Agreed at Meeting
30.03.16

NHS
Rotherham
Clinical Commissioning Group

Minutes	**Title of Meeting**:	**GP Members Committee (GPMC)**
	Time:	**12.30 to 15.30**
	Date:	**Wednesday 24 February 2016**
	Venue:	**G.04 Elm Oak House**
	Chairman:	**Dr Leonard Jacob**

Members or deputies Present:

Dr Leonard Jacob (LJ) Thrybergh Medical Centre	Central 2
Dr Simon MacKeown (SM) St Ann's Medical Centre	Health Village
Dr Tim Douglas (TD) Dinnington Group Practice	Rother Valley South
Dr Geoff Avery (GA) Blyth Road	Maltby/Wickersley
Dr Naresh Patel (NP) Broom Lane Medical Centre	Central North
Dr Bipin Chandran (BC) Treeton Medical Centre	Rother Valley North
Dr Suganya Ravi (SR) Parkgate Medical Centre - **Deputy**	Wentworth South

LMC Representative

Dr Subbannan Sukumar, LMC Representative	LMC

Apologies

Dr Sophie Holden (SH), Market Surgery	Wath/Swinton
Dr Srini Vasan (SV) York Road Surgery	Wentworth South
Dr Gokul Muthoo, LMC Representative	LMC

In Attendance:

Lynn Hazeltine (LH) York Road Surgery	Practice Managers' Rep
Barry Wiles (BW) Maltby Service Centre/Clifton MC	Practice Managers' Rep
Dr Julie Kitlowski (JK) Chair Rotherham SCE	SCE
Dr Richard Cullen (RCu) Vice Chair Rotherham SCE	SCE
Chris Edwards (CE) Chief Officer	CCG
Ian Atkinson (IA) Deputy Chief Officer	CCG
Keely Firth (KF) Chief Finance Officer	CCG
Cheryl Rollinson (CR) Secretariat	CCG

No.	Item	Action
	Declarations of Pecuniary or Non-Pecuniary Interests Drs Avery, Chandran, Douglas, Jacob, Kitlowski, MacKeown, Patel, Ravi and Sukumar had an (indirect) interest in most items. In addition, Dr Jacob has a particular interest in items relating to TRFT as he is employed by them on a sessional basis and Dr MacKeown has a particular interest in items relating to Rotherham Hospice as he is employed by them.	
1.	**Feedback on GP Ward Rounds** A strategic summary of the ward rounds was received. Background information was provided whereby SCE GPs had joined the ward rounds in Jan-Feb 2015 and feedback and actions were established in June. SCE GPs then rejoined the ward rounds in Nov-Dec 2015 to understand if improvements had been made. JK explained that the statistics around reducing the delays to discharges were good and that partnership working has been positive. Members were informed that conversations around social care have been difficult but work is progressing. CE explained the processes around discharges and reported that one of the key areas for improvement was actually starting the discharge documentation and processes earlier.	

	NP raised concerns around the quality of the discharge process and felt that this had not been addressed. Following examples shared, JK stressed that it was really important to understand if issues are related to the lack of care package available on discharge or if the patient was discharged but not medically fit. It was felt that the processes were working if re-admissions have been reduced however it needs to be understood what activity should take place within in the hospital and what can take place in the community. A big challenge is to ensure alternative levels of care are commissioned appropriately. Noted that the registrars had previously identified concerns but no action was taken, the purpose of these ward rounds is to hold organisation's to account. GA suggested seeking views from F1's and F2's to understand any issues they see with patients coming through CCC which may be dealt with elsewhere or may cause issues with discharges. Noted that in regards to intermediate care beds, community physician expertise needs to follow the patient as some patients in these beds require nursing input. Members discussed the pressure to discharge patents and examples were shared. Concerns were also expressed about the amount of GP time needed to care for patients in care homes so that they don't get re-admitted. In regards to the ward rounds, JK advised that SCE GPs no longer attend but senior officers are still involved. GP and consultant communication is still an issue. The CCG will engage with consultants on the 15 March to discuss key messages. JK reminded all members that **any areas of clinical concerns or patient harm need to be reported asap.**	**Locality Reps**
2.	**2016/17 Financial Plan & Commissioning Plan**	
2.1	*Financial Plan* KF presented the financial plan covering the allocation, cost pressures, investments and the QIPP. An in depth breakdown of the financial allocation and costs pressures was presented and discussed. KF also confirmed the following investments which have been proposed as priorities in the Commissioning Plan: 1- Mental Health Parity of Esteem 2- CAMHS 3- Seven Day Working 4- Hospice at Home 5- Case Management of Over 75's 6- Social Prescribing 7- Community Transformation 8- Primary Care Members were also informed of the current financial challenges and explained that conversations would be needed around achieving financial balance. **KF stressed to members that Rotherham CCG were in deficit and action is needed to change the situation.**	

	Following questions from members, KF confirmed the following: • Seven day working is a national requirement and Rotherham CCG were ahead of the game by identifying the requirement in 2014. • Growth next year will be a lot less. A line by line review will take place in June to explore where costs can be reduced and the impact assessed. • Detailed and lengthy discussions had taken place with SCE around clinical thresholds, 20 have currently been identified for review. As an organisation we need to consider what other CCGs have implemented and we need to ensure that current pathways are being implemented correctly. We will also need to understand if NHS 111, 999 and Care UK are all working in accordance with our pathways. • There has been an underspend on Case Management in 2015/16 but KF clarified that if there was further underspend next year then we would need to consider the funding elements moving forward. KF confirmed that the CCG would be in balance for 2015/16 but only due to non-recurrent benefits. IA stressed that given the financial position, there will be a strong emphasis on clinical thresholds over the coming months and that this piece of work will be fast paced. Members strongly felt that clear messages around the financial challenges and clinical thresholds need to be sent to patients. Noted that joint communications across Rotherham will be vital. *Commissioning Plan* 2.2 Noted that the draft version circulated was not for approval as some areas were still being developed. IA advised that the Health & Well Being Board have been consulted. LJ stressed that providers should not be seeking additional investments for services that should already be delivered or have already had investment to support. KF acknowledged that the financial landscape has changed following the recent allocations and that we need to preserve and protect the Rotherham system and that providers and commissioners will need to work in partnership to achieve this. Agreed that a comprehensive final version of the commissioning plan, which will include finances, will be received at March meeting for approval and recommendation to the Governing Body.	**IA**
3.	**Chair and Vice-Chair Reselection**	
3.1	7 out of 8 localities were represented at the meeting and therefore quorate.	
3.2	No locality rep was in attendance from Wath/Swinton.	
3.3	A vote was undertaken and there was a **unanimous decision from the 7 localities in regards to the following appointments:** **Chair Dr Geoff Avery** **Vice-Chair Dr Simon MacKeown**	
3.4	The changes will come into effect from 1 April 2016.	**LJ**
3.5	Agreed Dr Jacob would need to nominate a replacement representative for	

	Central 2 Locality, to commence from 1 April 2016.	
3.6	Agreed discussions would take place at April's meeting in regards to GPMC representation on the various CCG sub-committees.	*Fwd Agenda*
4.	**The Future of PLT**	
4.1	Members were updated on the recent vote of confidence and were informed that 3 practices had indicated they were not happy with the direction of travel from the CCG. LJ and JK will visit these practices to discuss their concerns	
4.2	A suggestion was made around PLT events to further improvement engagement between practices and the CCG.	
4.3	JK shared the following proposal with the committee: Move PLT to quarterly meetings and make them more focused on GP training Retain in-house PLT	
4.4	Members discussed the suggestion and a number of views were shared. • One of the key benefits of PLT was networking with other GPs • Highlighted that sometimes the quality of PLT is low • The current time commitments of a full half a day can have implications for practices. • The GP update event held on Saturday last year was better • Safeguarding Training of staff at PLT should remain	
4.5	It was felt that localities would be asked to discuss the proposals further including costs, quality, frequency and content.	
4.6	Agreed LJ and JK would discuss outside the meeting how responses could be obtained and would be discussed further at March meeting.	**LJ/JK** *Fwd Agenda*
5.	**Minutes of Previous Meeting & Matters Arising**	
5.1	Minutes dated 27 January 2016 were approved.	
5.2	**Matters Arising:** *5.2.1 Emergency Centre Contract and Governance* – (Item 4.6 in previous minutes). LJ emphasised the need of involving Primary Care from the beginning. *5.2.2) Rotherham Institute of Obesity* – (Item 7.1.1 in previous minutes). A further response had been obtained from Public Health following questions raised by the committee at January's meeting. The response included detailed explanations around surgery referrals. Members discussed access to Tier 3 and Tier 4 services noting that nationally, Tier 4 services may become a CCG responsibility in the future but this has yet to be confirmed however the CCG are investigating elements of specialized services. Members noted the unsatisfactory outcome but felt they had received up to date information on the situation and no further action would be required at this time. *5.2.3) School Nursing* – (Item 7.1.3 in previous minutes). Noted that Public Health have been invited to March meeting to provide an update on school nursing, health visiting and commissioning intentions for Public Health.	*Fwd Agenda*

	5.2.4) RDaSH Letter Templates – (Item 7.2 in previous minutes). RCu was asked to take forward the action around how GPs could input into the RDaSH templates based on the points provided at January's meeting.	**RCu**
	5.2.5) Adult ADHD – (Item 7.5.2 in previous minutes). IA clarified that the CAMHS transformation includes reviewing the ADHD element. Noted that the CCG have commissioned a limited ADHD adult service. Members also raised concerns around eating disorders and wished to understand how the funding element for this has been utilised. Agreed that IA would produce a summary of the services commissioned from RDaSH, including costs which will be discussed at April's meeting following contract agreement.	**IA** *Fwd Agenda*
5.3	**RDaSH Issues Log**	
	The log was accepted by members No issues were raised.	
	Members also wished to see the RDaSH log containing the same level of information at the TRFT log. This would be fed back to the contracting team that produced the document.	**CE/CR**
5.4	**TRFT Issues Log**	
	The log was accepted by members. No issues were raised.	
	In regards to the issue around CEA monitoring for Colorectal Surgery, RCu explained that this was a genuine mistake as the consultant was not aware that the process was different in Rotherham compared to Sheffield.	
	In regards to the issue around Gynaecology Pre-Op Clinics, it was noted that the pre-op assessment team were not working as it should be and that some appointments have been cancelled. Members were clear that a clear protocol was needed to ensure patients get back onto the waiting lists. JK advised that top tips for pre-ops had previously been produced but would liaise with Dr Birks and Dr Barmade about the feedback.	JK
	In regards to both logs, members wished to understand what the unresolved issues were and agreed that the full log of outstanding issues for both RDaSH and TRFT would be brought to the committee on a quarterly basis.	*Fwd Agenda*
5.5	**Locality Feedback:**	
	Enclosure 5.3 was noted and members elaborated on the following issues:	
	Contract for New Emergency Centre – locality stressed the importance of Primary Care having the correct level of involvements within the new structure.	
	Dermatology – It was felt that the criteria should be recirculated so that GPs understand what goes to Dr Bader and what goes elsewhere. Noted that the criteria around Melanoma is really restricted.	
	Removal of Deprivation Funds - JK explained that as part of the bucket proposal, deprivation will be taken into consideration and factored in. CE provided background to PMS premiums and explained that the quality indicators for years 2, 3, 4 will allow practices to earn premiums back through targets.	
	Phlebotomy Service Changes – JK explained that discussions are ongoing around phlebotomy services however the current usage of practice slots are only 50% utilised. Members fed back that patients are being turned away from Phlebotomy and that there are issues with patients under 16. JK agreed to	**JK**

	feed this back into the internal discussions.	
5.6	**Feedback from GPMC Members attending sub-committees** **5.6.1) Community Transformation** – No further meetings have taken place following last month's update. **5.6.2) Mental Health Transformation** - GA provided a verbal update following the last meeting: • The 18 week target for Dementia is on track. • The Dementia LES is being discussed at LMC on the 14 March. GA to provide an update at March meeting. • IAPT 6 week target is down. • RDaSH have a 2% financial increase but have a £4m efficiency challenge in 2016/17 **5.6.3) System Resilience Group** TD provided a verbal update following the last meeting: • YAS 8min red one alters remain at 67% against the 75% target. This is an ongoing issue. • TRFT have implemented escalation software to identify red alerts during busy periods. • Noted that community staff get diverted to the hospital during high risk periods to help support discharges. • Feedback received in regards to winter pressures money and practices unable to recruit. KF explained that there was some funding provided nationally two years ago which the CCG had added to because the actual amount received was less than that published, this was used for various pilots and was detailed in the 2015/16 Commissioning Plan. KF was under the impression that the funding and recruitment was complete but agreed to review. • The CCG are currently reviewing what the Sheffield model for discharge to assess involves. Noted that availability of community services is key. **5.6.4) AQUA** – No update received.	**GA** **KF**
6.	**Feedback from Key Issues Discussed at CCG Governing Body**	
6.1	The main issues discussed at the last Governing Body meeting had been discussed at previous GPMC meetings. Copies of Governing Body papers and minutes can be accessed via the CCG website www.rotherhamccg.nhs.uk/governing-body-papers.	
6.2	LJ highlighted the following key discussions: 1- CAMHS and IAPT waiting times. A contract performance notice has been issued for IAPT. 2- TRFT lost monies on the CQUIN which was mainly linked to coding issues. 3- Patient Safety and Quality reports, all practices have received information on female genital mutilation.	
6.3	*February Chief Officers Report*. Received and noted for information, no issues were raised. CE highlighted the information on the recent vote of confidence: *In accordance with the CCG's constitution, Rotherham CCG undertakes a vote of confidence from its member's each year. Two questions were asked:* *1. Do you have confidence in the executive teams of the CCG? 97% - 33 out of 34 practices said 'Yes'.*	

	2. *Do you have confidence in the direction of travel? 91% - 31 out of 34 practices said 'Yes'*	
7.	**Feedback of Key Issues Discussed at Strategic CE**	
5.1	JK updated members on the following areas: • *SCE Development* – JK explained that a month of development has been scheduled for the SCE GPs to help understand if clinical direction and leadership is being demonstrated. • *LMC* – Noted that relationship between the CCG and LMC are positive and healthy, detailed discussions are taking place around various key areas.	
8.	**Practice Managers Feedback**	
8.1	BW advised that the last meeting had discussed the following: • *Telephony* – Practice managers felt that the upgrade of the telephony systems was not a good use of funding. • *Safeguarding* – Practice managers were not happy with the response received from the CCG in regards to workloads associated with Safeguarding. • *Care Homes* – Work is progressing.	
8.2	Noted that a formal letter has been sent to both JK and CE regarding these issues and the Practice Managers concerns.	
8.3	BW / LH agreed to review and consider the form and function of the Practice Managers forum and whether any changes / improvements are needed.	**BW/LH**
9.	**Items for Information**	
9.1	*Minutes of System Resilience Group 06.01.16 -* Received and noted for information.	
9.2	*2016/17 Commissioning LIS* – NP queried the status of next year's information. Members were informed that the finances for next year are still unclear and discussions are still ongoing with LMC. Members felt the lack of information and communication to practices was a concern, CE agreed to review and provide an update on the position at March meeting.	**CE** *Fwd Agenda*
	Next Meeting Wed 30 Mar (G.05 Birch, Oak House) • Agenda Items Deadline – Close of Play Wed 16 Mar • Paper Deadline – Lunchtime Wed 23 Mar	