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NHS Rotherham Clinical Commissioning Group

Minutes	**Title of Meeting**:	**GP Members Committee (GPMC)**
	Time:	**12.30 to 15.30**
	Date:	**Wednesday 28 October 2015**
	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 – Items 1,2 & 3	Health Village
Dr Sophie Holden (SH), Market Surgery	Wath/Swinton
Dr Tim Douglas (TD) Dinnington Group Practice	Rother Valley South
Dr Bipin Chandran (BC) Treeton Medical Centre	Rother Valley North
Dr Naresh Patel (NP) Broom Lane Medical Centre	Central North
Dr Srini Vasan (SV) York Road Surgery	Wentworth South
Dr Susan Jespersen (SJ) Wickersley Health Centre - *Deputy*	Maltby/Wickersley

LMC Representative

Dr Gokul Muthoo, LMC Representative	LMC

Apologies

Dr Geoff Avery (GA) Blyth Road	Maltby/Wickersley
Keely Firth (KF) Chief Finance Officer	CCG
Barry Wiles (BW) Maltby Service Centre/Clifton MC	Practice Managers' Rep

In Attendance:

Dr Julie Kitlowski (JK) Chair Rotherham SCE	SCE
Lynn Hazeltine (LH) York Road Surgery	Practice Managers' Rep
Chris Edwards (CE) Chief Officer	CCG
Ian Atkinson (IA) Deputy Chief Officer	CCG
Cheryl Rollinson (SR) Secretariat	CCG
Dr Phil Birks (PB) SCE GP Lead *Item 2 Only*	CCG

No.	Item	Action
	Declarations of Pecuniary or Non-Pecuniary Interests Drs Chandran, Douglas, Holden, Jacob, Jespersen, Kitlowski, MacKeown, Patel, Vasan and Muthoo 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. **Item 3 –** Specific conflict of interest noted for all GPs present as providers **Item 6.4** – Specific conflict of interest noted for all GPs present as providers	
1.	**Health & Well Being Strategy**	
1.1	Noted that the content of the strategy had been discussed in detail last month whereby the Director of Public Health was present. JK reported on the high level priorities which are emerging.	
1.2	**Health & Well Being Board** – Noted that this is developing well and Rotherham are on level with other areas in regards to co-chairing and having a joint board.	
1.3	**Delivery of Strategy** – This is a concern as Public Health budgets are being restricted. Work around prevention is a particular concern and whether or not the CCG can contribute. Obvious areas include sexual health, drugs & alcohol and smoking cessation. A main concern is around delivery of services to patients and patient choice.	

1.4	**Priorities** – Difficult to identify if the focus should be around big picture or more targeted work in deprived areas.	
1.5	**Drugs & Alcohol Services** – Noted that there is a public consultation on the proposed changes, the CCG are preparing a general response as well as a specific response on services. **All members were asked to provide their views on the strategy and priorities to JK by the end of W/c 02.11.15**	**Locality Reps**
1.6	Members questioned if CASH had been taken over by GUM. JK clarified that there are ongoing conversations around funding Mirena for heavy menstrual bleeding. Noted that both services are located in the same area at the hospital, however the services are both commissioned differently.	
1.7	NP expressed particular concerns around Health Visiting, which were raised last month, and questioned what actions are being taken. If services are being withdrawn, can they be considered as part of next year's PMS premium indicators? JK confirmed that as yet the impacts of any changes have yet to be determined.	
1.8	Following these discussions, members felt that overall the strategy was positive and right for patients whilst acknowledging there is a challenge in regards to delivery and implementation. The strategy will inform the CCGs commissioning plan as well as Public Health intentions. Noted that the Health & Well Being Board is the body which would be held accountable for delivery of the strategy.	
1.9	It was **agreed that the concerns and queries** around health visiting, sexual health, drugs & alcohol and smoking cessation would be raised for examination and clarification as follows: 1- Monthly CCG & Public Health Liaison Meeting 2- The Public Consultation 3- Health & Well Being Board	**JK/CE**
2.	**Community Transformation**	
2.1	Dr Birks (PB) attended the meeting to discuss this item. Members were informed that the Community Transformation Meeting is now bi-monthly and the next meeting is scheduled W/c 02.11.15.	
2.2	From the report received, PB identified the following key messages: • Unscheduled admissions for over 65's are reducing • There has been a reduction in long stay patients. SCE are now participating in ward rounds and the CCG have commissioned the safer care bundle which includes twice daily ward rounds. Attendance is dictated and includes social workers. SCE are holding the Trust to account, they observe how functional the ward rounds and are learning where blocks occur.	
2.3	**District Nursing** - Members discussed the single point of access for district nursing and felt that further clarification and communications are needed to confirm that GP practices can still use the normal previous methods to contact District Nurses as well as using the single point of access. **Agreed PB would raise this at next week's meeting to ensure this is clarified and communicated**. LJ suggested a letter should be sent to all GPs, Practice Managers, Practice Nurses and copied to District Nurses to clarify policy and process.	**Locality Reps** **PB** **PB/JK**
2.4	**Bed Closures** - All members present had particular concerns around the proposals for reducing non elective beds and felt that a proactive approach was needed for the winter period. Members discussed examples of bed waits and	

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	patients being discharged early and then seeking a home visit from GP. Members were unclear if this was related to the lack of beds but strongly felt that whatever the underlying issue is, it cannot increase the workload in Primary Care.	
2.5	Following discussions, members felt that this issue with beds was a contractual one which needed addressing and as a committee they could not support further bed closures at this time of year**. Agreed PB would discuss these issues with Dominic Blaydon.**	**PB**
2.6	**Communications** – SM raised concerns about the increase in the number of follow up letters relating to medication and tests. PB assured members that the contracting team is aware and that this is being investigated. LJ reported that Dermatology is also not accepting referrals from the Tissue Viability Nurses but the Cardiovascular department is. PB agreed to review this with the Contracting Team.	**PB**
2.7	NP requested a plan of action regarding the priorities set out in the report to include timescales and responsibilities. It was felt this should be reported to GPMC.	
3.	**Assessment of Primary Care Capacity** **Conflict of interest noted for all GPs as providers – No decisions made, only agreement on the process around how further discussions should be taken forward**	
3.1	Members were informed that a number of discussions have taken place between the CCG and LMC in order to address resource and capacity issues needed to meet the CCGs strategic direction.	
3.2	A survey monkey has been sent to all GPs to gain their views.	
3.3	A further discussion between GPs, the CCG and LMC has been scheduled after PLT on the 12 November. Noted that these discussions will be challenging, however a consensus is needed in regards to how the CCG proceed with meeting the Commissioning Plan.	
3.4	Noted that the direction of travel (as previously supported by GPs) is that where appropriate secondary care would transfer to primary care. However following the feedback received of late, there is a concern that Primary Care may not have the capacity and resources to support this direction of travel anymore and therefore the discussion on the 12th November has been arranged.	
3.5	As a CCG, we need to clarify and confirm how our plan will be delivered moving forward i.e. via Primary Care or alternative providers.	
3.6	Members undertook detailed discussions and each locality representative were provided with the opportunity to share their views and feedback. Following deliberations, it was apparent that there was a 50/50 split around how the work should be managed.	
3.7	**As a committee, members agreed the following principles** in anticipation of wider discussions on the 12 November: 1) The committee supported the CCG commissioning plan proposals to continue transferring work from secondary to primary care through the use of LES's as a strategy 2) A as committee, they felt that if there are resources (i.e. appropriate finances) to accompany the transfer of care then the issues of capacity	

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	can be sorted i.e. through recruitment and the use of different staffing models 3) If there is no capacity, the committee were still in favor of the idea of transferring work from secondary to primary care but look to the LLP or other practices to meet the need 4) The process of organising LES's needs to be transparent and GP input should be from the beginning to ensure incentives are relevant to the expected workload **LJ to convey the unanimous opinion of the GPMC in the 12th November meeting**	**LJ**
3.8	It was felt that one of the main fundamental issues that needed to be explored is to confirm what is meant by 'core work'.	
4.	**2016-17 Commissioning Plan – Feedback on Locality Consultation**	
4.1	IA confirmed that in regards to process, all localities had been consulted on the plan and the CCG had also attended Scrutiny. Feedback is expected from other stakeholders over the next few week.	
4.2	IA verbally reported on the common themes from the 6 priorities following locality consultation. **1- Joint Commissioning with RMBC** • There is common agreement in regards to the direction of travel. • The overall strategic plan and individual plans on priority areas will be feedback to GPMC in due course. **2- Children's** • Strong messages are coming through is regards to accessing CAMHS. • When referring into the single point of access, GPs expect for patients to either be seen or referred on. Bounce backs are not helpful to patients. • Other feedback included the CCG providing clarity on children's pathways and the importance of bed availability in pediatrics. **3- CSE** • All localities supported the direction of travel and positive feedback had been received in regards to MASH. • Suggestions had been made about developing the information from MASH and that training on safeguarding needs to be more practice specific. **4- Hospital** • In regards to the CCC, all localities except one supported that direction of enhanced pathways. • On the whole feedback had been positive for the CCC. • There had been strong messages regarding community nursing and access and in regards to IT/Interoperability, there were strong feelings that this has been attempted many times. **5- Primary Care** • Strong messages around capacity being a concern • Self-care and patient education appears to be a priority • Feedback had been received around making Rotherham a more attractive place to work, suggestions on how this can be achieved is welcomed but it is a priority in the strategy. **6- Mental Health**	

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	• 2 localities had the perception of long waiting times and patients being bounced around pathways. • Despite being in services, some patients end up coming back to practices. • IAPT access and waiting times is a priority • Strong messages in regards to the CAMHS transformation and supporting parents in behavior management.	
4.3	In regards to mental health waiting times, SJ suggested the use of key worker for those patients who DNA and then come back to practice. If a key worker is assigned that they can work with the patient leading up to their appointment so that they don't DNA. IA clarified that pathways and improving access is a key work stream and would consider the suggestion.	
4.4	NP questioned the financial planning aspect and what actions are being taken to address any overspend. CE clarified that financial allocations are expected in December and that work is needed to understand the risks from in year pressures. The CCG does have a 1% contingency to cover any unexpected overspend but any overspend identified in year will be reviewed by the relevant committee (CRMC, Mental Health QIPP, Medicine Management) and they will be responsible for considering actions for mitigation.	
4.5	The financial plan will be received for approval by GPMC in March 2016. Worst case scenarios was discussed last year, however if GPMC feel that the financial plan does not meet their expectations that the scenarios can be revisited. More constructive discussions can take place once financial allocations have been confirmed.	
4.6	GM questioned why CSE was a separate priority. CE clarified that the CCG have an obligation to provide health services to victims (i.e. post abuse counselling, training of staff). IA also explained that some patients may already be in the system and these plans will further support them.	
4.7	BC questioned as what does efficient become dangerous for patients. JK felt that further work could be done to reduce duplications and bouncing around pathways which will support the efficiency agenda without causing harm. Members were also assured that the Cost Improvement Programmes of both main providers are reviewed regularly by the CCG and the CCGs Chief Nurse is heavily involved in the process.	
4.8	IA welcomed any further comments and suggestions from members and the wider GP population over the next few weeks.	
5.	**Minutes of Previous Meeting & Matters Arising** Minutes dated 30 September 2015 were approved.	
5.1	**Matters Arising:**	
	5.1.1) Health & Well Being Strategy – (Item 2 in previous minutes). Members requested a written update next month from Terri Roche on the suggestions and comments made at Septembers meeting.	**CR**
	5.1.2) Gastroenterology – (Item 6.4.1 in previous minutes). Members requested an update on the recruitment processes following changes in this department. **IA agreed to obtain feedback on the specific questions posed**: a) Who will be replacing Dr Hoeroldt b) Who do GPs refer to for Hepatology work c) Who is responsible for ERCP (Endoscopic Retrograde Cholangio Pancreatoscopy) work	**IA**

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	d) Members also sought assurance around GI bleeds. Is it medical or surgical gastro?	
	5.1.3) Rheumatology – (New Item). SV reported concerns around who to contact in this department.	
5.2	**RDaSH Issues Log**	
	The log was accepted by members. The following comments were noted:	
	IAPT – LJ verbally advised that he had noticed that waiting times for Mental Health referrals to CBT had reduced however there is still a concern that there are variations across localities. **Agreed this feedback would be shared with Dr Brynes and the contracting team.**	**CR**
5.3	**TRFT Issues Log**	
	The log was accepted by members. The following comments were noted:	
	District Nurses – NP reported that at locality level, they had agreed with their Band 7 clinical lead that they would carry out annual COPD/Diabetic reviewed on housebound patients under their care but this isn't happening. NP still felt strongly that a standard template of the job roles would be beneficial to ensure all localities received the same service. **JK agreed to review this with Dominic Blaydon.**	**JK**
	District Nurses – Members still expressed concerns that geography distribution needs to be reviewed as it was felt that some District Nurses are undertaking too much mileage in order to manage patients. **Agreed this feedback would be shared with Dominic Blaydon.**	**CR**
	Emergency Centre – Responses to three issues on the log were still outstanding, as yet localities had not received a response. **Agreed CR would follow up.**	**CR**
5.4	**Locality Feedback:**	
	Enclosure 5.3 was noted and members acknowledged that responses would be provided in next month's issue logs.	
5.5	**Feedback from GPMC Members attending sub-committees**	
	Community Transformation – No issues to report. SMc had not attended the last meeting, the next meeting is schedule W/c 02.11.15. Noted that these meetings are now bi-monthly.	
	Mental Health Transformation – No issues to report. GA had submitted apologies to the last meeting and was not present today to provide any further updates.	
	System Resilience Group – LJ advised that GPMC representation on this group was being reviewed due to implications of practice commitments. **Agreed that the last set of minutes would be circulated to members to consider if they wish to be the representative for GPMC, individuals to contact LJ by Monday next week.**	**Locality Reps**
	AQuA - No issues to report as these are bi-monthly meetings and there hadn't been one this month.	

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	LJ expressed his expectations that as of next month, GPMC representative on the above groups should prepare to provide a verbal summary of the meeting they last attended.	**Locality Reps**
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 gave a high level overview of what had been discussed at the last meeting: • CCG us contributing to CSE drama workshops taking place in schools over the next two years • RCu is now the SCE lead for CAMHS as it links with joint working with the Local Authority • Merger of Brinsworth and Surgery of Light • CAMHS Transformation Plan • Hyper acute stroke units • Prescribing management and overspend • Q2 A&E waiting time targets • 18 week waits for referral to treatments – at 95.7% • IAPT Waiting times	
6.3	*October Chief Officers Report*. Received and noted for information, no issues were raised. Members agreed for **Healthwatch to be invited to a future meeting** to discuss their role and what additional work they are doing for the CCG in regards to patient engagement.	**CE**
6.4	*Minutes of Primary Care Sub-Committee 19.08.15.* Received and noted for information, any queries or feedback can be sent to Jacqui Tuffnell. **Conflict of interest noted for all GPs as providers – No decisions made, comments and feedback only ** Members queried the draft performance dashboard mentioned in the minutes. LJ confirmed that the dashboard is a central collation of all the existing information that is used to compare practices i.e referral data, QoF points, achievements in different areas of work. Noted that the Primary Care Sub-Committee is considering the dashboards use for annual visits and assessments but this has yet to be finalised. RCu confirmed that all the data will also be available on RAIDR when accessible. NP questioned if concerns and suggestions raised at annual visits will be fed into the sub-committee. Noted that Dr Page is the lead for this area, he attends the visits and as part of his role will feedback any concerns and suggestions to either the Primary Care team or the sub-committee, whichever is more appropriate. Members raised concerns around the closure of Chantry Bridge and the impact om other practices. CE explained that the process had been inherited but **agreed to the principle of early communications with practices should a similar situation arise now the CCG has delegated responsibility.**	**CE**

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7. 7.1	**Feedback of Key Issues Discussed at Strategic CE** JK updated members on the following areas: • Council Culture of Working – noted this is still a challenge but SCE colleagues are working with the Local Authority. • Prescribing Overspend – Noted that this is relation to generics being more expensive than branded products. • GP & Consultant workloads – A letter is expected from Conrad Wareham in regards to consultant workloads and what should and shouldn't be directed back to GPs. • Ward Rounds – Noted that these start today; **members requested an update on what SCE GPs are observing.**	**JK**
8.	**Practice Managers Feedback** Summary of the last Practice Managers Forum were received for information.	
9.	**Items for Information** No items to note.	
10.	**Any Other Business** *GPMC Annual Report* – Members agreed an extension for the 2014/15 annual report would be submitted in November. *Winter Plan* – Noted that this is reported via the System Resilience Group (SRG), CE confirmed that there were no new monies for consideration.	**LJ**
	Next Meeting Wed 25 Oct 2015 12:30-15:30 (G.04 Elm, Oak House) • Agenda Items Deadline – Close of Play Wed 11 Nov • Paper Deadline – Lunchtime Wed 18 Nov	

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