Agreed at Meeting
25.05.16

NHS
Rotherham
Clinical Commissioning Group

Minutes	**Title of Meeting**:	**GP Members Committee (GPMC)**
	Time:	**12.30 to 15.30**
	Date:	**Wednesday 27 April 2016**
	Venue:	**G.04 Elm Oak House**
	Chairman:	**Dr Geoff Avery**

Members or deputies Present:

Dr Subbannan Sukumar (SS) High Street Surgery	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 Sophie Holden (SH), Market Surgery	Wath/Swinton
Dr Srini Vasan (SV) York Road Surgery	Wentworth South
Dr Bipin Chandran (BC) Treeton Medical Centre	Rother Valley North

LMC Representative

Dr Gokul Muthoo, LMC Representative	LMC

Apologies

None to Note

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
Kate Tufnell (KT) Head of Mental Health Contracting *Item 2 Only*	CCG
Dr Russell Brynes (RB) SCE GP Lead *Item 2 Only*	SCE
Giles Ratcliffe (GR) Consultant in Public Health *Item 3 Only*	Central 2

No.	Item	Action
Declarations of Pecuniary or Non-Pecuniary Interests Drs Avery, Chandran, Cullen, Douglas, Holden, Kitlowski, MacKeown, Muthoo, Patel, Sukumar and Vasan had an (indirect) interest in most items. Dr MacKeown has a particular interest in items relating to Rotherham Hospice as he is employed by them.		
1.	**Financial Plan Update**	
1.1	KF explained that following the recommendation made by GPMC last month, Governing Body discussed the financial plan in Public at the April meeting whereby the plan was rejected as the risks around the £4m for the Emergency Centre were unclear therefore an extraordinary Governing Body meeting was held 13 April where a revised plan was approved.	
1.2	The CCG have undertaken a number of meetings to discuss options with NHS England and it was acknowledged that to stop building the Emergency Centre was not an option.	
1.3	KF reported that the position for 2016/17 is extremely challenging if the CCG is to deliver the planning objectives and the obligated recurrent requirement of 1% headroom, a 1% operating surplus and 0.5% contingency.	

1.4	There are risks to achieving financial balance in 2016/17 particularly around the contract with the Trust. Whilst the efficiency intentions are logical and clinically justified, the pace at which both the CCG and the Trust are able to reduce costs at the required levels will remain a challenge.	
1.5	The approach to the 2017/18 plan is underway in order to ensure that a robust strategy for the sustainability of the local health system can be achieved.	
1.6	The report sets out the QIPP assumptions for the forthcoming years and the detailed breakdown surrounding these QIPP areas will be going to Governing Body in May.	
1.7	KF highlighted the range of risks as detailed in the paper and confirmed that there are no reserves to access if there are problems in year. The approach to mitigate this risk will be a further review of each line of expenditure with the appropriate challenge regarding continuing the investment.	
1.8	Following questions from members around the operating surplus, KF confirmed that in previous years this had been 'banked' for CCGs to draw down at a later date however this year, due to changes in the national rules, we cannot currently draw down this money.	
1.9	Members felt strongly that the changes to the financial rules significantly penalises CCGs who are working efficiently and is an unfair system. Members felt it was unacceptable and demoralising. KF assured members that these messages have been fed back to NHS England on multiple occasions.	
1.10	KF confirmed that the current plan ensures that the CCG are no longer viewed as in deficit and would not place within the regime for CCG's failing to achieve the business rules.	
1.11	JK explained how the Trust Development Agency and Monitor are merging to become NHS Improvement which will be a positive step forward.	
1.12	Following a question from Dr Muthoo, CE explained the 5 year forward view and confirmed that 44 areas have been identified for the Sustainability and Transformation Plans. Rotherham CCG is part of the South Yorkshire & Bassetlaw footprint and the plan needs to be produced by the end of June.	
1.13	**GP Members noted the amended proposal, acknowledged the challenges and risks inherent within the plan and approved the recommendation that the Governing Body approve the plan on 4 May 2016.**	
2.	**RDaSH Contracting Update**	
2.1	Dr Russell Brynes & Kate Tuffnell attended the meeting to provide an update on the outcome of the 2016/17 Mental Health and Learning Disability contract negotiations.	
2.2	KT explained that as part of the 2016/17 contracting round, the CCG has agreed a one year contract with RDASH using the NHS Standard contract. The value of the Rotherham element of this for 2016/17 excluding CQUIN is £29,790,888 (£2,511,438 for the delivery of Learning Disability services and £27,279,450 for the delivery of Mental Health services).	
2.3	During discussions KT clarified that in regards to eating disorders; £145k was additional money from NHS England provided as part of the CAMHS transformation, this will be used to develop the 0-19 CAMHS eating disorders service through a prevention and treatment model. Discussions will be needed	

	with all services around how the pathway could be better aligned.	
2.4	NP felt it would be helpful if GPs could receive a short briefing of all services available and how they can be accessed. RB explained that a top tips document is being considered for GPs.	
2.5	In regards to the Learning Disability service, a quality visit is being arranged and RB is also arranging to meet with the Learning Disability consultant. KT also explained that we have seen a shift in activity from the hospital and into the community. For 2016-17 the Eligibity Criteria has changed for LD services from an I.Q of 50 to an I.Q of 70, this will mean that additional numbers of people may access the service.	
2.6	In regards to intervention in psychosis, a new national target has been set whereby when people are diagnosed, they should receive access to treatment within a few weeks. Initially this has been a discreet team within the service who used to see 14-35 years old but again the criteria has now changed. **KT agreed to share this information with all GPs.**	**KT / IA**
2.7	RB clarified that the Community Mental Health Team for Older People will see patients if they are referred by fax rather than telephone. Members felt that this team was integral to the success of the Dementia LES and access arrangements need to be agreed.	
2.8	Members questioned if RDaSH would be able to deliver the outcomes expected, it was noted that the CCG are working closely with them but the new structure does involve having a more Rotherham focus.	
2.9	IA explained that in terms of challenges, the QIPP savings will be important to sustaining the provision of care. Discussions are underway with RDaSH.	
2.10	KT clarified that an associate contract relates to cross boundary activity and explained that if anyone from Rotherham wished to access cross boundary services because they were closer to home, than we are responsible for paying for that activity. IA explained that the contracts are based around year on year activity which is analysed and profiled.	
2.11	Members were informed that work will be taking place this year to look at how autism services can be enhanced for diagnosis. Once a diagnosis is obtained, treatment is received from Social Care however clinical care and peer support is provided. NP felt that support for families was lacking, **KT explained about the parent forum and agreed to share details on how this can be accessed.**	**KT / IA**
2.12	KF confirmed that the Mental Health Payment by Results workstream will be underway this year, updates will be provided as and when information is available.	
2.13	Members received an update and assurances regarding a high cost Learning Disability Placement. **It was agreed that confidential information would be redacted from the paper circulated with the agenda and resent so that members could discuss the high level contract elements in localities.**	**KT / IA**
2.14	Following discussions, GPMC noted the outcomes of the 2016/17 Mental Health and Learning Disabilities contract negotiations. Members felt that the update provided a useful breakdown of the various Mental Health contracts and the funding associated with each.	
3.	**Update on Public Health Commissioning Intentions**	
3.1	Giles Ratcliffe, Consultant in Public Health attended the meeting to discuss the update paper around the 0-19 integrated child health services.	

3.2	GR explained that over the past 18 months commissioning responsibility for the 0-19 child health programme (including school nursing, health visiting, allied services and specific porgramme i,e Breast Feeding) has transferred to Public Health in the local authority.	
3.3	Majority of these services are currently contracted from the Trust but all the services are managed individually. In line with local authority policy these services are required to go out to tender and Public Health are currently looking at integrating all services into a single specification and tender	
3.4	GR explained that the Public Health Grant has also been reduced by over £1,300,000 per year for 2016/17 and by a further amount of over £400,000 in 2017/18 which will impact upon future commissioning.	
3.5	The tender is due to go out in May, with a view to providing notification of the new provider in Sept / Oct. Services will commence with the new provider from April 2017.	
3.6	GR stressed that one of his concerns is the Vaccination & Immunisations element as this contract is still currently managed by NHS England. It is unclear at present if the current contract will continue as it is, so this element would have to be reviewed after the tender process is complete.	
3.7	Noted that the CCG has been consulted and feedback has been provided around technical aspects, including the service specifications.	
3.8	GR welcomed any feedback from GPs which could be used to inform the tender process. The following feedback was noted: 1- Not enough school nurses available in schools 2- School Nurses no longer undertake hearing tests for children 3- Mobile technology and multi-media maybe options for consideration as ways of improving access to the services 4- Feelings around increased GP workload and duplication may become apparent 5- GPs need to know the responsibilities of School Nurses and how to access them 6- Consider how communications between GPs and both school nurses and health visiting as relationships are poor 7- GPs need to understand how Primary Care will be expected to link in with services 8- No engagement between Primary Care and Public Health in general, dialogue needs to be improved as Primary Care are only receiving a monthly email bulletin 9- The changes will lead to a contract which is not fair or like for like	
3.9	GR advised that in terms of staffing levels, the tender only sets out the expectations, anticipated outcomes and costs. The specification does not set out the required level of staff as it is up to the service how they meet the specification. In reality there are fewer staff available but through the tender, Public Health wish to encourage innovation. Noted that as the budget is less, providers may struggle to expand their staffing levels unless there are existing gaps that could be filled such as vacant posts.	
3.10	GR explained that an integrated contract will ensure that all services are provided by the same people which should break down any barriers when children go through the 0-19 pathway.	
3.11	Noted that the Memorandum of Understanding (MOU) between the CCG and	

	Public Health is being reviewed.	
3.12	**CE agreed to discuss with Public Health how to increase their profile with Primary Care.**	**CE**
3.13	**Following these discussions, GR advised that the feedback received would be reflected upon and consideration around what needs to be included in the tender will take place.**	
3.14	GR was thanked for attending today's meeting and members extended an invite for GR to return to GPMC to provide further updates as and when required.	
4.	**2016/17 Commissioning LIS / PLT Review**	
4.1	JK explained that the pressure of increasing workloads in primary care has been flagged up to the CCG on numerous occasions by member practices and as there are also significant financial pressures, there is a need to make efficiencies across all areas.	
4.2	JK explained the reasons as to why the frequency of the PLT / Commissioning events were being review and highlighted the preferred option of changing these events to 4x ALL GP events instead of 6 external PLT and 2 Commissioning events a year.	
4.3	JK also highlighted the preferred option in regards to the 2016/17 LIS whereby the proposal would be to fund the closure of the practice instead of a GP to attend commissioning events so that all GPs could attend, Practice Manager Commissioning events would become part of the 'ALL GP' events and provide audit monies for completion of the two audits only.	
4.4	The following feedback had been noted by SCE: 1- Potential loss of income to practices 2- Questioned whether the changes would reduce GP workload 3- PLT is used to deliver key messages and information related to commissioning areas and questioned if this would affect the delivery of the commissioning plan 4- Concerns that Rotherham would lose GPs by not providing education 5- Agreed that all GPs should be involved in Commissioning events 6- Agreed with reducing the number of LIS audits	
4.5	Feedback was welcomed from members whereby a mixed view was expressed in regards to changing the frequency of events: 1- Members felt that there was a good intention to reduce money and refocus officer time 2- Catering at the events were questioned as the money could be used elsewhere 3- GP Update event worked well in terms of clinical training but is different from PLT 4- Some members questioned that as a commissioning organisation, should we be focusing on GP education 5- In order to achieve commissioning objectives, a forum was needed where GPs and consultants could engage 6- Noted that not all GPs interact when attending these events, attendance is used for PDP points 7- Suggested using technology as a means of delivering education 8- Members suggested considering 4 all GP events a year rather than 6 and making them longer.	

4.6	Overall members felt that careful management of these processes is needed and all members need to be involved in the decision making process.	
4.7	In regards to the audits, it was noted that time needed to undertake these were an issue and in fact there are no audits which would add value to the CCG. Any recurrent money not used would be an efficiency saving.	
4.8	KF confirmed that there is growth in the plan for Primary Care and that there is a national uplift which is being discussed via the Primary Care Sub-committee.	
4.9	**Following discussions, it was agreed JK would arrange for a survey monkey to be sent to all GPs to seek feedback on the options around audits and events.**	**JK**
5.	**IT Update**	
5.1	Following discussions around the MIG / Portal for data sharing last month, RCu explained that the portal will coordinate information from different clinical systems into one location, including hospital date which is richly available.	
5.2	This information would support case management but as the portal expands more patients will be included. Hospital doctors will also be able to view out patients lists and relevant medication / medical concerns.	
5.3	Noted that the portal also has a results tracker.	
5.4	RCu advised that there are a few practices that won't be able to sign up to access the portal at present as HCIC approval is awaited in regards to servers being able to 'talk' to each other.	
5.5	**Noted that the process on how to access the portal had been sent to practice managers however it was acknowledged that further communications may be needed. Agreed RCu would ask Wendy Lawrence to resend the information to practices.**	**RCu**
5.6	In regards to the GP laptops, an evaluation process is underway to identify when and where laptops are being used.	
6.	**Review of GPMC Representation on CCG Committees**	
6.4	Members reviewed GPMC representation on key CCG committees and agreed the following would remain: Community Transformation Community – Simon MacKeown System Resilience Group – Tim Douglas Audit, Quality and Assurance Committee – Sophie Holden IT Strategy Group – Simon MacKeown	
6.2	In regards to representation on the Local Enhanced Services Task & Finish Group, this is an ad hoc meeting and representation is based on availability at the time and is only required when a LES is being developed.	
6.3	**Members discussed representation on the Mental Health QIPP meeting as GA no longer had capacity to attend since moving into his role as GPMC chair. There were no GPMC volunteers therefore it was agreed CE/IA would consider options on how GP representation could be sought from the wider GP community.**	**CE/IA**
7.	**Minutes of Previous Meeting & Matters Arising**	

7.1	Minutes dated 30 March 2016 were approved.	
7.2	**Matters Arising:**	
	7.2.1 Communication of Key Messages to GP Members and Public – (Item 3.5 in previous minutes). CE confirmed that key messages are being prepared but are not yet finalised.	
	7.2.2 Community Transformation – (Item 7.6 in previous minutes). GA advised that he had received the paper on how the pilot locality had been selected. He assured members that the process had been robust and agreed the paper would be added to next month's meeting for information.	**GA** *Fwd Agenda*
	7.2.3) Blood Testing – (Item 8.5 in previous minutes). JK reported that when the Trust had been challenged on the process and the impact on potassium levels, they have advised that there have been no changes. Noted that SV has written to the lab on multiple occasions and reported that they cannot provide information out of hours as they don't have access to clinical records. **SV agreed to share with JK all communications and his log.**	**SV**
	Members noted from the TRFT issues log that the delay in bloods being analysed has already been raised by Dr Clitherow on behalf of the CCG with Dr Lord (TRFT) and a discussion is to be held at the next Laboratory Committee in regarding to contacting GPs when potassium levels exceed 6.0 rather than 6.5 which is the recent change in guidance that the Trust is following. Dr Clitherow will report back after resolution has been agreed	
7.3	**RDaSH Issues Log**	
	The log was accepted by members. No issues were raised.	
7.4	**TRFT Issues Log**	
	The log was accepted by members.	
	In regards to the MSK Service, SS explained that on Choose & Book there are two options. There is a slight difference and if the option is selected whereby the patient is referred for general physio, then the referral will come back to GPs rather than the service referring the patient on to the MSK service**. JK agreed to clarify if this process was correct.**	**JK**
7.5	**Locality Feedback:**	
	Enclosure 7.3 was noted and members elaborated on the following issues:	
	IAPT Guidelines / Referral Process – Notes that the number of forms to be completed has increased. Concerns raised that not all GPs present were aware of the forms. A response will be provided at next month's meeting.	
	Phlebotomy Service – Concerns that patient choice is compromised and that patients are instructed to see their GP. Noted that the clinician who orders the tests is responsible for the results. A response will be provided at next month's meeting. SV also raised concerns around tests requested by Community Midwives as GPs are not aware if the midwives are reviewing the results.	
	Palliative Care Nurses – SS explained how a GP had been contacted by the private community team twice in a week, seeking advice. JK explained that the perfect locality pilot will identify exactly what roles and responsibilities are needed in the community.	

	Two Week Wait Patient Referral – JK stressed that if there are clinical risks than these need to be raised asap via the issues log.	
7.6	**Feedback from GPMC Members attending sub-committees** **7.6.1) Practice Managers Forum –** BW highlighted that practice managers to feel PLT is important for mandatory training. Noted that a separate discussion had taken place around the future of practice manager forums and the CCG are reviewing how these can be consolidated into the 'All GP' events. In regards to medical records, SM reported that when practices are receiving large print outs from other practices, clinical information can be lost or hidden. Noted that this is an NHS England responsibility and agreed **GA would raise at the next Primary Care Sub-Committee as an NHS England representative attends.** **7.6.2) Community Transformation** – No meeting until next week. **7.6.3) Mental Health Transformation** - IA provided a verbal update following the last meeting: • A paper will be coming to GPMC in 2 months' time around CAMHS transformation and performance • The QIPP savings work is key • The Dementia LES is progressing, there are now 24 practices signed up. **7.6.4) System Resilience Group** - TD provided a verbal update following the last two meeting: • Received an update today on the community transformation and information on the perfect locality pilot which is due to commence on 1st July 2016. TG did raise GPMC concerns from last month. Noted that it was important that Dominic Blaydon attends localities as soon as possible to obtain feedback to inform the pilot. • Discussed readmission rates, the Trust have done an audit and initial results are in line with expectations. A&E attendance has improved recently. • YAS performance has been disappointing **7.6.5) AQUA** – No meeting until May. **7.6.6) IT Strategy –** No meeting until June.	**GA** **IA** *Fwd Agenda*
8.	**Feedback from Key Issues Discussed at CCG Governing Body**	
8.1	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.	
8.2	*April Chief Officers Report*. Received and noted for information, no issues were raised.	
8.3	*Joint Collaborative Commissioning Proposal for 999/NHS111* - Received and noted for information, no issues were raised. Noted that Wakefield CCG are the lead for Yorkshire & Humber.	

9. 9.1	**Feedback of Key Issues Discussed at Strategic CE** JK updated members on the following areas: • *Sustainability Transformation Plan* – JK informed members that South Yorkshire & Bassetlaw (SY&B) CCGs and Local Providers have to coordinate a place plan detailing the transformation plans for all areas. Andrew Cash is currently the lead for SY&B. Meetings have taken place this week with neighbouring colleagues and the plan needs to be in place by June. **Agreed that a standing item would be added to the GPMC agenda for the next two months for CE to provide updates on progress.**	**CE** Fwd Agenda
10.	**Items for Information** *Minutes of System Resilience Group 02.03.16 -* Received and noted for information. *Minutes of Primary Care Sub-Committee 09.03.16 -* Received and noted for information.	
	Next Meeting Wed 25 May (G.04 Elm, Oak House) • Agenda Items Deadline – Close of Play Wed 11 May • Paper Deadline – Lunchtime Wed 18 May	