SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 17 July 2013

PRESENT: Councillors Mick Rooney (Chair), Sue Alston, Katie Condliffe, Roger Davison (Deputy Chair), Tony Downing, Adam Hurst, Martin Lawton, Diana Stimely, Garry Weatherall, Joyce Wright and Clive Skelton (Substitute Member)

Non-Council Members (Sheffield Healthwatch):-

Anne Ashby and Alice Riddell

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillor Janet Bragg and Councillor Clive Skelton attended the meeting as the duly appointed subsititute, and Councillor Jackie Satur and Helen Rowe (Sheffield Healthwatch).

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified where resolutions may be moved to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest.

4. MINUTES OF PREVIOUS MEETINGS

4.1 *17th April 2013*

The minutes of the meeting of the Committee held on 17th April 2013, were approved as a correct record, subject to the substitution of the words “Sheffield Healthwatch” for the words “Sheffield LINk” and, arising therefrom:-

(a) it was reported that:-

(i) the visit by the Committee to St. Luke’s Hospice would be arranged for September 2013;

(ii) a response had still not been received from Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, in connection with the Council’s proposal to no longer to provide, free of charge,

individual small items of daily living equipment costing less than £50 and regarding the setting aside of funds, for a hardship fund, to assist those who could not afford daily living equipment, and it was requested that the Policy and Improvement Officer should contact Councillor Lea as a matter of urgency; and

(iii) details of the Committee's responses to the Sheffield Health and Social Care NHS Foundation Trust Quality Account 2012/13 had been circulated to Members of the Committee, for comment and approval, prior to submission; and

(b) the Committee requested the Policy and Improvement Officer to contact John Reid, Director of Nursing and Clinical Operations, Sheffield Children's Hospital Foundation Trust, requesting details of the results of the asthma audit which would be repeated in terms of the provision of advice to child asthma suffers; and

4.2 *8th May 2013*

The minutes of the meeting of the Committee held on 8th May 2013, were approved as a correct record, subject to the substitution of the words "Sheffield Healthwatch" for the words "Sheffield LINk" and, arising therefrom:-,

(a) it was reported that:-

(i) a letter expressing the Committee's concerns regarding the lack of a national framework and regulation for male circumcisions had been forwarded to the Secretary of State for Health; and

(ii) there was no further progress in terms of the proposed joint Yorkshire and Humber Health Overview and Scrutiny exercise on the review of adult congenital heart disease services; and

(b) the Committee requested:-

(i) the Policy and Improvement Officer to (A) look into the position regarding the further data which was required before the briefing note on the arrangements for the holding of a joint meeting with the Children, Young People and Family Support Scrutiny and Policy Development Committee, on the End of Life Care for children up to the age of 18, could be circulated, (B) chase a response from the Health and Wellbeing Board

with regard to the provision of assistance to those voluntary and faith organisations offering help and advice to patients with mental health, drug and alcohol problems and (C) ensure that a response is provided to Councillor Adam Hurst with regard to the issue he raised relating to the Malnutrition Universal Screening Tool; and

(ii) Anne Ashby to find out whether a discussion on communication issues between the Sheffield Teaching Hospitals Foundation Trust and Sheffield LINk (now Sheffield Healthwatch) had taken place.

4.3 *15th May 2013*

The minutes of the meeting of the Committee held on 15th May 2013, were approved as a correct record.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 There were no questions raised or petitions submitted.

6. SHEFFIELD CLINICAL COMMISSIONING GROUP - COMMISSIONING INTENTIONS 2013/14

6.1 The Committee received a report on the Sheffield Clinical Commissioning Group's Commissioning Intentions 2013/14.

6.2 Dr Ted Turner, GP and Governing Body member of the NHS Sheffield Clinical Commissioning Group, reported on the background of the Clinical Commissioning Group (CCG), indicating that the Group had formally been established on 1st April 2013, on the back of the Health and Social Care Act, and had replaced the Primary Care Trust in the City for most of its functions. The Group included all 88 GP practices in the City, which had all signed up to a written constitution, and would be responsible for arranging the commissioning of healthcare services in the City.

6.3 Dr Turner referred to the four aims set out in the Group's prospectus and the proposed changes which would hopefully improve the quality of care and the patient experience, as well as releasing resources to invest in quality improvements and actions to reduce health inequalities.

6.4 Tim Furness, Director of Business Planning and Partnerships, Sheffield CCG, reported that all 88 GP practices had been asked for their views on what they thought the CCG should be doing, of which responses had been received from around 30 practices. Mr Furness reported in more detail on the proposed work of the Group, which included work on the Right First Time initiative, children's health and

the work required in response to the Francis Report. He referred specifically to the Financial Plan, which set out details of the investments made and what investments were planned.

6.5 Members of the Committee raised questions and the following responses were provided:-

- It was difficult to provide definite assurances that there would be sufficient funding allocated to each of the 88 GP practices to provide adequate healthcare services for all their patients. There would always be issues regarding funding as there were likely to be cases of overspend and underspend by practices. However, although each practice had an indicative budget, the CCG managed its funding at a City-wide level rather than a practice level. Primary Care services were contracted by NHS England, therefore funding for such services was dependent on the Government in terms of any renegotiation of the contract. On a local basis, the aim was to transfer services out of hospitals and move them closer to people's homes, which should be better for the patient, and cost less. There were mechanisms being brought into place to ensure fair shares, but there would always be some elements in terms of funding which could not be controlled as well as others. With a growing demand for healthcare, but flat funding, there would not be enough funding to allow the NHS to continue operating as it had done in the past and therefore, there was a need to change the way patients' needs were met. One such way would be to focus more on preventative measures.

- There were areas of the City where there was a higher concentration of people suffering from cancer or other serious health problems and, there were certain communities, such as the Roma/Slovak community, living in certain areas of the City, with specific health needs. The CCG wanted to focus resource on those areas and communities with a higher risk of certain illnesses, such as cancer and Hepatitis B.

- In terms of the number and location of GP practices, compared to need, the National Commissioning Board, which had a Local Area Team, was responsible for GP contracts, and the Scrutiny Committee would need to discuss this issue with them.

- A lot of the issues raised, relating to raising the life expectancy age, screening for cancers and other illnesses, together with the need to encourage people to go for screening, the increase in certain illnesses due to the increased levels of immigration and the issues surrounding illness caused by pollution or stress, now fell under Public Health, which was part of the Council. It was accepted that all the above issues needed focussing on as they

could all make a major difference to people's health. The Group was very keen on engaging with voluntary organisations and educating people to do more to look after themselves. The Health and Wellbeing Board, established as a partnership of the Council and the CCG, regularly looked at such issues.

- It was accepted that there should be better communication between GPs and patients after patients had left hospital, and if GP practices contacted patients within 24 hours of leaving hospital, this might help reduce re-admission levels. There were communication issues associated with this, such as GPs receiving notification too late or a lack of clarity in terms of patients' notes, but the Group was looking at how such communication could be improved.

- The CCG had allocated funding to put into the GP practices for purposes of care planning, whereby practices would be expected to use the funding to undertake more work. This could include the recruitment of additional staff in order to undertake the additional work requested by the CCG. It was hoped that the contract would be finalised in September 2013, and that the funding transferred at this point.

- As part of the consultation on the CCG's plans, more focus had been placed on seeking the views of GP practices in 2012, as opposed to patients. The CCG representatives acknowledged that the Group must do more and there were plans to improve the Group's engagement with Sheffield Healthwatch and other relevant groups and organisations, particularly in connection with its plans for 2014/15. Through the Health and Wellbeing Board, the Group was liaising with the Council on the wider integration of health and social care. The CCG was committed to working with the Council to ensure that health and social care money in the City was used as efficiently as possible to meet people's needs.

- The CCG had planned to review its Intermediate Care Strategy as part of the Right First Time programme and then decide what services needed to be commissioned. The CCG did not have any capital assets, therefore had no direct interest in buildings, other than to ensure that they were being used to the best of their capacity.

- In terms of current Local Enhanced Services, particularly the provision of such services in care homes, whilst the CCG had put enhanced services in place as it recognised that people in care homes were sometimes at particular risk of being admitted to hospitals, it would be the role of NHS England to look at the provision of other services in care homes, such as dental

services.

- There were no specific targets set in terms of waiting times for Child and Adolescent Mental Health Services (CAMHS) and Memory Management Services, although the Group was aware that there needed to be an improvement in such times. The waiting time used as a guide was the 18 weeks referral to treatment standard, and the CCG was working with CAMHS to improve their response times.

- With regard to one of the CCG's priorities in terms of Clinical Quality Improvement – to ensure compliance with national standards and guidance for cancer care and reduce unwarranted variation – the term 'unwarranted variation' was used by the CCG to describe the circumstances where GP practices' different referral rates did not appear to be explained by differences in their population. The Department of Health had decided that it should be the duty of the CCG to support the work of the Area Team in maintaining and improving the quality of primary care.

- The CCG Board included 10 GPs, two Clinical Directors, four representatives elected by GPs and four representatives nominated by the CCG's locality groups.

- Engagement with patients was viewed as a major issue for the CCG. At the present time, a number of people received information on a regular basis. The level of information was relatively basic, but if people requested more detailed information, this could be arranged. The Group was considering the possibility of sub-contracting some engagement work to voluntary sector organisations.

- All 88 GP practices in the City were signed up to membership of the CCG. Around 60 were represented at the last membership meeting therefore, whilst the Group was relatively happy with the level of involvement at the present time, it was accepted that further work was required in this area.

- It was accepted that the plans to reduce the number of hospital-based first outpatient attendances by 40% and the number of hospital-based follow-up attendances by 80% by 2016, could be seen as ambitious, and possibly prove to be more than achievable. It had been considered that this approach was better than being too conservative. The CCG expected to make savings from reducing outpatient attendances, which would be spent on improving the quality of care and reducing health inequalities, for example, targeted screening for Tuberculosis and Hepatitus B in the Roma/Slovak community.

- The comparatively high rates of child admissions for lower respiratory tract infection were not yet understood, and there was a possibility that the data regarding this was flawed.

- Taxis would not be used as part of the contract with the Yorkshire Ambulance Service for emergency ambulance services, but the CCG had invited tenders for a contract in respect of non-emergency transfers. This would not be a 'blue light' service, but simply for transferring people who were not mobile, to other health services. The CCG would send a briefing note to the Scrutiny Committee with more information on this issue.

- Regarding the relative impact of deprivation and older age, it was noted that, in the most deprived parts of the City, people did not live as long and old age may be relative.

- The CCG does not currently have a problem, as other areas have reported, of senior clinicians retiring, and not being replaced. There was less risk of this in Sheffield than in other places as there was an excellent medical school in the City, with a strong emphasis on GP services. In terms of the loss of senior clinicians, there was less of a hierarchical structure in practices these days, so this was not considered a major issue in terms of leadership of the practices.

- As part of the CCG's intentions, whilst there were no plans to reduce the levels of administrative staff in 2013/14, the former Primary Care Trust, during the last three years, had been required to meet targets in terms of reductions in management spend, which had resulted in a reduction in staffing levels prior to the establishment of the CCG. However, the CCG had a ceiling in terms of management spend, which was set nationally. Considerably more would be spent on the provision of clinical advice, rather than administrative costs, compared to the Primary Care Trust. There would obviously still be a need for administrative staff, but the focus would be more on supporting the clinicians.

- With regard to initiatives such as additional wellbeing services for people with enduring mental health problems, the Personality Disorder Pathway and improving forensic care for people with learning difficulties, the CCG hoped to release enough money, through savings, to invest in these services, and would not be able to make those improvements until it was sure they were affordable.

- The change in CCG expenditure in terms of mental health from 2012/13 to 2013/14 equated to a reduction of approximately

£200,000, as a result of NHS efficiency requirements.

- In terms of the continued work with the City Council and Sheffield Children's NHS Foundation Trust, on the 'Future Shape of Children's Health' programme, the plans to ensure good transition from children's to adult mental health care, including the care of 16 and 17 year olds, was viewed as a priority. However, the CCG could not commit to spending money that it did not have, so there would be a need to free up funding from elsewhere to enable this to happen.

- As part of the work with children and young people, the plans to 'review respite care services and develop proposals to improve respite care for children with complex medical needs' refers to children with both physical and mental disabilities, who had been placed in care outside the City. The CCG believed that it would be beneficial for many of them and their families if there were more local services to support them, and felt that planning for them as a group, rather than as individuals, would help services to be developed.

- There was a City Council run Implementation Group on the Autism Act, which advised the CCG on the specification for the new diagnostic service, which was being procured at the present time.

- It was confirmed that the CCG's current patient and public engagement work included the Learning Disabilities Parliament, through the Learning Disabilities Partnership Board.

6.6 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the comments now made and the responses provided to the questions raised;

(b) identifies (i) the need for discussions (A) with the National Commissioning Board's Local Area Board regarding GP practices in the City, including the numbers, location and skill mix and (B) between the Committee and Jeremy Wight, Director of Public Health, regarding public health investment;

(c) requests (i) clarification on the Committee's role with the Health and Wellbeing Board and (ii) that it has the opportunity of viewing and commenting on the Clinical Commissioning Group's Communications Plan in terms of its commissioning intentions for 2014/15, specifically regarding its plans in terms of engagement, prior to its publication; and

(d) thanks Tim Furness and Dr Ted Turner for attending the meeting and reporting on the Clinical Commissioning Group's Commissioning Intentions 2013/14 and responding to the questions now raised.

7. WORK PLANNING 2013/14

7.1 The Policy and Improvement Officer submitted a report containing details of the proposed approach to work planning for the Committee during 2013/14.

7.2 He indicated that there was a need for Members to look at how the Committee could have an increasingly bigger impact, in terms of the work it undertook.

7.3 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the comments now made; and

(b) agrees that the two existing Task and Finish Groups continue and complete their work, with the current Members and Chair of each Group being re-appointed.

8. DATE OF NEXT MEETING

8.1 It was noted that the next meeting of the Committee would be held on Wednesday, 18th September 2013, at 10.00 am in the Town Hall.