NHS
Rotherham
Clinical Commissioning Group

Minutes	**Title of Meeting**:	Rotherham CCG Primary Care Committee
	Time:	1:00pm
	Date:	13th April 2016
	Venue:	G.04, Oak House – Rotherham
	Reference:	JT / RC
	Chairman:	Robin Carlisle

Present

Robin Carlisle	RC	Lay Member
Jason Page	JP	Lead SCE GP for Primary Care
David Clitherow	DC	RCCG SCE GP
John Barber	JB	Lay Member
Dawn Anderson	DA	Head of Primary Care Quality
Chris Edwards	CE	Chief Officer
Jacqui Tuffnell	JT	Head of Co-commissioning
Garry Charlesworth	GC	NHS England
Sue Cassin	SC	Chief nurse
Geoff Avery	GA	Chair – GP members committee

In Attendance:

Wendy Allott (WA) – Deputy Chief Finance Officer
Nathan Batchelor (NB) – Healthwatch Rotherham
Becky Stevens – Administration Officer (Minute Taker)

Observing: Officer from Local Pharmaceutical Committee

		Action
1.	**Apologies** Apologies were noted for Phil Birks.	
2.	**Declarations of Conflicts of Interest and Pecuniary or Non-Pecuniary Interest** The GP members have a general conflict for all items as providers of primary care in Rotherham. For 3 items in item 5 specific decisions are required from the committee so GP members will be asked to leave before the decision is made. JP registered a specific conflict of interest under item 5, Single handed practices.	
3.	**Patient & Public Questions** There were no public questions raised.	
4.	**Minutes of the last meeting and action log**	

	The minutes of the meeting 9th March 2016 were agreed as accurate. <u>Action log</u> The Actions points were reviewed and agreed. A discussion took place with regards to having a strategic estates group in Rotherham. CE is discussing this with RMBC as the CCG is not responsible for property. The primary care committee will review the estates strategy in 6 months time. <u>Matters arising</u> Remedial breach notice – GC had a discussion with colleagues responsible for the CCGs in South Yorkshire. It was agreed that when a remedial notice is issued to a practice, the first action will be to refer it to the relevant CCG with an opinion from NHS England on the action to be taken. A discussion took place with regards to asking the views and opinions of LMC when producing particular papers. It was agreed by the committee that when relevant and feasible the LMC should be asked for its views before papers come to committee.	
5.	**Strategic Direction – JP, GA and DC remained within the committee for discussion on all of the following items but left the room before any decisions were made.** **Quality Contract Update** This is a significant piece of work which is taking place and discussion had taken place at the previous meeting regarding how much the committee wants to be involved. It was agreed to provide a regular update and the committee would be informed about any issues which are being raised. Further guidance has been issued regarding conflicts of interest in relation to co-commissioning – this recommends that if there is a conflict during sub-group and related committee work, the issue should be discussed at the primary care committee. JT feels that there has been really good progress with this in two meetings. A draft has now gone out to all practices and we have had some good constructive feedback. All Lead GPs and Practice Managers across Rotherham have received a copy to provide wider consultation. Sub-contracting was discussed, support is needed. A key concern of the LMC is if practices fail to support other practices to deliver the contract there is a potential that they could choose to cease providing all LESs and commence only providing essential services. This would have a significant impact for patients and practices. The aim is to make the contract as good as possible to prevent this from happening. **Demand management KPI** - With regards to demand management, it is proposed that there is a key performance indicator (KPI) for reducing follow-ups. This is within the Bolton contract and its purpose is to ensure patients are swiftly transferred back to primary care following	

secondary care intervention.
JP had concerns around GPs not having control over bringing patients back into primary care and stopping follow-ups within secondary care.
DA felt that an alternative option would be to have a KPI for the conversion rate of referrals.
NB asked if there was anything to learn from Bolton's contract. JT responded that Bolton presented a report after 6 months showing improvement, but we have no detail regarding how this was achieved.
GA had questions around the CCG approach to conversion being at odds with follow-up reduction. JT responded that conversion related to the potential that the referral was inappropriate rather than ensuring swift transfer back of patients following secondary care intervention.
SC identified her concern regarding this metric without the GPs having more control, it was accepted that it is part of our plan for GPs to manage patients and have more control before the metric becomes live.
JP, DC & GA left the room at this stage

Access standard - There was debate regarding urgent access for children under 12. The standard was proposed that the cut off for contacting the practice for same day assessment should be 4pm however it was now being proposed to amend this to 2.30pm to meet royal college guidelines. Discussions have taken place around practices providing some form of assessment (telephone or physical) if the patient is able to attend or be contacted by 6pm.
JP's thoughts were that achieving this would depend if a call is sufficient or if a child always needs to be seen in practice.
DC's thoughts were that a 2.30pm cut off is too early as in his experience there are lots of children wanting to contact their GP after school time. DC's opinion would be to go for 6pm.
CE questioned the consequences if GPs are not achieving the 6pm option. JT responded that GPs would then risk not meeting the 60% target in the contract.
General consensus was for the contract to state that some form of contact with a child is required but not necessarily physical contact. It is important that this is clear in the contract and there will be flexibility where it is difficult for a GP to see the child within the time frame outlined in the contract.

Single Handed Practices
A discussion took place at the last meeting and a decision is to be made today. The primary care committee is asked to approve the proposal to require robust business continuity plans from practices who are requesting to become single handed. Where it is considered that the plan is not sufficient, a request can be refused.
JP supported the paper but felt that it is the work behind the scenes and support required that is causing concern. JP felt that a process needs to be in place for practices with only one or two partners where one partner decides to drop out and then this leaves one or two partners to run the practice single handed. JP also noted that switching from PMS to GMS is a very easy process and the CCG has less influence on the decisions of GMS practices.
JB's thoughts were that we are trying to encourage practices to merge and become bigger practices, therefore evidence should be requested from practices to show that they have considered merging and why

they have decided against it.
GA thought that it was about how the process will be managed and pre-planning is needed. Problems may occur when practices cannot find locums etc.
JT explained that nationally all practices have to have a business continuity plan. This process is about being fair to all practices and having a plan in place for single handed practices.
CE felt that the CCG need assurance from the practices that they have looked at all options, but also we need to support the practices and a CCG supported options appraisal should take place.
GC agreed with CE and felt that there is support for GP practices to have business continuity plans. Whilst GMS doesn't require permission to change partners it has got to evidence that it has a robust plan in place to deliver a service to patients.

Dementia LES
JP explained that when this LES came out 6 months ago there were major Issues with training and practices were not achieving the LES. LMC were not involved from the start of producing the LES and it was later discovered that they should have been. The new LES has now been agreed by LMC and finances have been increased which are now more appropriate.
JP is in agreement with signing up to the LES at his practice and feels that this would be good for all practices.
GA had concerns about cross cover between practices and capacity but it was felt that more practices are likely to sign up when neighbouring practices sign up and have success with the LES.
CE explained that If the uptake in any particular locality is low then this will be discussed with chair of that locality.
It was agreed that the purpose of the additional investment in this area was to provide additional capacity for dementia patients. Because the number of dementia patients is growing there will be no savings from reducing capacity in secondary care but existing memory clinic capacity can be used for more severe patients.

JP, DC & GA left the room at this stage. All three were conflicted as they are providers. JP was specifically conflicted in relation to the single handed paper as he has not been able to recruit substantively to a partner vacancy and is currently single handed with locum GP support.

The committee proceeded to make a decision regarding these 3 issues:

With regard to the quality contract:

Reduction of follow-ups KPI - The committee came to a decision to support the development of this KPI as a metric, with a plan to have a 2 year programme in place to enable GPs more control. To advise negotiators to think about the financial weight they give to the metric and about GPs not yet having full control over the outcome.
The CCG to put pathways in place to make this KPI achievable.

Access standard - It was agreed that the cut off would be 6pm for GPs to provide a safe clinical assessment.

With regard to the single handed practice paper:

	It was agreed to approve the paper subject to including a statement which outlines that a CCG supported options appraisal should take place. This will include considering if the practice is eligible for vulnerable practice support. With regard to the Dementia LES: The committee approved the Dementia LES. **JP,DC and GA returned to the meeting and the Chair updated regarding the decisions of the committee.** **Primary care development fund update** JT informed the committee that we are still waiting for the paperwork from NHS England and therefore the bid has not progressed. GC informed the committee that draft paperwork is out at the moment on a national basis. A draft template has been sent out to local area teams for comment. There are plans to refine the process as it is currently a 5 stage process. The portal is planned to open 28th April 2016. This is approximately 3 months behind. Nothing further for the committee to action at this stage.	
6.	**Quality & Performance Management** **Primary Care Dashboard** JP very much supports the dashboard. There will bea change for some practices due to the figures now being based on cluster average rather than Rotherham average in line with the work being undertaken on the Quality contract. A discussion took place regarding whether we use the cluster approach or Rotherham going forward as this has significant resource implications. It was recommended that we start using the cluster based dashboard. RC brought the attention of Shakespeare Road practice to the committee, this is the most deprived practice yet apparently has a low number of staff – observations such as this raise questions to be discussed at quality visits. It was agreed to support the cluster based approach and the committee were happy with the dashboard.	
7.	**Finance** **Implementation of GP contract 16/17** There is now more detailed guidance about the detail of the contract settlement. The CCG have been working through financial planning and have amended the budgets, this has been built into the plan. Significant increase in the global sum this year and higher than expected. This has been managed by the CCG and has now gone into primary care. WA explained that from a financial prospective there is a £1.6million growth allocated this year, but we are consuming all of this for the settlement.	
8.	**Items for escalation / reporting to the governing body** • Dementia LES	

9.	**Any Other Business** No items were raised	
10.	**Date and time of the next meeting** 11th May 2016, 1pm Elm Room, Oak House	

2016 Meetings (1pm)

11th May – Elm Room, Oak House

8th June - Elm Room, Oak House

13th July – Elm Room, Oak House

10th August – Elm Room, Oak House

14th September – Elm Room, Oak House

12th October – Elm Room, Oak House

9th November – Elm Room, Oak House

14th December – Elm Room, Oak House