipated that Dr Sorsbie would return to her substantive post in early November.

133/18 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

Professor Mark Gamsu, Lay Member, declared a conflict of interest in the following item in his role as Chair of Sheffield Citizens' Advice :

Performance, Quality and Outcomes Report: Position Statement: Update on Improved Access to Psychological Therapies (IAPT) (paper H).

The Chair agreed that, as the paper was providing an update to members and they were not being asked to make any decisions, there was no reason why Professor Gamsu could not remain in the room and

take part in the discussion.

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

134/18 Chair's Opening Remarks

The Chair advised that he had no further issues he wished to draw to Governing Body's attention at this stage.

135/18 Questions from Members of the Public

Members of the public had submitted questions relating to Birch Avenue and Woodland View nursing homes, and to urgent care in primary care before the meeting. The CCG's responses to these are attached at Appendix A.

The Director of Commissioning and Performance advised Governing Body that responses to the latter would also be circulated to the Overview and Scrutiny Committee (OSC), to the next meeting of the CCG's Urgent Care Programme Board for information, and be placed on the website as an appendix to the minutes of this meeting. **BH**

136/18 Update on Key Issues including New Governance Arrangements for the Sheffield Safeguarding Children's Board (SSCB) and Sheffield Adult Safeguarding Partnership (SASP)

Ms Jane Haywood, Independent Chair of the Sheffield Safeguarding Children's Board (SSCB) and Sheffield Adult Safeguarding Partnership (SASP), was in attendance for this item and provided an oral update on the key issues, which included an update on the work of the respective Boards, key issues for the coming year, and the new governance arrangements for the Boards.

With regard to the work of the Boards, she advised members that it was encouraging to see the very strong partnerships within both Boards, an acceptance of challenge in Sheffield, and a problem solving attitude, and clear processes and systems.

a) <u>Safeguarding Adults Key issues</u>

A Quality Assurance Framework was being developed across all partners. A good training programme was in place, which the previous year had included work to review their approach to self neglect, from which an action plan had been developed. Work had been undertaken to understand adult sexual exploitation, which was increasingly becoming a problem, with a view to try to get those people into a safe place. There was also a very active customer forum, with work this year being undertaken to prepare an annual report, which would include a video diary, and being involved in some of the training they do.

b) Safeguarding Children Key Issues

Work had been undertaken with the National Society for Prevention of Cruelty to Children (NSPCC) Children to help build knowledge to help parents, carers and children. A number of safeguarding conferences had taken place, there was a continued focus on child sexual exploitation, including the training of staff at sports centres on how to make people feel safe. There was active engagement from young people in the work of the Safeguarding Board, who were also invited to attend the Safeguarding Board development day, and would like the Children's Safeguarding Strategy to state very clearly how they were involved in this work and its delivery.

Governing Body welcomed the chance to consider how the CCG engaged vulnerable adults and young people and how to get that voice heard.

Due to the close links, joint work was being undertaken between the two Boards, especially around transition of young people into adulthood and how the most vulnerable people struggle to make that transition. A programme of work, led by the CCG, was now underway to pull that transition work together and to give people clear pathways, with a paper to be presented to the next Board meetings on the governance around this.

Priorities for this year included young people's mental health, which led straight into the problems of sexual exploitation and transition, focusing on new processes, wider sexual exploitation, and the new Quality Assurance Framework, which were all well supported by the partner organisations.

With regard to new governance arrangements, it had taken some time to put these in place, and would include a reorganisation by April 2019 of the Boards to Local Safeguarding Partnerships which would include membership from the Police, CCG and Sheffield City Council (SCC), but would retain an Independent Chair and keep a focus on Sheffield. Ms Haywood clarified the partners were removing the operational Boards in an attempt to try and save resources, although would be establishing respective working groups, with the aim being that these new arrangements would give more flexibility and be more cost effective. However, they would still, as a group of partners, need to hold each other to account.

Ms Haywood thanked the CCG for its support and partnership working. She asked how the CCG heard the children's voice and how it influenced and shaped what we were doing, and requested that they be involved at the start of any proposals, not when we were at implementation stage. She also asked that the CCG consider who it would like to commission to provide a service, how to involve them in the safeguarding process, what we would like them to do, and how we

would hold them to account. The CCG also needed to keep a strong focus on transition, and consider in particular about how people working with adults were also trained to work with young people, as there was a huge difference in how each service worked, and it needed to be a priority to make it all clear and simple as possible for our workforce.

Dr Majoka, GP Elected City-wide Representative, joined the meeting at this stage.

Ms Haywood also explained that, with regard to serious adult reviews, whilst there was a lot of support and intervention for these vulnerable adults, they had not managed to keep them safe, and questioned whether what they were doing was right and targeted or whether it needed to be delivered in a different way.

Governing Body discussed the update and raised the following key points and issues.

Whilst they welcomed the update, with regard to transition they needed clarity on the work that was being undertaken in terms of the students coming into Sheffield. Ms Haywood clarified that the work that had been undertaken on transition had been to look at Sheffield based partnerships and had not been taken into universities. She would feed Governing Body's comments back to the respective Boards.

Members also asked for clarity relating to safeguarding issues that happen within families, and if there was support provided on parenting skills as it was difficult to get non statutory help. Ms Haywood explained that this had come out as a theme within the work the Local Authority had undertaken on safeguarding, but there was a lack of resource to be able to provide this support. However, there was an emphasis on prevention and supporting the families, and reports would be presented to the respective Boards on how early intervention was working. The Accountable Officer reported that she was a member of Gold Command with the Police on the work they were doing around organised crime, which had a link to child sexual exploitation, reports from which were presented to the Safeguarding Boards.

Governing Body agreed that it was essential to hold a mandatory training session for them to be appraised of what their corporate responsibility was in terms of the changing governance arrangements for safeguarding.

The Chair thanked Ms Haywood for attending the meeting and for her very helpful update to Governing Body.

137/18 Minutes of the CCG Governing Body Meeting held in Public on 6 September 2018

The minutes of the Governing Body meeting held in public on 6 September 2018 were agreed as a true and correct record and were signed by the Chair.

Members noted the questions from members of the public that had been raised at the meeting and the responses to these, however, noted that follow up responses to two questions relating to Birch Avenue and Woodland View would be included in the next report.

The Accountable Officer advised Governing Body that the CCG was receiving questions for the Integrated Care System (ICS) which, for now, the CCG would be addressing whilst the ICS was reviewing its governance arrangements and resolving how it would be addressing questions from the public.

138/18 Matters Arising

There were no matters arising that were not on the agenda.

139/18 Review of NHS Sheffield CCG Constitution

Mrs Sue Laing, Corporate Services Risk and Governance Manager, was in attendance for this item.

The Director of Finance presented this report which advised members of the key issues of NHS England's proposed new model Constitution for CCGs and sought their approval in principle for work to commence on the suggested way forward for a new Constitution for the CCG, and to then present a summary of proposed key changes to Governing Body in January. This would include a proposal to only ask our Member practices for their approval in relation to significant changes to the Constitution. She clarified that we needed to significantly update our existing Constitution, with advice from our lawyers, in order to achieve compliance with NHS England, and by not doing this we would miss out on the flexibility it would give us to support joint working, collaboration and commissioning within the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS). **JN/SKL**

She advised members that all CCGs were being encouraged to use the new model which meant that there would be a hugely similar element to those of SYB CCGs, especially in respect of the SYB Joint Committee of CCGs (JCCCG) and its Terms of Reference, which we would want to keep local. She advised that the Corporate Services Risk and Governance Manager would be discussing this further at the SYB Governance Leads network.

The Governing Body:

- Approved in principle that the CCG should move to adopt a new Constitution based on the new national model which the CCG would recommend to its Member practices and then to NHS England for approval.
- Approved that work would be undertaken to prepare documents which could be considered by Governing Body in January 2019, having first been considered by the CCG's Audit and Integrated Governance Committee (AIGC) in December 2018.

140/18 Review of Terms of Reference for Primary Care Commissioning Committee (PCCC)

Mrs Sue Laing, Corporate Services Risk and Governance Manager, was in attendance for this item.

The Director of Finance presented this report which summarised proposed revisions to the PCCC's Terms of Reference which the committee had agreed in September 2018 to recommend to Governing Body for approval in November. She drew members' attention to the summary of proposed minor changes listed at section 2 and shown as tracked changes throughout the document. Section 2 also reported on the discussion the committee had had in relation to whether or not its membership should be changed to include an out of area GP as a voting member. The rationale for their agreement that there would be no added value in doing this was also set out at section 2. Ms Nield, Lay Member and Chair of the PCCC advised members that the GP members of the committee felt they had the opportunity to brief the voting members before any decision was made, and they also had the benefit of local knowledge so had felt that an external GP was not needed.

The Director of Finance clarified the following:

Item 7e of Section 3 Role of the Committee: Approval of the commissioning proposals where the Governing Body determines that conflicts of interests prevent decisions being taken by the Governing Body as set out in the CCG's Standing Orders – this related principally to primary care which was where there was most likely to be conflicts of interests from Governing Body GPs, and Governing Body's quoracy did not allow a decision or vote to be made without any GPs in attendance.

Section 4 Membership – Senior Primary Care Manager was the job title of the NHS England representative attending the meeting.

Governing Body GPs agreed that, as a Membership organisation, they wanted to ensure that the GP voice was being heard. The Accountable Officer clarified that the lead Clinical Director that attended PCCC as a non voting member was a GP but also the Clinical Director for Primary Care so was adding his expertise into that area, and also that the PCCC GPs felt they were engaged in discussions and had their views recognised. Dr Edney, Healthwatch Sheffield representative, who also attended PCCC meetings as an invited attendee, commented that she felt that the GP voice in the meetings was very much heard and respected.

Members considered whether the six activities set out in item 7 of section 3 of the Terms of Reference were objectives of the CCG or the PCCC, and suggested that the wording be changed to state that the committee would oversee the activities.

The Governing Body:

- Gave delegated authority to the Director of Finance to review and **JN**

amend the Terms of Reference of the Primary Care Commissioning Committee, as noted above.
- Subject to the above, approved the revised Terms of Reference of the Primary Care Commissioning Committee,

141/18 2018/19 Sheffield CCG Priorities and Development of Commissioning Intentions for 2019/20

Ms Sandie Buchan, Head of Information, Performance and Performance Management Office (PMO), was in attendance for this item.

The Director of Commissioning and Performance presented this report which re-presented the CCG's objectives and priority areas for 2018/19 following discussion and proposed amendments made at the September Governing Body meeting, presented the process for developing the CCG's priorities and commissioning intentions for 2019/20, and noted NHS England's guidance on the approach for planning for 2019/20.

He advised Governing Body that the work had been co-ordinated by the Programme Management Office (PMO), contracting, finance and portfolio teams, aligning the nine priorities to the CCG's goals and objectives, national requirements as well as the ICS and ACP objectives, ensuring they sat over adults and children's services. The outputs and programmes we were trying to deliver were summarised in the report. The work to develop 2019/20 priorities would follow a similar process, with these being presented to Governing Body for approval in January 2019. **BH**

Part 2 of the report detailed the process being undertaken to develop the CCG's commissioning intentions (CIs) for 2019/20. The Director of Commissioning and Performance clarified that we need to continue to do this as an individual statutory organisation, incorporating those key objectives through both the ACP and ICS, and it would be a bottom up project management approach, working very closely with the finance and contracting teams, portfolios and partners of the CCG. He drew members' attention to the CCG's own proposed timescales for the 2019/20 contract planning round, in the absence of national guidance which was expected in December, which proposed that contracts be signed by the middle of March 2019 with the final process complete by April 2019.

With regard to the Cancer priority, the Accountable Officer suggested that as the objective talked about ensuring pathways and services were designed and developed to support early diagnosis, better treatment and aftercare, it should include be more specific about the initiatives the CCG had in relation to end of life and living with and beyond cancer. **BH**

Members asked if the following changes could be made to the CCG's aims and goals (Appendix 1):

To work with Sheffield City Council to continue to reduce health inequalities in Sheffield to be changed to: **To work with Sheffield City Council and other partner organisations to reduce health inequalities in Sheffield.**

Become a person-centred city: promoting independence for our citizens and supporting them to take control of their health inequalities across the Sheffield population to be changed to: **Become a person-centred city: promoting independence for our citizens and supporting them to have more control of their health and wellbeing through reducing health inequalities across the Sheffield population.**

Members gave delegated authority to the Director of Commissioning and Performance to amend and capture the changes they wanted to make and then to reflect them in the other key documents in the organisation. The Director of Finance reminded members that they had approved the aims and goals in March / April **BH**

Members asked if the CCG would be sense checking what 2019/20 planning means for the public. The Deputy Director of Communications explained that there would be an expectation that every local system engaged with its patient and public population, and hopefully there would be some national funding forthcoming for us to be able to do that.

Members agreed that the schematic was very helpful and was a good effort at bringing everything together but asked that workforce planning was referenced in the transformation programmes. The Director of Commissioning and Performance advised members that the schematic would feed into the organisation's performance development review (PDR) process and help to set individual's objectives for next year. **BH**

The Governing Body:

- Approved the list of priorities for the CCG for 2018/19, subject to amendments made as noted above.
- Approved the proposed process to develop the CCG's commissioning and contracting intentions, and financial plan for 2019/20.
- Noted the guidance on the "*Approach to Planning*" that had been issued by NHS England.

142/18 Month 6 Finance Report

The Director of Finance presented this report which provided information on the CCG's financial position at Month 6, 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 despite a number of financial pressures and risks, the CCG was broadly on track to deliver the planned surplus, but there would continue to be a challenge to manage the financial position going into winter. She confirmed that the CCG was holding limited reserves for additional activity pressures over winter but as previously discussed, the only additional national funding for winter / delayed transfers of care (DTOC) had been for Local Authorities. NHS organisations were expected to manage within existing funding. The CCG, via the Primary Care Commissioning Committee (PCCC) at its September meeting, had prioritised using £300k of slippage on primary care delegated budgets for additional access. As part of the system wide action plan to address DTOCs particularly as part of winter planning, she

confirmed that the Accountable Officer had offered £150k- £200k funding for initiatives through the voluntary sector as an important component of the CCG's contribution, as this also supported the CCG's Care Outside of Hospital Strategy..

The Director of Finance drew members' attention to section 2 (page 5) that reflected, for the first time, the context of the CCG's financial position within the ACP and ICS. She advised that she had presented a report on behalf of the six ACP partner organisations to the ACP Board the previous day that summarised where they were reporting they were at Month 6, and reported that, except for Sheffield Health and Social Care NHS Foundation Trust (SHSCFT), three of the four NHS organisations were reporting they had significant risks to delivery of their financial positions, and Sheffield City Council (SCC) was forecasting a significant overspend on social care for adults and children, with each organisation reporting appropriately to its respective Regulator. She also advised Governing Body that there were only certain formal risk share arrangements in place across the system, for example as with the Better Care Fund (BCF) and the Section 75 Partnership Agreement in place between the CCG and SCC.

She commented that the CCG needed to understand what its financial position was in the context of these two systems. Members agreed that it was useful to have the local context when considering the CCG's own financial position, and welcomed receipt of regular ACP / ICS updates.

Finally, the Director of Finance clarified that, with regard to delivery of the cash position (as set out in section 4), of which the CCG received a limited amount that was designed to manage its revenue position, CCGs were not allowed to either keep, invest or bank cash, which meant that we were only planning to report a minimal cash balance at year end.

The Governing Body considered and noted the risks and mitigations to deliver the year end planned position.

143/18 Update on Month 6 Quality, Innovation, Productivity and Prevention (QIPP) Plan

The Director of Commissioning and Performance presented an overview of the CCG's QIPP position as at Month 6 and an update on the progress of delivery by year end.

He reminded members that they had agreed an £18.5m total at the beginning of the year, and that we had always had an unidentified shortfall of £752k against plan on which Deloittes had been working with us to look at opportunities for where efficiency savings could be achieved. He explained that he had tried to give an honest assessment on the current position, as set out in section 2, and was now forecasting delivery of £15.6m as there were a number of schemes and initiatives we anticipated would not achieve their expected outcomes.

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He advised members that a new QIPP Working Group had been

established to keep a focus and challenge on programmes within the plan, which included Mr Wike, Locality Manager, Central, who had joined the group for one day a week and would be working with practices to help generate ideas for potential projects.

With regard to the work we had undertaken with Deloittes, the Director of Commissioning and Performance drew members' attention to the adoption of the Aspyre programme management reporting software that had been adopted and was regarded as an area of good practice, and advised that we were working with the ICS to see if they wanted to commission this and work to a similar reporting mechanism.

The Director of Commissioning and Performance clarified that Deloittes had reviewed the QIPP plan from a theoretical, not a practical, basis, with the outcome of the review positive and reaffirming some of the work we were already doing, but not giving us any 'quick wins' for this year. He also drew members' attention to section 3 which set out areas the CCG thought there was more opportunity to look at for the 2019/20 QIPP as it was thought the main benefit for implementing these would be next year. He advised that Deloittes had been very reassuring, engaging and supportive to staff, they had brought with them a good cross section of people, and had quickly written three business cases for us, which we had not had the capacity to do.

Members discussed whether or not it was feasible to include representatives from our provider organisations, including SCC, on our QIPP Working Group. The Director of Finance clarified that it was important for the CCG to have its own internal group but that many projects were very clearly linked into either the ACP or ICS workstreams. She commented that the ICS had just established an Efficiency Board and that the Chief Nurse was the CCG's representative on this Board which would oversee a prioritisation set of key efficiency programmes across commissioner / provider sectors.

The Governing Body considered and noted the reported Month 6 QIPP position and the revised year end forecast position.

144/18 Performance, Quality and Outcomes Report: Position Statement

As noted under minute 133/18, Professor Mark Gamsu, Lay Member, had declared a conflict of interest in the update being provided on Improved Access to Psychological Therapies (IAPT), in his role as Chair of Sheffield Citizens' Advice.

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 including areas of improvement and challenges, as detailed on the first two pages of the report.

a) Diagnostic Waits: The position at Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) for waits for peripheral neurophysiology, Dexa scanning, and echocardiography continue to improve following

implementation of its recovery plans.

b) Cancer: Performance against the national standards looked positive for us as a CCG although there were still significant challenges with STHFT struggling to meet those standards from a provider perspective.

c) Early Intervention Service in Psychosis (EIP): Governing Body noted the good improvements that had been made by the EIP to meet the national standards.

d) Quality

The Head of Medicines Management advised Governing Body of the following:

i) Never Events and Serious Incidents: No new Never Events had been reported since the last meeting, however, this area would always be shown as Red as three had been reported to date, against a target of zero.

ii) Healthcare Associated Infections (HCAIs): Although it was an improving picture, Governing Body noted that there had been nine cases of Clostridium Difficile (C.diff) at STHFT in September, against a target of five, and the CCG had had 12 community cases. Root Cause Analysis (RCAs) were being undertaken to determine the cause of all cases.

e) Other Issues:

i) Improved Access to Psychological Therapies (IAPT):
Professor Gamsu, Lay Member, commented that he felt that, as there wasn't a solution to addressing issues relating to systematic debt, it would be difficult to improve the performance of the proportion of IAPT patients moving to recovery. The Director of Commissioning and Performance agreed to discuss this with him outside of the meeting but advised that the IAPT data was fairly reliable as it was given to the CCG by the provider, and data collection was subject to external scrutiny. He advised that, following his discussion with Professor Gamsu, he would raise with the service as to whether it was taking on a considerably wider brief than was stated in the report. **MG/BH** **BH**

Members suggested that, maybe in future when we were considering how to commission services such as IAPT, we consider moving away from a disease based model to a wellness based model.

ii) Provider Care Quality Commission (CQC) Ratings: Ms Forrest, Lay Member, expressed concern regarding the number of care homes in the city that were rated as either Requiring Improvement or Inadequate as we needed an excellent social care system in addition to the excellent support system already in place in the city. The Accountable Officer responded that she would arrange for more work to be

undertaken by the care homes team in this regard, with a view to an update being presented to Governing Body for a detailed discussion at a later date. **MR/MP**

f) Presentation on Urgent and Emergency Care: System-Wide Assurance

The Director of Commissioning and Performance gave a presentation that updated Governing Body on A&E four hour waits performance in Sheffield, delays in performance of ambulance handovers, and the approach that was being taken towards winter planning for 2018/19. He drew members' attention to the key issues.

A&E maximum four hour wait performance at STHFT was stabilising and the volatility in performance seemed to be reducing. The trust had recruited 30 nurses to additional posts. However, significant delays in ambulance handover times continued to have an impact across the system. The action plan in place to try and improve performance was summarised at slide 4, and included an update on the processes that were / would be put in place, including 24/7 consultant cover in A&E from early December and a senior member of the Yorkshire Ambulance Service NHS Trust (YAS) being embedded within A&E.

The reporting mechanism for the winter period was summarised at slide 6. Using a system-wide approach to winter planning, an operational Winter Resilience Group to focus on A&E performance, and a System-wide Transport Group had been established, with membership from all key partners across the system. The Director of Commissioning and Performance drew members' attention in particular to slide 8 which highlighted approaches to discharge, which would be key to maintaining flow throughout the system during the winter period.

The Director of Commissioning and Performance drew members' attention to slides 11 to 22 which gave background and context to the new Ambulance Response Times (ARP) targets, which fundamentally changed the way in what the ambulance service was now expected to do and deliver in terms of patient outcomes. He also advised Governing Body that procurement had now commenced in relation to provision of 111 services, with a proposal for a preferred bidder expected to be presented to Governing Body in private in December.

Dr Hudsen welcomed the addition of a 24/7 consultant in A&E, especially as evidence suggested that the more senior the person the patient saw, the more likely they were to leave the hospital without being admitted.

Mrs Nield, Lay Member, was pleased to see a recommendation for the neighbourhood approach, including using services in the voluntary sector, and the approach to maintaining resilience within the system.

The GPs asked if activity in primary could be concurrently measured as they would also absorb a lot of the activity. The Director of Commissioning and Performance explained that feedback on activity

would also be received from a sample of practices in addition to feedback on activity that was going through the hubs, to help partner organisations understand how busy primary care, and other organisations, also were.

Finally, the Director of Commissioning and Performance advised that a copy of the slides and presentation would be published on the website as part of the papers from today's meeting. **BH**

The Governing Body:

- Noted Sheffield performance on delivery of the NHS Constitution Rights and Pledges.
- Noted key issues relation to quality, safety and patient experience.
- Noted the presentation and update on the system-wide approach being taken to urgent and emergency care.

145/18 Continuing Health Care (CHC) Development: Ongoing Care Programme 2018/19

Mr Paul Higginbottom, Senior Programme Manager Ongoing Care, and Ms Alison Hall, Continuing Health Care (CHC) Clinical Lead, were in attendance for this item and provided an update with regard to continuing health care (CHC) developments currently being delivered through the Ongoing Care Programme. They advised that the report was for noting but also was seeking assurances from Governing Body about the direction of travel. Mr Paul Higginbottom drew members' attention to the key highlights.

Section 2 set out how the team was striving to improve service development, and included engagement with families of people receiving funding, engagement with voluntary care forums, close working with Healthwatch Sheffield, and an integrated approach to workforce development which was extremely important for them and would include training on the new framework for CHC, and development of a new CHC Standard Operating Procedure (SOP). A key focus remained on making sure that the people using the service were able to have a 'stronger 'voice', the introduction of a CHC newsletter and survey, and on the exploration of a better use of technology to be able to be more transparent. A workshop to identify the CHC's core operating values and required behaviours to support collaborative working had been arranged to take place on 6 November.

The Healthwatch Sheffield representative welcomed the work that was being undertaken, and especially that the team was taking the patient voice on board which was contributing to how service improvements could be shaped and developed.

Members agreed that this was a very valuable piece of work that was being undertaken and that it was very important to have the patient voice to inform and shape the work, and that it was comforting to think the CCG benchmarked well on a range of things, and could carry on improving.

Ms Forrest, Lay Member, advised that she had observed one of the

weekly CHC funding review panels and had been really impressed and assured by the level of knowledge and empathy expressed from the panel members, especially as a lot of the focus had to be on those families that did not understand the CHC funding process. Ms Hall commented that the tool they used to ask the questions sometimes felt impersonal with meant that their staff did have to be empathetic, however, those patients at end of life could be fast tracked through the system which meant they did not have to complete the form. Mr Higginbottom advised Governing Body that they were also looking at developing a CHC awareness raising session, with a very simple video developed to communicate that to people, as it was about education in the general public and their health and social care needs.

Finally, Governing Body acknowledged the hard work undertaken by the CHC teams, especially as it was sometimes undertaken in stressful and difficult circumstances.

The Governing Body:

- Noted the CHC service developments.
- Recognised the positive impact the developments would have on individuals in receipt of services, and their representatives along with the health and social care workforce.

146/18 Quarterly Update on NHS Sheffield CCG Governing Body Assurance Framework (GBAF)

The Director of Finance presented this report which updated members on the second review of the Governing Body Assurance Framework (GBAF) up to and including 28 August 2018. She advised that the level of review that had been undertaken by the CCG's Senior Management Team (SMT) was set out in section 2a, with a summary of the consideration undertaken by the Audit and Integrated Governance Committee (AIGC) of the arrangements in place for managing the organisation's strategic risks set out in section 2b.

The Director of Finance drew members' attention to section 2a which reported that the SMT had reviewed the scores for three risks and had agreed that the scores for risks relating to engagement and Parity of Esteem should be reduced, but the score for achieving the QIPP should remain at 16 due to the level of unidentified QIPP. They had also agreed that a new risk (4.6) relating to Delayed Transfers of Care (DToCs) should be added to the framework. She advised that SMT would review Quarter 3's position later in the month.

She drew their attention to section 2b which reported that SMT had cross referenced the top 10 risks in the document "*What Keeps CCG Governing Bodies Awake at Night*" to the CCG's risks in the GBAF.

The Director of Commissioning and Performance clarified that with regard to Principle Risk 5.2: Unable to secure timely and effective commissioning support to enable us to adequately respond and secure delivery to existing and new emerging requirements. Quality of externally purchased

commissioning support (IT and data management) falls below required levels, this related to the challenges the CCG had with its existing provider from a business intelligence / information technology (IT) point of view, which we kept trying to rectify with limited success. However, we were currently trying to assess what we would do when the contract with them expired in March 2020.

Finally, the Director of Finance also reminded members that, if they had not already done so, they should complete the CCG's Internal Auditor's survey on the effectiveness of the organisation's framework of governance, risk management and control, which would form part of the Head of Internal Audit's Stage 2 Opinion.

All to note

The Governing Body:

- Considered the GBAF at the end of the second review period.
- Noted the additional risk added to the GBAF.

147/18 Summary of Petitions Received by NHS Sheffield CCG

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

148/18 Communications and Engagement Quarterly Update

The Deputy Director of Communications presented this report which provided members with a summary of communications and engagement activity and their impact from 1 June to 30 September 2018. She drew members' attention to the key highlights.

Although there had been less media coverage in the last quarter, it had been more positive than previous, with more web and social media activity especially around the CCG's urgent care proposals and the CCG's work around dementia services, which would feed into development of the draft Dementia Strategy. The Accountable Officer's new blog had also been well received. The focus for the next few months would be on the second wave of the CCG's urgent care review, especially around patient education and where people needed to go to access services.

Professor Gamsu, Lay Member, and Chair of the CCG's Strategic Patient Engagement, Experience, Equality Committee (SPEEEC) advised

Governing Body that at the SPEEEC's last meeting they had received information from Healthwatch Sheffield about grants that were available to support engagement, which the CCG might want to take account of going forward in terms of possible joint funding. He also commented that he had seen significant improvements in relation to the CCG's communications and engagements since the appointment of the Deputy Director of Communications, even though it continued to be an increasingly difficult environment.

The Chair acknowledged the processes that had been put in place within the communications and engagement team. He suggested that, due to the popularity of the Accountable Officer's blog, other members of Governing Body and also Clinical Directors, may wish to do the same. **All to note**

Finally, the Accountable Officer thanked the Deputy Director of Communications and her team for all their hard in pulling this work together.

The Governing Body received the report and noted the work undertaken and its impact.

149/18 Accountable Care Partnership (ACP) / Integrated Care System (ICS) Update

The Chair presented this item and updated Governing Body on the following key issues.

The Accountable Officer was now working two days a week with the ICS as lead Chief Executive with responsibility for population health and primary care, with the Director of Commissioning and Performance acting as Accountable Officer during this time. Funding was coming into the city to support the development of neighbourhoods, and review of hospital services was ongoing at ICS level. £370k had been made available to support population health and prevention for the ICS and the Accountable Officer would update Governing Body at the next meeting as to whether or not funding for this could be increased. **MR**

The Director of Finance tabled copies of the signed ICS Memorandum of Understanding (MoU) which, she advised, had been noted, and the direction of travel supported, by Governing Body in private on 6 September 2018. She advised that a copy of the document would be published on the website as part of the papers for today's meeting. **JN(CRH)**

The Director of Finance also recommended the ACP / ICS papers circulated separately under item 20b to members for reading. The Accountable Officer agreed to feedback to the ICS that Governing Body members sometimes found these papers difficult to read. **MR**

The Governing Body received and noted the update.

150/18 Reports Circulated in Advance for Noting

The Governing Body formally noted the following reports:

a) Governing Body Assurance Framework (GBAF) *(to support main agenda item 16*
b) Accountable Care Partnership (ACP) / Integrated Care System (ICS) Papers *(to support main agenda item 19)*
c) CCG Chair's Report
d) CCG Accountable Officer's Report
e) Report from the Audit and Integrated Governance Committee
f) Report from the Joint Clinical Commissioning Committee of CCGs (JCCCG)
g) Report from the Primary Care Commissioning Committee
h) Report from the Quality Assurance Committee
i) Serious Incident Quarterly Update

Members were asked to let the Chair and Accountable Officer know if there were any additional items they felt it would be helpful to include in the Chair's / Accountable Officer's reports. **All to note**

151/18 Any Other Business

a) Reports to Governing Body

The Chair commended authors of Governing Body papers for the way that papers had been presented to this month's meeting, making them more concise and succinct, etc.

b) Gluten Free Prescribing Commissioning Policy

The Director of Commissioning and Performance confirmed that an update would be presented to Governing Body in January. **BH**

152/18 Summary of Meeting: Three Key Messages from the Chair

The update received in relation to the new governance arrangements for the Sheffield Safeguarding Children's Board and Sheffield Adult Safeguarding Partnership, and the new Governing Body responsibilities in relation to safeguarding.

The proposed changes to the Primary Care Commissioning Committee's Terms of Reference, and proposed changes to the CCG's Constitution.

The preparations that were taking place to ensure appropriate arrangements were in place in primary care for winter.

The helpful update given on the ongoing arrangements for Continuing Health Care (CHC).

153/18 Date and Time of Next Meeting

The next full meeting in public will take place on
Thursday 10 January 2019, 2.00 pm – 5.00 pm, Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU.

Questions to NHS Sheffield CCG Governing Body 1 November 2018
(copied to SCC Health Scrutiny Committee)

Submitted by Ruth Milsom – Sheffield Save Our NHS – 10 October 2018
The following questions relate to the CCG's letter addressed to the Scrutiny Committee c/o Councillor Pat Midgley, dated 2 October 2018: CCG response to the Scrutiny Committee's recommendations and questions on Urgent Care in Sheffield delivered on 21 August 2018.

1. **Thinking about students who typically use the Broad Lane Walk-In Centre, rather than register with one of the city centre GP practices:**

> *See SCC Scrutiny Committee Q4: CCG response paragraph 1*
> "[Many students} use the walk in centre as an alternative to registering with a GP practice in Sheffield. This is matter of ongoing concern as it means not only that these students do not get the continuity of care afforded by being registered with a practice but also that the city does not receive the money for their care. Practices in the areas close to the university are continually promoting the benefits of registering and write to all new students to encourage them to register, as well as promoting this during the annual „freshers" weeks". Additional registrations would increase income to the practice, enabling them to increase their staffing if required to meet demand."
>
> [CCG letter to SCC 'Health' Scrutiny Committee (Councillor Pat Midgley), 2 October 2018]

Q1a) How many students living in Sheffield are currently not registered at a GP practice? (Please give absolute number and percentage of student population)

CCG response: *As a CCG, we do not hold information of numbers of students not registered with a GP practice. However in undertaking analysis of people who visit the walk in centre and place of registration, in 2018 there were 5397 20-29 year olds registered outside of Sheffield. However, there are four caveats. 1) These attendances might be multiple, 2) people might not be students 3) the age band does not match exactly to the age range of university students which would normally start at 18, and 4) There would also be a numbers of students who have not attended the walk in centre.*

Q1b) What sum of statutory per capita funding would be brought into Sheffield's GP practices altogether, were these students all to register at local practices?

CCG response: *Given that there are a number of caveats in the data above, it is difficult to base any firm financial calculations using these numbers. As part of the global sum, each practice receives £87.92 per patient as part of their national core contract. This sum is subject to weighting based on the Carr-Hill formula, based on a number of elements, such as age and sex and other additional needs. There are additional national income streams related to quality and enhanced services and locally commissioned services which general practices receive. The national income streams come directly into practices and therefore it is up to the practice how they use that income. They could use their additional funding to increase numbers of appointments offered if appropriate.*

Q1c) how far would this potential additional funding go towards expanding capacity for i) ordinary booked GP appointments, and ii) urgent GP appointments in neighbourhood surgeries, in relation to planned expansion of capacity inherent in the three original 'Options' for Urgent Care reconfiguration in Sheffield?

[Understood from the CCG's responses to the SCC Scrutiny Committee: a sum of £1.152 million had been assumed in the original business case]

***CCG response**: Any potential additional funding outside of the Global sum could be used to increase clinical appointments and infrastructure which could support practices working more collaboratively, should they want to. As a proxy – for Winter 2018/19, the CCG is providing an additional £300k to General Practice to fund additional clinical appointments. This equates to about 15,000 appointments over 4 months.*

Q1d) is there any scope for Sheffield's universities and FE establishments to implement automatic GP registration on behalf of all enrolled students? [This was certainly the norm when I came to the University of Sheffield in 1989; clearly rules and regulations have changed over time, but can this be explored?]

***CCG response:** The two practices with the majority of student registrations have a number of initiatives to encourage students to register at their practice, especially during 'freshers' week.*

Q1e) has the CCG attempted – or does it know of any attempt – to engage any student bodies (e.g. Students Union / Sheffield Labour Students / Socialist Students) in helping to run registration campaigns amongst students? If not, is this something the CCG will consider promoting?

***CCG response:** The CCG has attended Freshers Fayres in recent years at both Sheffield University and Sheffield Hallam with the aim of encouraging students to register with local practices, alongside information about where to access appropriate healthcare in the City. We could explore this again with student bodies going forward if this is a priority area.*

2. Regarding the matter of transport and travel in the context of patients attending urgent appointments or unscheduled visits to urgent facilities:

> *See SCC Scrutiny Committee Q4: CCG response paragraph 4*
> "Access to NGH was one of the key areas discussed in the workshops we held to consider the consultation feedback. From this, we agreed a number of actions that needed to be taken (attached at appendix 4), including work with STH, South Yorkshire Transport Executive and community transport providers to look at how transport to NGH could be improved. We have also committed to exploring the possibility of a shuttle service from the city centre and other alternatives to support people on low incomes to access services."
>
> [CCG letter to SCC 'Health' Scrutiny Committee (Cllr Pat Midgley), 2nd October 2018]

Q2) In working "with STH, SY Transport Executive and community transport providers to look at how transport to NGH could be improved," is the CCG simultaneously holding conversations with these bodies regarding the problem of patients attempting to travel across neighbourhoods?

***CCG response:** We have undertaken some analysis on distances travelled within every neighbourhood. If Neighbourhoods remain part of the new proposals in the new consultation, we will work closely with neighbourhoods, practices and SY Transport Executive and Community Transport to consider travelling options as part of this remit.*

> *See SCC letter to CCG (detailed below), point 3, paragraph 2*

> "For us, the detail of how far residents might have to travel to get to a GP practice in their 'local area' is incredibly important. It can be easier to travel all the way into the city by public transport than across a neighbourhood."
>
> [SCC 'Health' Scrutiny Committee letter to CCG on Urgent Care plans in Sheffield, 21st August 2018; published as Appendix 4 in Paper F 'Urgent Care In Primary Care' presented to PCCC on 20th Sept 2018]

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3. On the issue of patients mistakenly presenting at A&E when their injury or condition should be attended to at the MIU or at an urgent GP appointment:

> *See SCC Scrutiny Committee Q5: CCG response paragraph 2*
> "In addition, NHS England is likely to associate failure to implement a UTC with poor A&E performance, which will put the city under increased pressure and scrutiny. It would also jeopardises access to the Sustainability and Transformation Funds that providers get if they achieve A&E targets, which could bring significant extra investment into the city. Negotiation on this if the target is narrowly missed would be supported if the system can demonstrate it has done everything required to achieve the target, such as establishing a UTC."
>
> [CCG letter to SCC 'Health' Scrutiny Committee (Cllr Pat Midgley), 2nd October 2018]

Q3a) Please would the CCG explain what is meant by "NHS England is likely to associate failure to implement a UTC with poor A&E performance"? Is this to do with preventing unnecessary A&E attendances (i.e. patients presenting at A&E with minor illness or minor injury)? Or are there other criteria?

CCG response: *NHS England's two main drivers for urgent treatment centres are to contribute to the improvement of A&E performance nationally and making access to services clearer. With this in mind, NHS England's expectation is that once in place, they will expect reduced attendance at, and conveyance to A&E as a result of simplified access as well as improved patient convenience as patients will no longer feel the need to travel and queue at A&E. 'NHS England Urgent Treatment Centres – Principles and Core standards 2017'.*

Q3b) If the mis-use of the A&E department is one of the largest factors in the drive for reconfiguration, then all the most readily available and cheapest solutions to this should be explored fully and immediately. What options and possibilities are being explored and/or already employed by the CCG in terms of improving signposting and local knowledge of how to navigate the system and attend the most appropriate facility?
(Some suggestions: periodic public information items on local radio stations, in local papers and magazines; posters displayed in all GP surgeries; 'back of bus' advertising campaigns; social media campaigns; collaboration with community groups to propagate information; city-wide mailing.)

CCG response: *Throughout the year NHS Sheffield CCG run a number of campaigns to promote the services available in the city and the most appropriate services to use. For example we work with pharmacists to promote their services and the conditions they can advise on. We also have a long standing Choose Well campaign that encourages people to think about their ailment and how best to treat that – whether that be self-care or choosing the right service. These campaigns are on and offline (social media, printed press, radio etc.)*

The winter months can be challenging for the NHS, especially for urgent and emergency care services. While the NHS can usually manage high levels of A&E attendance, the

seasonal increase in hospital admissions can lead to repeated and sustained breaches of the urgent and emergency care standard, which is that 95% of patients should be seen, treated, admitted or discharged within 4 hours of arrival at A&E. NHS Sheffield CCG has developed a local winter communications plan for Sheffield which aims to ensure that people who are most at-risk of preventable emergency admission to hospital are aware of and, where possible, are motivated to take, actions that may avoid admission this winter. We will be working with all partners (provider and council) to deliver this plan.

The plan includes campaigns that:

- *Promote NHS 111 and the correct use of the service to prevent unnecessary A&E attendances*
- *Promote flu vaccination uptake amongst pregnant women, children aged 2-9 years (targeting their parents), those with long term health conditions and over 65s to help reduce the number of people becoming seriously ill from flu and needing hospital admission*
- *Promote self-care and treatments for common conditions/how to stay well and safe during the winter months*
- *Promote alternate services (pharmacy, GP etc.) and promote the correct service for ailments (choose well messages)*

We will use the national Help Us Help You Stay Well This Winter campaign materials and branding in our local activity, along with existing Choose Well materials to make the most of available resources. We will be using a wide range of channels and materials including:

- *Press articles*
- *Blogs*
- *Broadcast media interviews*
- *Social media including YouTube*
- *Website info*
- *Partner websites*
- *Internal communications channels in each organisation*
- *Posters in GP practices, pharmacies and community venues across the city*
- *Videos in GP practices where available*

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4. Thinking about how the Urgent Care consultation was conducted:

See CCG 'Additional Points' on p.16

Consultation feedback

The Committee's response referred to the "overwhelmingly negative tone of responses" to the proposals. However, while there were some very strong views against regarding the adult UTC location and replacement of the MIU and WIC, it is important to acknowledge that there were also positive responses to all elements of the proposal and different opinions expressed in the representative telephone survey to those from people who chose to complete the consultation feedback form.

[CCG letter to SCC 'Health' Scrutiny Committee (Cllr Pat Midgley), 2nd October 2018]

Consultation data obtained via differing methods must be handled extremely cautiously. A consultation conducted by telephone is cannot avoid being more 'leading' than an on-paper or online equivalent.

Firstly, the recipient of the telephone call comes to the topic cold, whereas a person choosing to fill in a form or find the consultation online has most likely made their own decision to approach the subject, and has been considering it beforehand.

Secondly, handling a written consultation allows the participant to go back and forth, re-read information as many times as they like, and research the subject more thoroughly before committing themselves to their responses. A telephone consultation does not allow for background information to be sought and absorbed in the same way.

Thirdly, it could be argued that there is an inherent imperative to complete a telephone call quickly, and so participants in a telephone consultation might feel rushed into giving an answer.

Fourthly, questions posed by a surveyor to a participant can very easily come across in an inappropriate – leading – manner. For example, being asked "which of the following three options do you think is the best?" leads the respondent to choose one of the three. Unless the person conducting the survey informs the respondent in advance that there is an option to ignore that question and fill in an "Any Other Comments" box instead, that respondent does not have the same opportunity as a paper or online respondent.

Q4a) Did the CCG take these common-sense factors into account when analysing results of telephone consultations, or did it make an assumption that residents in the postcode(s) covered by telephone consultations actually do hold "different opinions to those from…the consultation feedback form"?

CCG response: *The different methodology was explained in writing and verbally to the decision making committee. This included the different techniques that were used not only in the online, paper and telephone surveys, but also at the public meetings and in semi-structured interviews with people socially isolated and from areas of greater deprivation.*
In addition, the decision making group were asked to individually read every letter received from members of the public, the notes from all public meetings (that had been transcribed from recordings during the sessions), all press coverage and all feedback received from providers and professional stakeholders in the City.

The telephone survey was not given greater weight than the wealth of data received in this variety of formats.

Q4b) Has the CCG made correlations between the responses gathered from telephone consultations (conducted in areas of relative deprivation), and the significant number of petition signatures collected by Sheffield Save Our NHS / Socialist Party in similar demographic area(s) of Sheffield?

> "We collected hundreds of signatures in Hillsborough & Southey during the May council elections campaign, both areas that are nearer to NGH than RHH. The main concern of people in those areas was how NGH A&E is already overstretched and having the only UTC there would just add to already long waiting times."
>
> Alistair Tice, Sheffield Save Our NHS / Socialist Party

CCG response: *The telephone survey was conducted by an independent organisation, as to not introduce additional bias to the feedback. We provided information, from an equality perspective, about who should be included but all information was anonymised. We*

therefore don't have access to data to directly compare who completed both the telephone survey and signed a petition. There may however have been duplication between these two data sources.

All petitions have been presented at our Primary Care Commissioning Committee and at Governing Body and the quantity of signatures have been included in reports – including petitions received after the consultation closed. This helps demonstrate our ongoing commitment to transparency and ensuring that the strength of feeling from local people was heard, prior to the decision to reconsider being made.

5. Regarding Physician Associates (PAs):

> *See Appendix 7: Workforce Planning for Urgent Primary Care, in Public Reports Pack 10102018, p.48*
> **"Physician Associates**
> The CCG has been involved with the Universities in Sheffield regarding Physician Associate (PA) training and some practices have already adopted this role into their teams. Further scoping is required to address concerns raised mainly among GPs as to the clinical training and expertise of PAs, the training support required and how this role compares to Advanced Nurse Practitioners; a role that may require less GP direction, is able to independently prescribe refer and order some diagnostic tests.
> Yorkshire and Humber have invested significantly in this role and are keen to facilitate internships and support placements. This will need further exploration.
> The role of the PA will continue to be explored with our key partners and universities to ensure that Sheffield will be able to deploy the trainees into primary care appropriately."

Q5) Will the CCG please provide a detailed explanatory document on 'Physician Associates', for the information of interested parties who may not hold specialist or specific knowledge of the role? This should address the following:-

- What is the clinical status of a PA, compared with other physician 'ranks' – trainee doctor; Junior Doctor; Registrar; Consultant; GP?
- Compare the expectations and competencies of the PA role to that of a Practice Nurse.
- How will patients be sure who they are consulting when they visit a medical practice or Minor Illness Unit? Bear in mind that most ordinary members of the public simply think of a 'doctor' as a fully qualified health professional in whom they can place their full trust in terms of diagnosis and treatment.
- What will PAs NOT be trained/qualified to do, and how will this be made clear to patients?
- Will patients have the ultimate say in what 'level' of physician they may access?
- Introducing a secondary tier of less qualified physicians into general practice seems to carry an inherent risk factor. How can triage systems ensure that patients are directed to the right person first time?

CCG response: *NHS England and the Faculty of the Physician Associates (PA) define a PA as a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision. (DH 2006).*

<u>Physician Associate Role</u>

The PA role provides a new way of working that will complement roles already developed in primary and secondary care and strengthen the multi -professional team. They have completed a generalist medical education covering a broad medical curriculum. They can work in hospitals, general practices and mental health settings. Like all other regulated healthcare professionals, the Physician Associate is responsible for their own practice, although they will always work under the supervision of a designated senior medical practitioner, and the medical consultant or general practitioner will retain ultimate responsibility for the clinical management of the patient. While they are classed as a "dependent practitioner" they are able to work independently with appropriate support.

<u>What do Physician Associates do?</u>
Physician Associates work within a defined scope of practice and limits of competence. They:
> take medical histories from patients
> carry out physical examinations
> see patients with undifferentiated diagnoses
> see patients with long-term chronic conditions
> formulate differential diagnoses and management plans
> perform diagnostic and therapeutic procedures
> develop and deliver appropriate treatment and management plans
> request and interpret diagnostic studies
> provide health promotion and disease prevention advice for patients.

Currently, physician associates are not able to:
> prescribe
> request ionising radiation (eg chest X-ray or CT scan).

With the latest report from Matthew Hancock (October 2018) acknowledging the need for formal registration of this and other Medical Associate Professions (MAPs), it is anticipated that these will follow once there is a formal register. MAP roles include:

- *advanced critical care practitioners*
- *physician assistants (anaesthesia)*
- *physician associates*
- *surgical care practitioners.*

MAPs augment the workforce, performing a range of tasks (under supervision) traditionally associated with doctors in training. They do not replace junior doctors but play their own part in bridging skills gaps, retaining skills and knowledge within teams, and maintaining continuity of care.

<u>Describing the PA role to patients.</u>
It is recommended that where the PA role is new to staff and patients that PAs develop an "introduction speech" describing their role in a few succinct sentences and that the organisation includes a description of the role either on a notice board, in a newsletter or on a staff information board along with other grades of staff. For example: -
"As part of our efforts to improve patient access and make it easier to get appointments, you may have noticed that your appointment is with a PA. PAs are university science graduates who have then undertaken 2 years of intensive medical training programme in both hospital and general practice settings. Although PAs are not doctors, they are highly trained clinicians. PAs work with our GPs and Nurse Practitioners to see, diagnose, investigate and treat all sorts of medical conditions."

<u>Describing the PA role to others in the service/practice.</u>

It is also recommended that there is an agreed practice or service protocol detailing the role of the PA in the specific workplace, their supervisor arrangements and how long arm supervision will be managed where appropriate.
There is an NHS Infographic that can also be used to advertise and detail the role for the service.
www.nhsemployers.org/maps

We want to ensure that the patient sees the right person first time. Introducing triage into first contact is one way to do this. Going through a range of questions lie a decision tree, will help the person triaging direct the patient to the most appropriate person. We recognise that triage or signposting varies across general practices and other primary care services and is an element we would like to address as part of our wider urgent care review.

Questions from Dorothy Dimberline to the CCG Governing Body 1 November 2018

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.

CCG response: *The CCG recognises that this is a really complex conversation particularly for those who have not experienced any health assessments before. We do share the information leaflets in advance of assessments, however we fully appreciated that these need to be more user friendly and are currently being redesigned with the support of the users. In respect of helping people understand the process we would advocate either working closely with the continuing healthcare nurses who are allocated to individual patients or another as you mention that you need someone that you trust to help this can be obtained from Age UK or Alzheimer's society who are very experienced in offering guidance. This has formally been recommended at previous meetings with carers*

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.

CCG response: *The support from the CHC nurses, Age UK and Alzheimer's Society would be able to work closely with individuals and help them to be able to speak out*