Agreed at Meeting
24.02.16

NHS
Rotherham
Clinical Commissioning Group

Minutes	**Title of Meeting**:	**GP Members Committee (GPMC)**
	Time:	**12.30 to 15.30**
	Date:	**Wednesday 27 January 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 Srini Vasan (SV) York Road Surgery	Wentworth 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 Sophie Holden (SH), Market Surgery	Wath/Swinton

LMC Representative

Dr Gokul Muthoo, LMC Representative	LMC

Apologies

Dr Julie Kitlowski (JK) Chair Rotherham SCE	SCE

In Attendance:

Lynn Hazeltine (LH) York Road Surgery	Practice Managers' Rep
Barry Wiles (BW) Maltby Service Centre/Clifton MC	Practice Managers' Rep
Dr David Clitherow (DC) – *SCE Deputy & Item 4*	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
Wendy Cutts (WC) Senior Contracts & SI Manager, Acute – *Observer*	CCG
Dominic Blaydon (DB) Head of LTC and Urgent Care – *Item 1*	CCG
Julia Massey (JM) Contracts Manager – *Item 2*	CCG
Lydia George (LG) Planning and Risk Manager – *Item 5*	CCG
Sarah Whittle (SW) Assistant Chief Officer – *Item 6*	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 4 - Conflict of Interest noted for Dr Jacob as a Hospital Practitioner at the Trust. LJ remained for the discussion but no decisions were required. Item 7.1.1 - Conflict of Interest noted for Barry Wiles as the RIO service is ran by Clifton Medical Centre, BW remained for the discussion but no decisions were required	
1.	**Update on Community Transformation**	
1.1	Dominic Blaydon attended to discuss the reconfiguration of community services. The following key areas were highlighted from the progress report circulated: • There will be a period of embedding for localities • Additional Band 3 resource has been identified for each team	

	• Community matrons are the interface between acute and community • A comprehensive review of system 1 template is underway • The implementation of the SEPIA system will allow full visibility if inpatients which is very user friendly and accessible. Long term this will help reduce length of stay. The system is only accessible by clinical leads at the moment but consideration is being taken in regards to District Nurses and matrons having access. • All teams are now doing antibiotics	
1.2	In regards to GP satisfaction this is reasonably good but there is a variable turnout in regards to completion. There is a degree of confidence that community nursing services is on the right track.	
1.3	A number of issues have been raised by GPs: 1) Travel times and geographical spread of nurses. This feedback has been taken on board and measures have been implemented 2) Experienced District Nurses leaving and new ones are less experienced, discussions are underway with the Trust 3) Staffing levels. There are currently 5 vacancies across the service, 7.4 staff on maternity leave and 6.8 staff on long term sick leave. Robust sickness management policies and contractual targets are in place.	
1.4	Integrated locality teams are being implement which will have single line management and where possible will be co-located with single point of access. A one year pilot for one locality is being planned for next year, a review will then take place before expanding across other localities. Further discussions with GPMC would be needed prior to this.	
1.5	DB outlined the next steps: • A review of current clustering arrangements is planned as well as a review of distribution of staff. • Set criteria will be used for integrated locality teams • New arrangements for phlebotomy will be introduced so that District Nurses will cover all patients from 1st April.	
1.6	Following queries from members, DB and IA explained the escalation process in relation to sever winter pressures. This is not a routine process but will be implemented when certain triggers are met. Resources would be moved temporarily to meet demand. However it was acknowledged that this is less likely now that CHC assessment sessions have been scheduled to support discharges so there is less of a risk that the escalation plan would be needed.	
1.7	SV raised concerns around heart failure nurses and their waiting lists. DB advised that they don't fall under the remit of community transformation but specialised nurses are being considered separately and will be discussed at a later date in regards to service delivery and pathways.	
1.8	SM raised concerns around the appropriateness of CCC referrals not always being established and that the flexibility of urgent GP referrals still needs addressing.	
1.9	NP informed members that there was a feeling of not working together as a team (i.e. GPs and community nurses) and asked if any formal arrangements could be put in place where all professionals met on a regular basis i.e. in-house PLT.	
1.10	In regards to IV antibiotics, members felt that a rehydration service would also be useful. DB advised that this has been raised at leadership meetings.	

1.11	LJ raised concerns around the activity levels and the distribution of District Nurses as detailed in the report and would welcome a review to compare the levels of activity and distribution amongst the localities.	
2	**Update on YAS Contracting Intentions**	
2.1	Julia Massey attending the meeting to discuss the update which includes YAS performance and the urgent care practitioner scheme.	
2.2	JM explained the challenges and difficulties faced by the service: 1) There are issues with ambulance turnaround at Northern General which impacts on the location of crews 2) There have been issues with B1 turnarounds but these are since been rectified	
2.3	The service has been looking at different ways of working but nationally YAS are performing well and Rotherham does get a quality service.	
2.4	In regards to the urgent care practitioners, there are two working out in the community and are targeted at less urgent calls which can be deflected away from A&E. These practitioners work autonomously. Noted that it would be mainly the routine paramedics who would contact GPs.	
2.5	Members advised that GPs were not aware of the urgent practitioner service. JM explained that Sheffield have a slightly different model. Rotherham has only just started this service which is activated by YAS. Once both posts are filled, we could look at how GPs could refer into the service but they are mainly linked to the 999 model. Before any expansion of the service, we have to be confident that expensive contacts via 999 can be reduced and capacity would need to be considered.	
2.6	TD explained at the last SRG meeting, TRFT had asked for a hospital ambulance liaison officer (HALO) which supports turnarounds in hospital. JM explained that a HALO was needed in Sheffield to support handovers but Rotherham are quicker.	
2.7	Concerns were also raised about Rotherham crews going to DRI and that Doncaster and Bassetlaw are doing internal diverts. CE explained that it's not a divert unless policy is followed and that this had been picked up.	
2.8	Members discussed cardiology conversation raised and reported that non-stemies needed to be addressed. IA reported that his has been a live issue for the last 12 months, with STHFT raising with DGH colleagues as a proposed service development.	
2.9	Noted that YAS have a handful of providers which are sub-contracted who now respond to all levels of calls e.g. St Jon's Ambulance. These are accredited providers.	
2.10	Members also raised concerns around the questions and criteria for requesting a transport for a patient within an hour. JM explained that it's the clinician on scene who makes the decision around how urgent a transport is and agreed to discuss GP response rates with YAS.	**JM/KF**
3.	**Evaluation Report December GP Commissionng Event**	
3.1	Received for information, following discussions of the content members wished to see in future reports a plan of action around how the comments, suggestions and issues raised at these events would be addressed.	

3.2	Members felt the report could be enhanced to include an actions and recommendations sections or a "you said, we did" format.	
3.3	CE would share the feedback with Dr Kitlowski and suggested after future events, a one page summary of what next could be produced for GPMC.	**CE**
4.	**Confidential Item - Emergency Centre Contract and Governance** **Conflict of Interest noted for Dr Jacob as a Hospital Practitioner at the Trust. LJ remained for the discussion but no decisions were required** 4.1 KF explained that a contractual framework needs to be agreed for the Emergency Centre which links to the governance framework and outlined two frameworks that are being considered: **Prime provider contract**, the CCG contracts with a single organisation which then takes responsibility for the day-to-day management of its own direct services and other providers that deliver care within the contracted scope or pathway. **Alliance contract** sees a set of separate providers enter into a single agreement with a CCG to deliver services, where the CCG and all providers within the alliance share risk and responsibility for meeting the terms of a single contract. 4.2 Whichever contract the CCG decides upon, it is the expectation that when contracts are up for renewal the new pathways in the Emergency Centre and Out of Hours will be tendered for by either the CCG or TRFT 4.3 KF informed members of 4 clear aims which have been set that the framework must meet: (i) To ensure that clinical governance is clear and robust; (ii) To hold providers to account for outcomes; (iii) To hold providers to account for streamlining the delivery of patient care across the peripheries of service providers; (iv) To shift the flow of money between providers. 4.4 Members were informed of key actions have been undertaken so far: • researching the technical properties of the different contract types • conference call with Monitor regarding the procurement issues of each option; • discussions with members of the Emergency Centre Intensive Support Team (ECIST); • discussions with Finance Directors of organisations working with similar contracts; • discussions with a national expert on Alliance Contracts; • discussions with the two providers currently providing the service. 4.5 The benefits of both types of contracts were outlined and KF stressed that transparency would need to be demonstrated and we would have to write a service specification which would be sub-contracted. The specification and most likely CQUIN, will be used to control the services. 4.6 In terms of future procurement, members were assured that the CCG would be involved in the procurement and seek assurances that the specification would be delivered. Primary Care leads would also be expected to be involved in the specification development and procurement.	

4.7	Noted that there are risks with both models and will be reliant on relationships and policies.	
4.8	KF also informed members of the outcomes of discussions with both TRFT and Care UK. These conversations were both positive and robust and will inform the options paper going to Governing Body in February.	
4.9	Members sought reassurance that the funding previously for WiC will be used to support patient access. KF agreed to consider how the funding could be preserved.	
4.10	In summary: The work undertaken has illustrated that there is no clearly defined option that the CCG can "clone" to fit to the Rotherham model. However there is an emerging theme with hospitals where services are to be integrated on a single site – the prime provider contract. Whilst there are risks and benefits of both contract models, the alliance model adds a layer of bureaucracy and complexity to what is a relatively straightforward single site integrated model of care. The prime provider model relies upon an appropriate level of competency and capacity with the provider to manage sub-contractors, risk share arrangements and clinical relationships. The prime provider model enables the risk to be borne and managed by the providers – the alliance model shares risk across CCGs and providers. The CCG continues to be capped on running costs and would not be in a position to increase capacity to support a complex contract. If the alliance model was more appropriate for the circumstances then the CCG would look to prioritise capacity to work within this framework, however, it does appear to add unnecessary complexity to the arrangements. The clinical negligence arrangements have not been clearly defined in any contract types but the prime provider contracts have generally enabled a much clearer and safer approach to the management of clinical governance and insurance.	
4.11	Members noted that the key elements required included: A strong service specification with outputs, contractual levers, competence to manage the service and strong relationships and policies. Members thanked KF for the quality and details identified within the paper.	
5.	**CCG Commissioning Plan**	
5.1	Noted that members had received ongoing updates at previous meetings. IA explained that there is no detail around the finance as allocations are currently being worked through. A specific session around finance is scheduled for February's meeting.	
5.2	In terms of the priorities, IA assured members that CCG GP leads are sighted on their development. Noted that some areas are awaiting national guidance.	

5.3	Feedback was welcomed verbally or via email and will be included in any final versions.	**Locality Reps**
5.4	A final draft will be received in February which will include finance and activity.	
5.5	Members discussed the 4hr A&E target, IA confirmed that the delivery of the target is a priority across the whole system. A contract performance notice has been issued and the Trust has an action plan in place that focuses on all areas to improve flow and not just on the front end.	
5.6	IA was asked to ensure that when the commissioning plan is received at the next meeting, the main changes are clearly highlighted including any financial implications.	**IA**
6.	**Process for Reselection of Chair**	
6.1	Sarah Whittle attended the meeting to discuss this item.	
6.2	Members were reminded that Dr Jacob will be stepping down from the committee as chair and that Dr MacKeown, current vice chair, was also up for re-selection.	
6.3	Noted that the chair and vice chair must be members of the committee and conflicts of interests will need to be considered.	
6.4	The following process was outlined: 1) Nominations for chair, vice chair or both should be emailed to Dr Jacob and Chris Edwards by the 11 February 2016 2) A vote will be undertaken at Februarys meeting	**Locality Reps** Fwd Agenda
7.	**Minutes of Previous Meeting & Matters Arising**	
7.1	Minutes dated 16 December 2015 were approved. **Matters Arising:** **Conflict of Interest noted for Barry Wiles in regards to RIO as the service is ran by Clifton Medical Centre, BW remained for the discussion but no decisions were required** *7.1.1 Rotherham Institute of Obesity* – (item 2 in previous minutes). Noted that a report from Public Health had been received in regards to concerns from last month's meeting, this was circulated via email to members. Noted that there had been 7430 referrals, 43% completion of programme and 36% of first attendees of the programme had achieved a weight loss. Members discussed the information and noted that for this year no patients have been referred for surgery and it was unclear why this is the case and suggested obtaining data on other area referrals for surgery via RIO. Following discussions members agreed that Dr Jacob would write to the service requesting information around referrals for surgery, specifically in regards to potential surgery patients who: • Are at the end of the pathway but unable to attend due to co-morbidities • Responded to treatment • Been referred to Tier 4 • Waiting for 6 months	**LJ**

	7.1.2 Mental Health Liaison Update – (item 3.2.1 in previous minutes). IA explained that as part of the adult transformation work, Adult Mental Health is being reviewed. They are looking at getting maximum provision for services, which will include looking at how locality link workers can support reducing DNA rates. This is a priority from a commissioning perspective and members will receive ongoing updates as this work is progressed.	
	7.1.3 School Nursing – (Item 3.5 in previous minutes). Members were informed that the council is undertaking a full review of the 0-19 pathway. The CCG will receive advance information for consultation and will seek views from members as and when this becomes available. Noted that we can only provide feedback as we don't commission the school nursing or health visiting services. Noted that feedback on consultations can be provided from both a CCG and practice view point. Following discussions it was agreed an invitation would be extended to Joanna Saunders to attend a future meeting to discuss school nursing and health visiting in detail.	Fwd Agenda
	7.1.4 Spot Purchase Beds – (Item 3.6.3 – point 5 & 7 in previous minutes). Following discussions at the last meeting, Dominic Blaydon provided clarity in regards to concerns raised. DB advised that assurances had been received from the Trust that GPs will be informed when a spot purchase is made. In regards to medical cover, the current arrangements are that either the patient would be temporarily registered with the practice responsible for covering that care home or retain their own GP. An audit of Primary Care activity showed that there is very little Primary Care activity generated by these patients, on this basis not changes are planned. SV questioned who would be responsible for patients admitted to care homes but are from out of area, a number of recent examples of one specific care home was referenced. Agreed DB and SV would discuss outside the meeting.	**SV**
	7.1.5 Primary Care Sub-Committee - (Item 8.2 in previous minutes). Noted that NP had received a response from the committee in regards to the suggestion around extending practice space to accommodate additional services.	
	7.1.6 Commissioning Plan & Financial Communications - (item 9.8 & 9.10 in previous minutes). CE advised that this has been deferred to March whereby more robust discussions could take place in regards to the points raised at the last meeting around ensuring that patients and the public are made aware of the financial implications.	Fwd Agenda
7.2	**RDaSH Issues Log** The log was accepted by members. In regards to the common themes, CE explained that access to services (IAPT and CAMHS) is high on the agenda and are in the commissioning plan. A performance notice has also been issued to the provider. Access issues have been well documented and progress is expected to be in place by 1 April 2016. From a patient perspective, the CCG feel there are credible plans in place to improve access.	
	Members felt it would be helpful if GPs could have an input on the RDaSH letter templates, indicating the following points: 1- A brief summary is only needed 2- Follow up of patients is lacking 3- Sporadic lack of communication in regards to Ferham clinic and other parts of RDaSH	RCu

7.3	**TRFT Issues Log** The log was accepted by members. No issues were raised.	
7.4	**Locality Feedback:** Enclosure 7.3 was noted by members. No issues were raised.	
7.5	**Feedback from GPMC Members attending sub-committees** **7.5.1) Community Transformation** – Discussed in detail during Item 1. **7.5.2) Mental Health Transformation** - GA provided a verbal update following the last meeting: • CAMHS transformation is ongoing • There are issues with Dementia waiting times due to sickness. There is a medium term plan to improve access with the LES. • In regards to ADHD services for adults, the current service is small and waiting times are an issue. Currently its one clinician working one day a week. A review of NICE guidelines and compliance is being undertaken. The service as its stands does work but doesn't function as it should. Services are underused at present and if more patients were referred than the service wouldn't cope. • CQC assessment, RDaSH is identified as good in 63 areas and adequate in 2. They do have an action plan to address these areas. **7.5.3) System Resilience Group** - Discussed in other areas of the agenda. **7.5.4) AQuA** - SH provided a verbal update following the last meeting: • YAS are focusing on what can be done next year and producing a detailed plan. • TRFT have lost funding in regards to coding issues between April and October 2015. As at the end of October there were only 10 cases still un-coded. • CSU arrangements have changed • GP Peer Reviews have been well received and the CCG are looking to schedule next years. • 2 members of staff have been recruited to the MASH service • A contract performance notice has been issued in regards to A&E • In regards to areas of poor performance, these are all on the CCGs risk register. • Noted that the Trust need to address the issues raised via CQC and these are overseen by Monitor. • Members discussed issues with Gastroenterology, CE explained how Working Together are looking into this but noted that issues of this nature should be raised via PLT etc. Members discussed the Trusts recruitment process and were informed that the Trust will be reviewing the sustainability of each individual service.	
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. LJ highlighted the following key points: • An update was received in regards to the Rotherham Older Peoples Forum, Helen Wyatt is pursuing a meeting between the Forum and RMBC. • New CCG scorecard, this will include 7 criteria of measurement and all CCGs will need to reflect on their commissioning plan.	

	• There have been observations of significant improvement in regards to the stroke services but there are still areas for improvement. • A&E performance notice issued. • IAPT performance notice issued. 8.2 *January Chief Officers Report*. Received and noted for information, no issues were raised.	
9.	**Feedback of Key Issues Discussed at Strategic CE**	
9.1	DC updated members on the following areas: • *Financial Challenges* – GPMC will receive this information at next month's meeting • *Prescribing* - £1m overspend next year in regards to anti-coags • *Clinical Restrictions* – CRMC are working on these in regards to the financial pressures.	
10.	**Practice Managers Feedback**	
10.1	BW advised that the meeting yesterday had discussed the following: • Infrastructure fund – the bid was successful and work is taking place to review what telephony systems are already in place. • Estates – A questionnaire has been sent around space utilization. • Commissioning Plan – there is a section on Primary Care • Claims Procedure • Safeguarding – Practice Managers have raised concerns around the amount of work involved. • DMARDs LES – An update was received	
10.2	Members discussed the pharmacist recruitment which has commenced; interviews will be in a few weeks. If practices what pharmacists then they need to let Stuart Lakin know. This is not mandatory but the skill mix in practices needs to be right. SV raised concerns that practices cannot get medical indemnity for pharmacists.	
11.	**Items for Information**	
11.1	*Minutes of System Resilience Group 09.12.15 -* Received and noted for information.	
11.2	*Minutes of Primary Care Sub-Committee 09.12.15 -* Received and noted for information.	
	Next Meeting Wed 24 Feb (G.04 ELM, Oak House) • Agenda Items Deadline – Close of Play Wed 10 Feb • Paper Deadline – Lunchtime Wed 17 Feb	