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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 1 September 2021 at 3.00 pm

To be held at the Town Hall, Pinstone Street, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Steve Ayris (Chair), Talib Hussain (Deputy Chair), Sue Auckland, Vic Bowden, Lewis Chinchen, Alan Hooper, Francyne Johnson, Bernard Little, Ruth Mersereau, Ruth Milsom, Abtisam Mohamed, Garry Weatherall and Alan Woodcock

Healthwatch Sheffield
Lucy Davies and Dr Trish Edney (Observers)

Substitute Members
In accordance with the Constitution, Substitute Members may be provided for the above Committee Members as and when required.

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

The Healthier Communities and Adult Social Care Scrutiny Committee exercises an overview and scrutiny function in respect of the planning, policy development and monitoring of service performance and related issues together with other general issues relating to adult and community care services, within the Neighbourhoods area of Council activity and Adult Education services. It also scrutinises as appropriate the various local Health Services functions, with particular reference to those relating to the care of adults.

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Members of the public have the right to ask questions or submit petitions to Scrutiny Committee meetings and recording is allowed under the direction of the Chair. Please see the website or contact Democratic Services for further information regarding public questions and petitions and details of the Council's protocol on audio/visual recording and photography at council meetings.

Scrutiny Committee meetings are normally open to the public but sometimes the Committee may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

If you require any further information about this Scrutiny Committee, please contact Emily Standbrook-Shaw, Policy and Improvement Officer on 0114 27 35065 or email emily.standbrook-shaw@sheffield.gov.uk

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE AGENDA
1 SEPTEMBER 2021

Order of Business

1. Welcome and Housekeeping Arrangements

2. Apologies for Absence

3. Exclusion of Public and Press
To identify items where resolutions may be moved to exclude the press and public

4. Declarations of Interest (Pages 5 - 8)
Members to declare any interests they have in the business to be considered at the meeting

5. Minutes of Previous Meeting (Pages 9 - 24)
To approve the minutes of the meetings of the Committee held on 7th and 14th July, 2021.

6. Public Questions and Petitions
To receive any questions or petitions from members of the public

7. Development of the South Yorkshire and Bassetlaw Integrated Care System (Pages 25 - 36)
Report of the NHS Clinical Commissioning Group (CCG).

8. Work Programme
Verbal update from Emily Standbrook-Shaw, Policy and Improvement Officer.

9. Date of Next Meeting
The next meeting of the Committee will be held on Wednesday, 29th September, 2021 at 4.00 p.m. in the Town Hall.

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Audit and Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

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SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 7 July 2021

PRESENT: Councillors Steve Ayris (Chair), Sue Auckland, Vic Bowden, Lewis Chinchen, Alan Hooper, Talib Hussain, Bernard Little, Ruth Mersereau, Ruth Milsom, Abtisam Mohamed, Garry Weatherall and Alan Woodcock

Non-Council Members (Healthwatch Sheffield):-

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Francyne Johnson.

2. APPOINTMENT OF DEPUTY CHAIR

2.1 RESOLVED: That Councillor Talib Hussain be appointed Deputy Chair of the Committee for the Municipal Year 2021/22.

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S H E F F I E L D C I T Y C O U N C I L

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 14 July 2021

PRESENT: Councillors Steve Ayris (Chair), Sue Auckland, Vic Bowden, Lewis Chinchen, Talib Hussain, Francyne Johnson, Bernard Little, Ruth Mersereau, Ruth Milsom, Abtisam Mohamed, Garry Weatherall, Alan Woodcock and Richard Shaw (Substitute Member)

Non-Council Members (Healthwatch Sheffield):-

Dr Trish Edney

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Alan Hooper. Councillor Richard Shaw attended as a substitute Member.

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 In relation to Agenda Item 7 (Item 6 on the minutes), (Adult Dysfluency and Cleft Lip and Palate Service) the following declarations were made:-

Councillor Vic Bowden declared a personal interest by virtue of her having a long connection with the Service and had served as a Trustee. Councillor Talib Hussain also declared a personal interest in the item due to him having a child who attended the Service.

3.2 In relation to Agenda Item 8 (Item 7 on the minutes) (Proposed Merger of Norfolk Park and Dovercourt GP Practices), Councillor Steve Ayris declared a personal interest by virtue of him being a patient at the Dovercourt Practice.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meetings of the Committee held on 10th March and 19th May, 2021 were approved as correct records.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 The Chair stated that five questions had been received from members of the public, all relating to Item 7 on the agenda (item 6 of these minutes) (Adult Dysfluency and Cleft Lip and Palate Service) as follows:-

5.2.1 My name is Kirsten Howells. I am the Helpline Support Manager and Programme Lead for the national charity, STAMMA, which is also known as the British Stammering Association. Since the closure of the specialist stammering service to new adult referrals from 1st April, our helpline and webchat services have been contacted directly by 3 Sheffield adults who stammer who have had their referrals to the service rejected, and from staff members in two other specialist NHS teams in Sheffield regarding three of their patients who have had their referrals to the service rejected. All 6 are urgently seeking therapy and support related to stammering.

Having a stammer can mean that everyday life is an obstacle course. Situations that fluent speakers take for granted can be really tricky for people who stammer. Think about the small things like buzzing in on the intercom at the GP surgery, but reception hang up when you can't say your name and they think someone's just playing games, being laughed at or mocked while ordering a coffee, or struggling to introduce yourself to new colleagues. Or the big things like being unable to work, because you've suddenly, out-of-the-blue, started stammering, or because the impact of a life-long stammer is affecting your ability to carry out your job. Or feeling suicidal because of the negative reactions of others to the way you speak, or having difficulty speaking in a police interview as the victim of a crime and those dysfluencies being misinterpreted as nervousness or lying. For these reasons and many more, some people who stammer seek support from speech and language therapy yet, in Sheffield, although there are therapists with specialist skills in this area, they are no longer able to accept referrals for these adults.

The Report of the Director of Commissioning Development states in Section 4.1 that the Trust would not expect any of the patients to require urgent treatment from a clinical perspective but, based on my own contact with the people who've had their referrals to the service rejected, I strenuously challenge that position.

In Section 2.8, the report states that the CCG is in the process of trying to procure treatment for the individual patients referred since 1 April from an alternative provider as a temporary measure. However, both STAMMA as an organisation and the patients I've been speaking to, including those who have contacted STAMMA this month, are unaware of alternative provision being in place.

Does the Committee consider that allowing the service to continue accepting new referrals whilst any necessary service reviews and consultations are underway, is preferable to a situation where the adults who stammer seeking support are effectively abandoned - rejected by the existing specialist service but with no alternative provision in place?

5.2.2 The Chair stated that he would respond to the question when the Committee

moved on to the next item of business and thanked Kirsten Howells for submitting her question and attending the meeting.

5.3.1 Isabel O'Leary, Clinical Lead Speech and Language Therapist at Sheffield Children's Hospital, had asked that background information be circulated to Members regarding the Adult Dysfluency and Cleft Lip and Palate Service. She attended the meeting and asked the following questions:-

(a) Why was the closure of an existing, long established nationally respected service to new patients carried out without a proper review or consultation and before any alternative provision had been secured and funded?

(b) Why did the Trust decide at short notice to "temporarily close the services for both pathways to new referrals from 1st April 2021…based on…risks." when these services have been operating without problems for decades?

5.3.2 The Chair stated that he would respond to the question when the Committee moved on to the next item of business and thanked Isabel O'Leary for submitting her questions and attending the meeting.

5.4 Emily Standbrook-Shaw, Policy and Improvement Officer, stated that questions from three individuals had also been received and she had agreed to read them out as follows:-

5.4.1 **Question from Dean Ridge –**

My name is Dean Ridge and I'm an IT Service Manager. I have stammered since early childhood, and I received speech therapy as a child and again in my early teens.

In 2011 at the age of 37, I referred myself to the specialist stammering service in Sheffield because I had reached a stage in my life where I needed extra support with my Stammer.
The SLT's helped me understand my stammer a lot more and introduced the concept of it being "ok to stammer" and not to hide it. I was a covert stammerer which meant I hid my stammer and did everything possible to avoid situations where I might Stammer and be found out.
We worked on acceptance and desensitisation to Stammering and this was literally life changing for me and has led to life decisions and experiences that simply weren't open to me before therapy. I am now a proud stammerer who isn't afraid to speak anymore.

For all of my adult life I would only say what I could fluently and now I say what I want to regardless of whether I stammer. This is such a massive difference for me in a world where communication is so important.

Since having therapy, I started a support group for adults who stammer in Sheffield. I have been interviewed four times on Radio Sheffield about Stammering, given lectures to SLT students at Leeds and Sheffield University and I am currently on the organising committee for a world conference for adults who stammer. None

of this would have happened without access to an SLT as an adult.

I know that the stammering service made a very important difference to my life, and I'm concerned to hear that this is no longer available. What are adults like me supposed to do when they reach out for help, perhaps due to concerns that have been building up over time, or because they've hit a crisis point and all they get is a rejection letter saying, sorry, there's simply no support for you here?

5.4.2 **Question from Louis Stansfield –**

For people like me, having a stammer is very tiring, I am constantly thinking about what I want to say and if I am going to be able to say it. For example, ordering a meal that I want rather than the one that is easiest to pronounce. This service is helping me to work through this and giving me the confidence I need to go into situations rather than avoid them. This includes tackling challenges in life that I have struggled with, such as job interviews and other potentially challenging situations. I reached the point where my stammer was affecting all areas of my life and my confidence was at rock bottom. When I learned of the SLT. Service I felt that I had been given a chance to improve my speech, and subsequently my mental health and this gave me hope.
Removing access to this service will in my view have a massive impact on the mental health and wellbeing of people that are already suffering and would leave people without urgent and adequate support that they may need. Would this be the case?

5.4.3 **Question from Jo Anderson -**

As an adult who stammers and has benefitted from the specialist adult service in Sheffield, I know how difficult it can feel under ordinary circumstances to reach out to a specialist service for support and know the importance of receiving input in a timely way. Within the context of covid, when many people are anxious about returning to more of a normal life, I imagine that for many adults who stammer, there will be increased anxieties about managing their stammer in social, work and educational settings. Therefore, I would like to ask:

- Why has the service been suspended at a time when needs will be as great, if not greater than ever due to challenges of managing a stammer in the context of returning to more of a normal life as covid restrictions are lifted?
- What is the justification for not funding a specialist adult service when we know that the significant social and psychological impact of stammering continues into adulthood and affects adults' mental health and ability to engage in work, education and social situations?

5.4.4 The Chair again stated that he would respond to the questions when the Committee moved on to the next item of business and thanked the questioners for submitting their questions.

5.5 Questions had been received regarding Agenda Item 8 (Item 7 of these minutes) (Proposed Merger of Norfolk Park and Dovercourt GP Practices), and it was agreed that these would be heard during that item of business.

6. ADULT DYSFLUENCY AND CLEFT LIP AND PALATE SERVICE

6.1 The Committee received a report which provided background context and outlined the current situation of the potential changes to the provision of Dysfluency and Cleft Lip and Palate Service for adults within Sheffield.

6.2 Present for this item were Lucy Ettridge (Deputy Director, Communications, Engagement and Equality, NHS Sheffield Clinical Commissioning Group (CCG), Kate Gleave, Deputy Director of Commissioning, NHS Sheffield (CCG) and Dr. Jeff Perring (Medical Director, Sheffield Children's NHS Foundation Trust).

6.3 Kate Gleave introduced the report and stated that she was aware that this Committee was usually concerned with adults and that matters dealing with children were under the remit of a different Committee but due to the increased demand for speech and language therapy assessments and treatment of around 8% year on year over the last six years, the Sheffield Children's NHS Foundation Trust, the CCG, the City Council agreed to undertake a review of the Paediatric Speech and Language Service in May 2019, which had stalled due to the pandemic, but the outcome of the review was now being finalised. The Trust, along with the CCG and the City Council, worked with colleagues in the education and voluntary sector and it became apparent that adults were being assessed and treated as well as children by the Service. Kate Gleave said that the CCG and the Trust had been in discussions to ensure that all needs and legal obligations were being met. The Service was not universally commissioned with some areas in the country having no adult service. However, the CCG was planning on commissioning a service for both assessment and treatment since the 1st April on a temporary basis whilst engagement work is undertaken so that we can fully understand patient needs. Patients will not have to undertake an assessment process whereby they were requested to go through of a panel process to determine whether they could be funded under exceptional circumstances. Kate Gleave stated that work was ongoing to identify another provider firstly we need to understand the service on offer as there were different service models and secondly to identify waiting times as throughout the NHS waiting times for all services have significantly increased. She said work had begun on equality and quality impact assessments with the intention to produce a combined Trust and CCG assessment to understand the impact of the decision which would help to tease out any potential issues that may arise. The Children's Hospital Service was well funded, this decision wasn't about funding cuts. Kate Gleave asked whether Members considered the closure to new adults would constitute a substantial change which would require formal consultation with the Committee.

6.4 Members of the Committee made various comments and asked a number of questions, to which responses were given as follows:-

- In terms of closing the Service to adults before alternatives had been found, both the Trust and the CCG have focused over the past couple of months on recovering from Covid and had chosen to prioritise work to special educational needs and disability services and supporting services with long waiting lists. This service had unfortunately dropped down the list of priorities.

- The risks and rationale were considered when carrying out the review as the Therapy Service treats patient cohorts significantly outside of the Trust's normal age range. The Service treats children up to the age of 16, and rarely up to the age of 18, but never to those in their 20s as there was limited capacity within the service and as a result, the Service was unable to meet all the demands placed on it. This review would create additional capacity to identify earlier specific needs and be able to see children sooner. There was also a lack of alignment with other adult therapy services which prevented integration and provision of care for adult patients. It was acknowledged that transition was vitally important but having a service that managed all ages was no longer appropriate and a pathway to transition people from paediatric to adult services was necessary.

- In an ideal world it would have been better to have a system in place before the service ceased accepting new referrals, however information received suggested that it was unlikely that there would be any referrals during transition, but it came to light that there were referrals, so the priority now was to find an alternative service for adults.

- It was not known whether the Head Injury and Neurological Department had been contacted, but it was confirmed that the Speech and Language Therapy Service at the Northern General Hospital have been contacted and that Service has confirmed that it was not able to offer any service at the present time.

- The CCG was looking into how long patients would have to wait to be seen both locally and nationally and would want to commission a service with shorter waiting times. This is being prioritised and it was hoped that answers were available towards the end of next week.

- The shortage of Speech and Language Therapists was not known. The expectation was that the service would be able to offer the opportunity to spend more time working with children and that capacity would be created.

- Over a number of years, there has been a lot of work around transition from child to adult across multiple services and it was acknowledged that in days gone by, sometimes young people did "fall of the cliff" when they reached a certain age. There are many services throughout the NHS that do successfully transition from one age group to another, so the Service was working to make the transition as seamless as possible. There was no certain set age as when young people reach the age of 16, they have different ways of thinking and have other stresses in their lives and perhaps may not be ready for more change, and also a recognition that at the age of 18, not everyone was ready to make the change, so there is a Transitions Register in place to enable patients to be seen for a while longer so that they could be transferred when ready.

- The CCG has been looking at service alternatives relatively locally in Rotherham and Hull and also the position in Barnsley and Doncaster. There

was a need to understand how best to meet the needs of patients whether through an online or virtual service versus how many would prefer face to face appointments and how that would impact on travel outside of the city.

- The process of looking for an alternative service started in January this year but was paused when it came to light the number of users that were likely to need the Service and due to the further lockdown, as previously stated, dropped down the list of priorities, but over the past three to four weeks alternative services have been identified and contacted to see if they meet our needs.

- The CCG has a legal duty to bring any substantial change to this Committee. There is no legally defined variation, so it was for the Committee to decide whether there was a substantial change which would trigger NHS consultation. The CCG was committed to a 12 week consultation period.

- As previously stated, there are many services within the NHS that require transition to adult services, but the speech and language therapy service is primarily a children's organisation and to provide the Service it did was in part an anomaly and therefore not appropriate to continue with that Service in the medium to long term.

- The decision was made around the type of service that it was, and the service was outside of the normal age range of the organisation, so to start implementing and developing it further would be inappropriate.

- The Trust have stopped all referrals temporarily, on the grounds of clinical risk which legally a provider is allowed to do, so what the CCG are now going to do, is to engage and consult with the users on future options. One option might be a status quo, so currently this would mean adults being seen at the Children's Hospital, but this is not viable. Its far from ideal, its not the perfect process and the Service will look at the impact of the change i.e. people might not be able to travel or take a zoom call or telephone call.

- The CCG approached a number of services including Hull. In terms of picking up the costs, if it means patients have to travel outside of Sheffield, the usual NHS rules concerning travel apply, whereby, if someone was able to travel through the patient transport service then travel costs outside the city would be free, and if someone doesn't meet the eligibility criteria, costs would have been met individually.

- The decision that was taken was based on a risk-based approach and it was taken by Sheffield Children's Hospital. Due to the pandemic, mental health across the board has been affected over the last 18 months and the health service as a whole were seeing increasing numbers of mental health issues. However, the question remains as to what Sheffield Children's Hospital is there for, and its reason to exist is to care for children, young people and their families, and the risks associated to this review was the risk to the Service and the significant concerns about its the capacity to treat young

children, and the consequences of continuing to manage the service. In taking the decision, the CCG does appreciate that a small number of adults would be affected by the proposed change.

- It was acknowledged that there might be some adults affected who would also be parents to children with multiple illnesses, mental health and disabilities and it was appreciated completely that that does have an effect on children and their life chances. The Service does not directly manage those issues but what it would do, would be to contact parents where appropriate and ask what they have in place.

6.5 RESOLVED: That the Committee:-

(a) thanks Lucy Ettridge Kate Gleave, and Dr. Jeff Perring for attending the meeting;

(b) notes the contents of the report and responses to the questions raised;

(c) unanimously agrees that this is a substantial change which requires formal consultation with the Scrutiny Committee;

(d) strongly recommends that Sheffield Children's NHS Foundation Trust reinstates the service to ensure that a proper, legal consultation and EIA can be undertaken;

(e) recommends that any future service that is commissioned is accessible to service users and isn't outside of South Yorkshire; and

(f) requests that an update be brought to the next meeting on what has happened to the service/update and actions taken from the recommendations made.

7. PROPOSED MERGER OF NORFOLK PARK AND DOVERCOURT GP PRACTICES

7.1 At the start of this item, questions were asked from members of the public and local Councillors as follows:-

7.1.1 Questions from Kim McMaster from Norfolk Park TARA

Why were patients misled? The Manor Top Clinic is earmarked for closure as it's not accessible to disabled patients, no parking, building is in disrepair, dangerous to cross East Bank Road etc.

Why were we told Manor and Castle Development Trust (M&CDT) had been appointed at the beginning of the process when they were not actually in place until over halfway through the consultation?

Why are we being consulted on a done deal, doctors have already quit their lease

before consultation started?

The patients of Norfolk Park are not happy with the proposals to merge and close our state-of-the-art building, and would prefer that the surgery became a satellite of Dovercourt and have doctors in there five days a week. (This has been done with another surgery locally).

How are patients with no access to transport supposed to get to Dovercourt?

In response, Abigail Tebbs, Deputy Director of Delivery, Primary Care Contracting, Digital and Estates, NHS Sheffield Clinical Commissioning Group (CCG) stated that as a result of the feedback on consultation and other work ongoing, the CCG would be stopping the consultation to show patients a revised proposal which would involve the merger still going ahead, but services would still be provided at Norfolk Park. She said she didn't have all the information available, but the same clinicians would be available at both practices.

7.1.2 **Questions of Councillor Ben Miskell**

The surgery itself is located in 8-year-old premises and is owned by Community Health Partnerships Ltd (CHP), a private company, wholly owned by the Secretary of State for Health and Social Care.

Given the ownership arrangement of the building, can representatives from the CCG confirm to Members of the Committee, that should the surgery close, the CCG and thus the taxpayer will still be liable to pay the rent on the empty space that is left?

Could the CCG also confirm the total cost that this would represent to the taxpayer for the ongoing rent of empty space in this building?

Can the CCG also confirm whether the GPs acted on the advice of the CCG in tendering notice to the landlord, prior to the commencement of the consultation period. As members of this Committee will understand, this action by the GPs, has caused significant resentment in the local community and concern that the consultation itself is a done deal.

If this is not the case, what action has the CCG taken with the landlord to investigate how services can continue to operate from the Norfolk Park premises in whatever form, given that notice has already been served to vacate the building?

As Committee members will have heard from Kim McMaster from Norfolk Park TARA, there are some serious concerns about the consultation itself. It commenced during a period where face-to-face contact was limited due to the pandemic. Stage 3 covid restrictions stayed in place for a further month, preventing full discussion of the issues and in particular excluded those from protected groups.

Moreover, Manor and Castle Development Trust was appointed only halfway through the consultation period to engage with community groups. Given this information, I am asking on behalf of the community that this Committee recommends that the consultation period for this proposal be extended.

I am also asking that the Committee use its powers to recommend against the proposal to close Norfolk Park Surgery, which will only serve to widen health inequalities in the area and will potentially create significant additional cost to the taxpayer, who will have to continue to pay for an empty building, whilst residents are denied their own local GP practice in Norfolk Park.

7.1.3 **Questions of Councillor Sophie Wilson**

Councillor Wilson referred to the petition and questions that have been submitted and asked at the two previous meetings of Full Council and the strength of feeling around this. Councillor Wilson raised questions around the proposed merger and the proposals to include the Manor Top Surgery. She said that concerns had been raised regarding residents in the Norfolk Park area travelling to the Dovercourt and Manor Top Surgeries and the potential problems this would create. Councillor Wilson also said that most residents had received the information regarding the merger via text message initially and then by letter. She expressed concerns that Councillors and health partners had not been able to hold face to face consultations with residents due to the pandemic and asked for the consultation to be extended by one month.

7.1.4 The Chair stated that he would respond to the questions during discussion on the item and thanked the questioners for attending the meeting.

7.2 The Committee received a report of the Director of Commissioning and Development, NHS Sheffield Clinical Commissioning Group regarding the proposed merger of Norfolk Park Health Centre with Dovercourt and consultation on the proposed closure of Norfolk Park Health Centre.

7.3 Present for this item were Abigail Tebbs (Deputy Director of Delivery, Primary Care Contracting, Digital and Estates, NHS Sheffield Clinical Commissioning Group (CCG)), Lucy Ettridge (Deputy Director, Communications, Engagement and Equality, NHS Sheffield CCG) and Dr. StJohn Livesey (Clinical Director, NHS Sheffield CCG).

7.4 Abigail Tebbs again reiterated that as the result of the feedback on consultation and other work ongoing, the consultation had been paused and a revised proposal would be shared with patients. She said that the merger would still go ahead, but services would continue to be provided at the Norfolk Park Practice. Ms. Tebbs said she didn't have all the information available, but the same clinicians would be available at both practices. She felt it was important to highlight the way the proposals work and the process that they go through. As independent contractors, general practices can make applications to the CCG to merge and/or close practices and the CCG has a duty to consider those proposals, taking into account a number of factors when making the decision. The CCG then has to develop and consider the proposals, go through the

appropriate public consultation and submit the application for consideration by the CCG's Primary Care Commissioning Committee (PCCC). In this case, the Committee has to consider what was best for the patients of the Norfolk Park practice and determine the health needs of those in that area and then decide whether or not to approve the application. With regard to the Manor Top Clinic, patients in the area were informed by letter and text message, that the longer term future of that Clinic would be the subject of further review, but it was not part of the proposals for this merger. The decision taken by GPs to terminate their contracts was not taken on the advice of the CCG, but it was communicated that any decision to terminate contracts would be supported when the lease of the Norfolk premises was surrendered. The owners of the premises, Community Health Partnerships Ltd (CHP), require the approval of the CCG to surrender the lease of the premises and as yet, the CCG has not given such approval for that. Ms. Tebbs stated that it was recognised that Norfolk Park was a good asset with excellent health care facilities, and there was a desire to see buildings of this nature being fully utilised.

7.5 Dr. Livesey stated that many GPs were at breaking point and often asked how much longer they were expected to carry on working under the conditions they do. He felt that the merger gave them the chance to be able to attract and retain doctors, something that hadn't been possible for a number of years. Dr. Livesey felt that the merger would give staff a feeling of security.

7.6 Abigail Tebbs then referred to the total amount of void space used at Norfolk Park and stated that a percentage of sessional space, e.g. consultation rooms, waiting rooms, etc. was completely unallocated. She said that the CCG was responsible for funding for the void space as well as rental costs and said that there was no overall cost increase for unoccupied space. She said she had had discussions with NHS Property Services and as yet approval had not been given for the termination of the contract. Consultation had been difficult during the pandemic but due to the timing of the request, the CCG had to continue with the consultation and the proposal had the full 12 week consultation period, and letters had been sent before text messages but there was only a matter of days between these platforms being used. It had not been possible to hold face to face public meetings as this would have delayed the consultation period, however that period was now to be extended.

7.7 Members of the Committee made various comments and asked a number of questions, to which responses were given as follows:-

- Information around the demographics of the local population and the longer term strategic and population growth in both the Norfolk Park and Dovercourt areas would have been submitted for consideration. The CCG would also consider what the impact on the quality of services would be should the merger go ahead and if there were any concerns, the CCG could ask for further work to be done or reject the proposal. The CCG was aware of increases in housing and future plans for that area, and part of the primary care planning was to ensure that there was sufficient primary care on offer in the future.

- GPs were contracted and independent, but the CCG does provide support to GP practices and provide leadership and support to ensure there was sufficient quality of services in Sheffield. There was a responsibility to ensure that a robust service was available in the area. It was stated that new models for working practices were emerging and it was time for change.

- The CCG has a responsibility to assess patient needs. There was no guarantee that if the contract were to be retendered there would be any interest from other providers.

- In terms of the impact on the Dovercourt surgery in terms of location, in approving any merger the PCCC would wish to be fully assured that the two practices were fully equipped to meet the demands placed on them by the emergence of larger practice lists. Norfolk Park was a very successful practice and successful in recruiting to their practice. What was presented in the application, was an assurance that the merger would provide both GP services simultaneously with good levels of support and more stability to both practices.

- Discussions were due to continue during the following days, and there was a need to ensure that the information available following such discussions was made very clear to all concerned.

- The GPs were the key drivers in this as the GPs at Norfolk Park felt they were unable to continue alone with the leadership model they had in place, that the practice was no longer sustainable, and the merger would bring stability to them. There were no plans for net loss of GPs as a result of the merger. GP hours would be more likely to increase not lessen. It would be wrong to say at this stage that there would be no reduction in GP hours, but the merger would make it easier to be able to recruit.

- There were no plans at present to close the Manor Top Clinic. Due to the very nature of the layout and accessibility of the building, the future of the Clinic could be reviewed in the future, but to include it now as part of this merger, would delay the whole process and the ambition was to complete the merger as soon as possible to offer stability to both practices. It was recognised that this had been a worrying time for patients and there would be nothing to be gained by changing things now. Discussions have been held regarding the future of the Manor Top Clinic and this would be addressed in the future.

- Both Practices already offer extended hours. Hours at the Dovercourt practice were earlier in the morning and opened later in the evening than at Norfolk Park. Patients of the merged Practice would be able to take advantage of those services on offer at Dovercourt, but details around this still needed to be determined.

- NHS England have received complaints from patients not being able to see their GP, even before the pandemic, but GP practices nationally were in a

very difficult position in attracting and keeping GPs, so there was a need to make sure there are strong foundations in place and try to find solutions and also ensure that Sheffield can attract more GPs to the area.

7.8 RESOLVED: That the Committee:-

(a) thanks Lucy Ettridge, Abigail Tebbs and Dr. Livesey for their contribution to the meeting; and

(b) notes the contents of the report and responses to the questions raised.

8. WORK PROGRAMME DISCUSSION

8.1 Emily Standbrook-Shaw stated that setting the Work Programme for the Municipal Year was not a simple process due to Transitional Committees having recently been established. She asked Members what they wanted to see on the Work Programme.

8.2 RESOLVED: That the following matters/suggestions be considered for inclusion in the Committee's Work Programme for the year ahead:-

- Integrated Care System consider placing as a standing item on every agenda as this matter will unfold throughout the year;
- Mental Health Services coming out of Covid;
- Compile a list of issues that the Committee may wish to consider over the year, which will develop as the role and work programmes of Transitional Committees develops.
- Access to Dental Services.

9. WRITTEN RESPONSES TO PUBLIC QUESTIONS

9.1 The Committee received and noted a report of the Policy and Improvement Officer setting out the written responses to the public questions raised at its meeting held on 10th March, 2021.

10. COUNCILLOR CATE MCDONALD

10.1 RESOLVED: That the thanks of the Committee be conveyed to the former Chair, Councillor Cate McDonald, for the work she has undertaken as Chair of this Committee, since May, 2019.

11. DATE OF NEXT MEETING

11.1 It was agreed that the next meeting of the Committee will be held on Wednesday, 29th September, 2021 at 4.00 p.m., in the Town Hall. Subsequent meetings will be held on 24th November, 2021 and 26th January and 23rd March, 2022.

Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee

Report of Brian Hughes, Deputy Accountable Officer, NHS Sheffield CCG

Subject: Development of South Yorkshire and Bassetlaw Integrated Care System

Author of Report: Lucy Ettridge, Deputy Director, NHS Sheffield CCG

Summary:
This report summarises the proposed legislative changes to clinical commissioning groups (CCGs) and integrated care systems (ICS), developments and transitions in South Yorkshire and developments in Sheffield.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	**X**
Other	

The Scrutiny Committee is being asked to:
The committee is asked to:

- Note the update and developments.
- Give support for the direction of travel for the ICS.
- Give support for the direction of travel in Sheffield.
- Agree that local accountability could be maintained from April 2022 by the ongoing section 75 arrangement and a continuation of the JCC.

Background Papers:

Category of Report: OPEN/~~CLOSED~~ (please specify)

Development of South Yorkshire and Bassetlaw Integrated Care System

1. Introduction

The Health and Care Bill which sets out integrated care systems (known as ICSs) becoming statutory NHS bodies is now in the committee stage of the legislative process. It is expected to receive royal assent early next year and changes come into effect on 1 April 2022.

The bill is a natural progression of and builds on the NHS Long Term Plan (2019). The reforms are fundamentally about delivering better integration at three levels: health and social care; primary, community and secondary care; and physical and mental health.

Better integration has been a priority since the last labour government, and these legislative changes will give us a real chance to improve the lives of Sheffield people and staff by reducing barriers and taking collaboration to new levels.

NHS organisations, local councils and other partners in South Yorkshire and Bassetlaw (SYB) have increasingly been working together as an integrated care system since 2018. NHS Sheffield CCG and Sheffield City Council are two of 23 organisations that make up the SYB ICS, which is currently a formal partnership, not a statutory body

By joining forces, ICS partners have developed better and more convenient services, invested more to keep people healthy and out of hospital and set shared priorities for the future.

Our response to the pandemic in Sheffield and the region showed the importance of joined-up working and accelerated the changes on which we had embarked - for example, through more provider collaboration.

Statutory ICSs will consist of a health and care partnership and an NHS body (The Integrated Care Board, known as ICB). The commissioning responsibilities of clinical commissioning groups (CCGs) and some from NHS England, together with existing non-statutory functions of current ICSs will form the basis of ICB statutory functions and responsibilities.

If the legislation passes according to the timetable, on 1 April 2022 South Yorkshire and Bassetlaw ICS will become a statutory NHS organisation. This means the CCG will no longer exist, but its functions and the vast majority of its staff will transfer into the new Integrated Care Board. Sheffield City Council will be a member of the South Yorkshire Health and Care Partnership.

Details of the bill might evolve as it passes through its many stages. Further guidance will be issued on place based partnerships. Therefore, the direction is emergent and adaptive, and we aren’t working to a blue print.

All partners in Sheffield and across SYB have been working hard to minimise disruption of the transition for staff and patients. This paper will set out some of the work and plans so far.

2. What is an ICS?

ICSs comprise all the partners that make up the health and care system working together in the following ways.

The statutory ICS arrangements (subject to legislation) will include:

- An ICS Partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- An ICS NHS body, an organisation bringing the NHS together locally to improve population health and care.

2.1. The ICS partnership

Each ICS will have a Partnership at a system level, formed by the NHS and local government as equal partners – it will be a committee, not a body.
Members must include local authorities that are responsible for social care services in the ICS area, as well as the local NHS (represented at least by the ICS NHS body). Beyond this, members may be widely drawn from all partners working to improve health, care and wellbeing in the area, to be agreed locally.

We expect the ICS Partnership will have a specific responsibility to develop an "integrated care strategy" for their whole population.

The chair of the partnership can also be the chair of the ICS NHS body but doesn't have to be – this would be for local determination.

2.2. The NHS Body (Integrated Care Board)

The functions of the ICS NHS body will include:

- Developing a plan to meet the health needs of the population
- Allocating resources to deliver the plan across the system (revenue and capital)
- Establishing joint working and governance arrangements between partners
- Arranging for the provision of health services including through contracts and agreements with providers, and major service transformation programmes across the ICS
- People Plan implementation with employers
- Leading system-wide action on digital and data
- Joint work on estates, procurement, community development, etc.
- Leading emergency planning and response

The ICS NHS bodies will take on all functions of CCGs as well as direct commissioning functions NHSE may delegate including the commissioning of primary care and appropriate specialised services

We expect the ICS NHS body will have a unitary board – members of the ICS NHS Board will have shared corporate accountability for the delivery of the functions and duties of the ICS and the performance of the organisation.

Other important ICS features are:

- Place-based partnerships between the NHS, local councils and voluntary organisations, residents, people who access services, carers and families – these partnerships will lead design and delivery of integrated services.
- Provider collaboratives, bringing NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.

2.3. Place-based partnerships

Place arrangements and leadership are for local agreement– partners within each ICS will want to decide how best to bring together the parties to address the needs of the place, building from an understanding of neighbourhoods and primary care networks.

It is recognised that 'Place' is where most of our people connect, both physically and emotionally, and it is why place-based teams will form the basis of the structure of the new ICS NHS Body, to provide certainty for our people and minimise the disruption for our functions and services.

An ICS NHS body could establish any of the following place-based governance arrangements with local authorities and other partners:

- Consultative forum, *informing* decisions by the ICS NHS body, local authorities and other partners
- Committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources

- A joint committee of the ICS NHS body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee
- Individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee
- Lead provider managing resources and delivery at place-level under a contract with the ICS NHS body

2.4. Providers and Provider collaborations

Organisations providing health and care services are the frontline of each ICS. The arrangements put in place by each ICS Partnership and ICS NHS body must harness the expertise, energy and ambition of the organisations directly responsible for delivering integrated care.

Providers will continue to retain their statutory duties and meet requirements under the NHS standard contract or relevant primary care contract, but with new relationships between commissioners and providers embodied in the composition of the ICS NHS board and ways of working across the ICS.

It is expected that providers will increasingly lead service transformation, potentially via delegation of functions from the ICS NHS body.

Primary care networks will play a vital role in place based partnerships. In addition to their partnerships at place level, Trusts/FTs are expected to join provider collaborative arrangements from April 2022. (Ambulance trusts, community trusts, and non-statutory providers are not *required* to join provider collaboratives but should where it makes sense.)

Each Provider Collaborative will agree on specific objectives with one or more ICS, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together on how this contribution will be achieved

3. What's happening in South Yorkshire and Bassetlaw ICS?

3.1. Boundary changes

Earlier this year, government ministers asked NHS England to set out options for ICS boundaries in specific geographies where upper-tier local authorities currently work across more than one ICS. The working principle was that coterminous boundaries delivered clear benefits in integration between local authorities and NHS organisations.

Following an assessment of the impact of changes for Bassetlaw, on 22 July the Secretary of State announced that the district of Bassetlaw would align with the Nottingham and Nottinghamshire Integrated Care System, not SYB. The change will take effect from 1st April 2022.

Until then, Bassetlaw remains a part of South Yorkshire and Bassetlaw Integrated Care System and are key partners in developments.

3.2. Draft System Development Plan

SYB ICS published our Draft System Development Plan in June this year. It is still very much in development and is designed to be a 'live' document to reflect the developing ambitions of SYB and its partners and the evolving national landscape, legislation, and policy progression.

This document starts to capture our collective approach to transition over the next 7 months (9 when published), recognising April 2022 is not a definitive endpoint for system development.

Throughout the ICS journey, we have continued to work towards and build on our vision for everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well for longer.

3.3. Development journey

Work to date: Phase 1: The Development Phase (November 2020 –April 2021)
Over the last six months (Phase 1) an overarching Steering Group has been convened from members of the SYB ICS partnership and has been overseeing work that builds on existing ways of working. The Group agreed the key building blocks within SYB are neighbourhoods, places, collaboratives, and the system and set up workstreams to look at:

- Establishing place-based partnerships
- How provider collaboratives will operate across systems
- How the nature of commissioning will change; and
- An integrated care system operating model.

The Steering Group set up a design sub-group, established from its membership to co-design several initial key products to shape the ICS during the transition to a statutory authority. The first of these products have been discussed by Boards, Governing Bodies and Committees and following feedback and review will come into operation from Quarter 2 and include:

- Health and Care Compact
- Health and Care Partnership Terms of Reference
- Development Matrix to inform. Place and provider collaboration development

Phase 2: Design, transition, and implementation (May to Dec)
As we progress our ICS development work taking into account the national requirements, we do so within a wider context. The work sits alongside business as usual and the recovery of services following the impact of Covid.

In Quarters 2 and 3 of 2021/22, we expect to confirm the CEO appointments along with other executive and non-executive appointments to the NHS Body (ICB). The designate chair was appointed in July. Pearse Butler, most recently chair of Blackpool Teaching Hospitals FT, will start at the ICS in September.

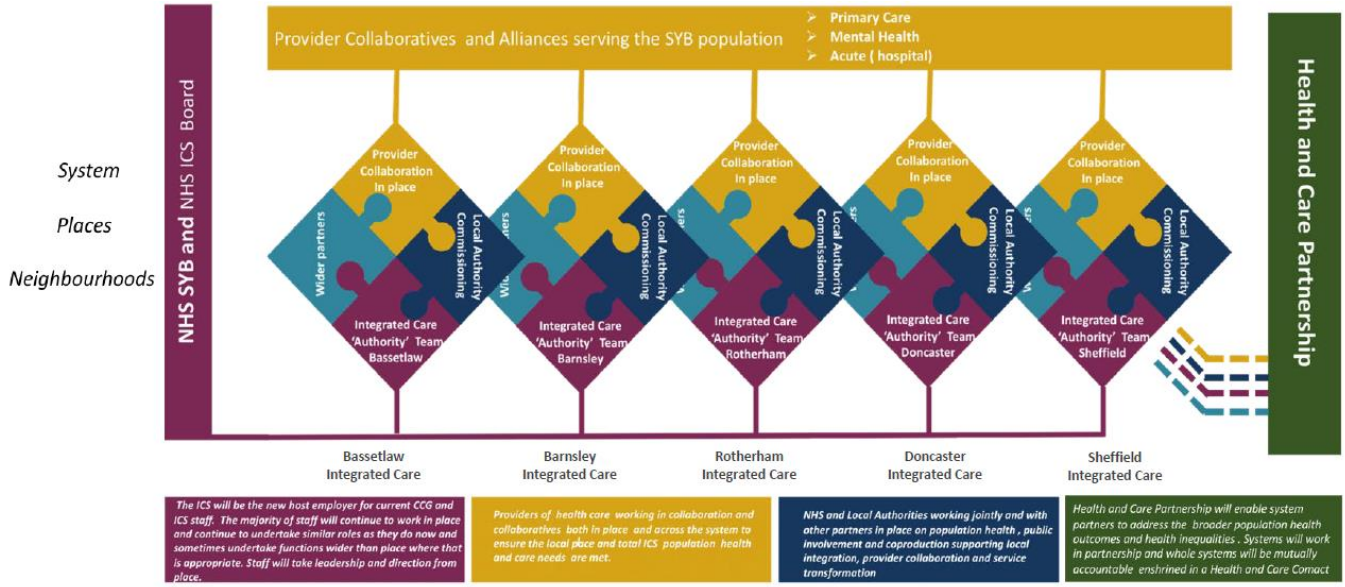
Following the readings of the Bill and subsequent guidance, we will be able to finalise and confirm the Health and Care Partnership and NHS Body arrangements and operating model.

Phase 3: Shadow Phase (January to March 2022)
In Quarter 4, there will be other designate appointments to NHS Body, completion of sender and receiver due diligence and submission of the System Development Plan. This quarter is described as the shadow phase.

Phase 4 – Statutory phase (April onwards)
In Quarter 1 of 2022/23 the new ICS body will be established with staff and property (assets and liabilities) transferred and Boards in place.

3.4. SYB Operating Model
A key output of our phase 1 work was our system operating model. With our system building blocks of neighbourhoods, places, collaboratives and system with the Health and Care Partnership and ICS body as the future employer. By place, we mean town or city and the system is South Yorkshire.

SYB features large places with weight-bearing infrastructure in each place, working in partnership with health and care. Provider collaboratives working both in each place and across the SYB system. Operating principles of subsidiarity and highly delegating structures.



Fundamental to the entire model is supporting the population that we serve through the organisations that provide health and care services and we are focused on creating a model which supports us in being able to deliver our quadruple aim for the benefit of local people.

The principles of the ICS are that the vast majority of its work and responsibilities will be delegated to place. that needs to have a home, which in Sheffield is likely to be the joint commissioning committee.

3.5. Communities and Places

Lots of work is happening to support the development of thriving places. The timeline below shows the priority next steps for our places in SYB as we continue to develop jointly through the transition year and beyond.

Over the last five years, all five places in SYB have established place partnerships with their local authorities and other place partners. In Sheffield, this is the Accountable Care Partnership or ACP. These partnerships have become the bedrock of SYB Place development and relationships.

Core to the proposals set out in the BIll is the fundamental building block of Place, and as we work together through the ICS Development Programme the formation and further

development of the place based arrangements are central to the developing operating model. In recent months, the Sheffield Place Partnership has been focused on developing:

- Place Partnership: Developing approach across all Partners, building on the progress to date
- Operating Model: Currently includes an ACP board with members from across Sheffield health and care providers and commissioners, this is under further development for April 22 to develop a weight bearing infrastructure
- Joint Commissioning: There is already a £400m pooled budget for joint commissioning through the local BCF in Sheffield and have been developing a joint outcomes based approach
- Vertical Provider Collaborative: Currently in development

A key focus for the next phase is to ensure that the Place Partnership can deliver on an ambitious scope and set of responsibilities aligned to the developing ICS Operating Model.

3.6. System Provider Collaboratives

The timeline and priority next steps are shown below. They are for developing our system provider collaboratives, to support our at scale development

The Integrating Care White Paper set out the focus for *Horizontal Integration, between places at scale where similar types of provider organisations share common goals such as reducing unwarranted variation, transforming services or providing mutual aid through a formal provider collaborative arrangement.*

Building on our arrangements across the System, the three developing Provider Collaboratives have been focused on coming together to outline their vision, approach, functions and desired form as part of phase 1 of ICS Development.

The approach across all three of the Provider Collaboratives is varied, to ensure that the services provided and approach is aligned to the needs of the system and the scale of provision required across SYB.

The next phase of work will include a focus on developing operating arrangements aligned to national guidance, delivering join priorities to support system recovery and establishing mechanisms as part of the ICS Operating Model to ensure representation from system

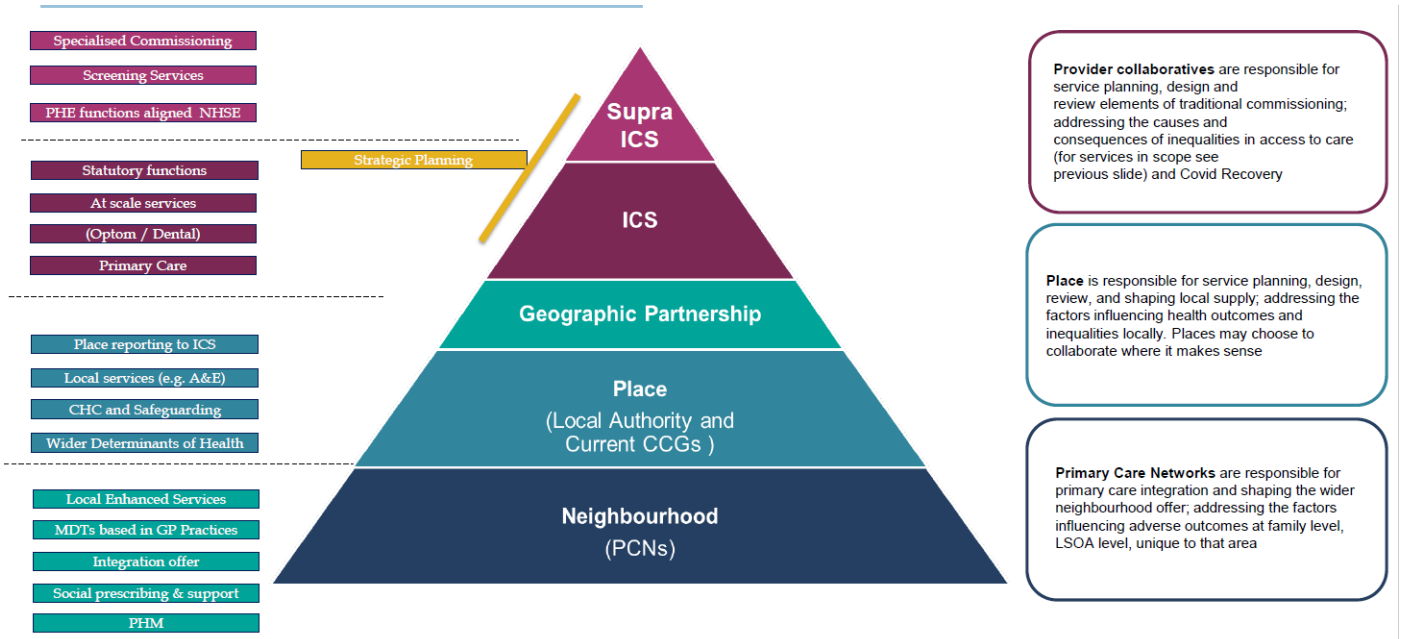
provider collaboratives and enabling approached to support delivery during 2021/22 and from April 22 and beyond.

It is recognised, that the journey for embedding this approach will take time, but given our collaborative approaches, we are in a key position to implement requirements from April 22 to best support the population of SYB.

3.7. Strategic Commissioning

The five CCGs in SYB have a long history of collaboration.

The focus is on building from the neighbourhood up, aligning CCG and NHS England commissioning through our regional work and SYB commissioning workstream and identifying key responsibilities for ISC, place and neighbourhood levels.



3.8. Work of the change and transition board

The focus of the work so far has been the reform of commissioning as part of the proposed legislative change. This includes a key focus on:

- Transitional Year 2021/22 Operating Arrangements
- Transfer of functions and people
- HR Framework
- Place and System Development (Commissioning)

Throughout Phase 1 the Commissioning Workstream has developed key outputs including:

- Development of functions mapping across the 5 CCGs and ICS including current staff aligned to functions
- Launch of the Strategic Commissioning Workstream in support of the JCCCG to further develop the approach to strategic commissioning

3.9. Future of Commissioning

The next steps for developing our approach for the future of commissioning and transition arrangements are shown below.

Transition commissioning arrangements

We have launched our Change and Transition Programme to manage the safe and effective transfer of duties from affected organisations to the Statutory ICS

Strategic Commissioning

We continue to work through our JCCCG to further develop our strategic commissioning functions, to increase system decision making, planning and further embed our Population Health Management Function Clear focus on strategic commissioning in the phase 2 design

Supporting our People

Throughout Phase 1, we have been focused on supporting our staff through our Commissioning Workstream, and as such have co-produced a staff engagement plan which outlines key steps throughout this process

The above areas form a key part of our Phase 2 work, where timelines are included aligned to the workstreams in section 2.

4. What will be different?

For the system

Integrated care systems are intended to bring about major changes in how health and care services are planned, paid for and delivered, and are a key part of the future direction for the NHS as set out in the NHS Long Term Plan.

They will be vehicles for achieving greater integration of health and care services; improving population health and reducing inequalities; supporting productivity and sustainability of services; and helping the NHS to support social and economic development.

They will significantly transform how the NHS operates, with NHS partners, with local authorities and with wider partners such as the voluntary sector.

Some of the key differences from the system now and 2022 will be moving ways of operating and focus to better achieve our ambitions, such as those shown below.

From:	To:
Competition	Collaboration and partnership working
Transactional and process driven	Strategic and outcome focussed
People working in organisations	A 'one workforce' approach
Statutory health commissioner in Place	Delegated responsibilities for Place
Organisational accountability	Organisational and mutual accountability
Overly bureaucratic processes	Streamlined processes
Performance oversight	Improvement support

South Yorkshire ICS will be ready to take on its new statutory role, working as one system, one organisation, one workforce and four place-based teams, to deliver its fundamental purposes of ICSs:

- Improving population health and healthcare;
- Tackling unequal outcomes and access;

- Enhancing productivity and value for money; and
- Helping the NHS to support broader social and economic development

South Yorkshire ICS has a clear quadruple aim of:
- Supporting better health and wellbeing,
- Improving outcomes for the local population,
- Focussing on the wider determinants of health and;
- Reducing health inequalities.

We can transform the lives of sheffield people in Sheffield but there are times when we will need to do things differently. This is where the city's residents will benefit from being part of a bigger system such as wider collaboration, shared expertise and shared services.

For patients and service users

Patients, service users, carers and staff are often frustrated that the multitude of health and care organisations in the city don't always work well together meaning they often have a worse outcome and experience. The focus on integration in these reforms sets out to change that.

In the ICS and Sheffield partnerships, we'll all pull together in a common direction, with some of the barriers of the current system eliminated such as competition and multiple autonomous organisations. The voluntary and community sector will be key partners and the voice of the public will be heard.

Local clinical and care teams will be supported to work collaboratively to provide joined-up, coordinated care that flexibly meets individuals' needs.

Care will be closer to home, thereby improving access, and they'll be a coordinated effort to reduce health inequalities.

As part of Sheffield's joint commissioning plan, a health and wellbeing outcomes framework is being developed. The ICS is learning from Sheffield and looking to do the same at the SYB level.

The Sheffield health and wellbeing outcomes will provide a strategic framework for the planning and delivery of health and social care services, focusing on improving the experiences and quality of services for people using those services, carers and families. It will be aligned to Sheffield's health and wellbeing strategy. Focusing on improving how services are provided, as well as the difference integrated health and social care services should make for individuals.

Sheffield's ACP has signed up to outcomes framework meaning commissioners and providers are working towards one set of outcomes for the city.

5. What are the proposals for Sheffield?

The ICS will have four strong and effective place based partnerships between sectors in– Barnsley, Doncaster, Rotherham and Sheffield.

On behalf of ICS NHS Body, a place based leader for Sheffield, who will be a member of the ICS executive team, will work with Sheffield partners in an inclusive, transparent and collaborative way to contribute to:
- Strong and effective place-based partnerships between sectors with full involvement of all partners who contribute to the place's health and care
- A continued strong strategic relationship with health and wellbeing boards.

They will have four main roles:

- To support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods.
- To simplify, modernise and join up health and care (including primary and secondary care where appropriate)
- To understand and identify people and families at risk of being left behind and to organise proactive support for them
- To coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

The place based director will be responsible for all the functions and teams which are delegated by the ICS. The NHS ICS Body will remain statutorily responsibilities.

6. What's already happening in Sheffield?

Sheffield's Joint Commissioning Committee (JCC), established in 2019, is the collaborative of the city's health and care commissioners: the CCG and council. This is a binding arrangement between both organisations, underpinned by section 75 of the Health and Social Care Act (2006), to contribute to a common fund that can be used to commission health or social care related services. Section 75 power allows a local authority to commission health and NHS commissioners to commission social care. It enables joint commissioning and commissioning of integrated services.

The JCC has a pooled budget of £408 million to provide a range of health and care services, including mental health, urgent and emergency care, community services, social prescribing, community equipment services, continuing care arrangements, and early intervention/prevention services.

On 15 February this year, the JCC signed off its first ever set of joint commissioning intentions for improved health and care services in the city. It is one of the largest examples of integration of health and care planning and spending in England.

The ambitious plan spells out how health and care services will work better to provide better experiences and outcomes for people in the city, as well as impacting on the health inequalities people across the city face.

The plan recognises at times that services are sometimes fragmented and how this affects the experiences of people using them. The plan spells out how services will look different from the perspective of Sheffield citizens.

In the plan, we demonstrate that both organisations have a shared vision, priorities and face the same set of challenges. By joining up planning and spending, it provides an important springboard for health, care and voluntary/community partner organisations across the city to join up care. This builds upon the many areas of areas partners across the city have been together on, before and during the pandemic.

This means we have solid foundations in the city already for place based working as part of the ICS. It puts Sheffield in a strong position ahead of the proposed legislative changes, meaning that decisions are made with a focus on integration/how partner organisations work better together for the benefit of citizens.

The formation of the plan has been the result of the relationships between the organisations and the alignment of teams around a common purpose: improving health and care for Sheffield people.

The interim guidance on functions and governance for integrated care boards outlines that people, property, contracts, service level agreements, licences and leases will transfer to the new ICB. This

would imply that the existing section 75 arrangement between SCCG and SCC will novate to the ICB.

7. Future accountability

The ICS statutory body will take on the CCG's legal responsibilities on working with overview and scrutiny committees.

We don't know yet if these will be delegated to the executive team at place. What we do know is there will be dedicated officers to work with Sheffield's Healthier Committees, or any successive committee as part of the move to the council's new committee model. This will ensure the continued communication and sharing of plans, strategies, and developments and proposed changes, working together, and ensuring we do the right thing for Sheffield people.

From April 2022, Senior people at the place team and/or the ICS will attend the committee where invited to be held accountable for NHS plans and delivery.

8. Recommendations

The committee is asked to:

- Note the update and developments.
- Give support for the direction of travel for the ICS.
- Give support for the direction of travel in Sheffield.
- Agree that local accountability could be maintained from April 2022 by the ongoing section 75 arrangement and a continuation of the JCC.