NHS
Rotherham
Clinical Commissioning Group

Minutes	**Title of Meeting**:	Rotherham CCG Primary Care Committee (PCC)
	Time:	1:00pm
	Date:	10th January 2018
	Venue:	G04, Elm Room Oak House, Rotherham
	Reference:	JT / RC
	Chairman:	Robin Carlisle

Present

Robin Carlisle	RC	Lay Member (Chair)	Member
Alun Windle on behalf of Sue Cassin	SC	Chief Nurse – RCCG	Member
Avanthi Gunasekera	AG	SCE Primary Care GP	Non-Voting member
Carolyn Ogle	CO	NHS England	In Attendance
Chris Edwards	CE	Chief Officer – RCCG	Member
David Clitherow	DC	SCE GP	Non-voting member
Geoff Avery	GA	GP Members Representative	In Attendance
Jacqui Tuffnell	JT	Head of Co-Commissioning RCCG	Member
Kath Henderson	KH	Lay Member	Member
Neil Thorman	NT	GP LMC	In Attendance
Rachel Garrison	RG	Senior Contract & SI Manager RCCG	In Attendance
Sara Hartley	SH	Contracts and SI Manager RCCG	In Attendance
Julie Murphy	JMu	Senior Contract & SI Officer RCCG (Minute Taker)	In Attendance
Chris Barnes	CB	Rotherham Connect Healthcare (Federation)	In Attendance
Serena Thorpe	ST	Rotherham Connect Healthcare (Federation)	In Attendance
Helen Wyatt	HW	Patient & Engagement Manager RCCG	In Attendance

		Action
1.	**Apologies** Sue Cassin – Chief Nurse Nichola Barnes – Healthwatch Wendy Allott – Chief Finance Officer Keely Firth – Deputy Finance Officer	
2.	**Declarations of Conflicts of Interest and Pecuniary or Non-Pecuniary Interest** **The GP members of the committee are partners in different practices across Rotherham. They have a direct interest in items that influence finances, resources or quality requirements for general practice in Rotherham. This applies to all items discussed in Items on the agenda. Any additional specific Conflicts of Interest and how the Committee addressed the conflict of interest will be noted under individual items.** Primary Care Committee noted NT & GA are board members for the Rotherham Connect Healthcare Federation.	

3.	**Patient & Public Questions** There were no public questions raised.	
4.	**Minutes of the last meeting and action log** The Minutes of the last meeting were agreed as a true and accurate record subject to the following amendment:- Item 5, Strategic Direction, Appeals process : - • **Action** – RG to liaise with Healthwatch….. • Should read - RG to liaise with Helen Wyatt, Patient & Engagement Manager RCCG…..	
5.	**Finance Report** **The report sets out CCG funding that is spent on General practice. The GP members have a direct financial interest in this item. As the item is primarily about understanding the CCG's financial treatment of primary care the chair proposed that all members could participate fully in the discussion** Review paper deferred till February/March 2018.	
6.	**Strategic Direction**	
6a.	**Patient Questionnaire Results (Access)** RG gave an overview of the results and the Primary Care Committee (PCC) acknowledged the huge response received in a short space of time. There are some gaps around the edges of the Rotherham however, the results are representative of the Rotherham demographics and population. RG/HW advised that there is further work to be undertaken around understanding the data, future technology e.g. video call (consultations), telephone triage, utilisation of hubs etc. to meet the Rotherham population's expectations. HW advised that patients reported being happy with services provided acknowledging that improvements in access can be made. RC enquired about the timescale for achieving the access requirements. CO clarified that the 1 March 2018 is a national deadline to achieve 50% coverage, not a local requirement. CO advised that given the issues over winter, whilst the formal date for achieving 100% is March 2019, it is more likely that this will be expected by December 2018. Trajectories are included in the GPFV as this is what RCCG will be monitored on. GPs in the room felt there was potential with the app as it would be linked to the option to have direct contact with the patient's own practice. Group then discussed the following:- • Potential apps within SystmOne. • Potential links into NHS 111 (algorithm is currently in place) • Links to care navigation. • Hubs appointment availability and continued promotion by various methods (clarity given that appointments are available any day of	

	the week incl. extended access). • Apps available (caution advised in only having one size fits all app as this is only one aspect of a solution, not the complete solution). • Management of GP appointments to enable general and emergency appointments Meeting next week prior to PLTC re utilising the extended access. <u>Proposal:-</u> As it is difficult to create more GP appointments, the proposal is to free up time and have patients use the rapid access app. Jo Martin is scoping this project and the options available and will ensure that the algorithm is used appropriately to manage LTC conditions and link into pharmacy. Potential timeline for decision is unknown at this time as there is no national app available and RG/HW to bring back the results of the scoping exercise in February 2018. KH advised that the NHS PPG event is next week. KH and NHSE Lay member will be in attendance and will provide feedback at the February meeting. **PCC note the paper and discussion and will receive the scoping paper at the February meeting identifying potential options available.**	
6b.	**Magna / Brookfield Merger** ○ Cover paper ○ Magna/Brookfield business case ○ Magna/Brookfield Boundary **The GPs will be bound by the details of this paper, should they make any appeals; as such they will remain in the room for the discussion but will be asked to leave before a decision is made.** **HW remained for this discussion** SH advised that a formal business case has been submitted to take the merger forward. Practices have undertaken patient engagement utilising MJOG, PPGs and stakeholders. There has been no negative feedback from wider practices to the merger and there are no restrictions of patient choice as other surgeries in the area. In the second submission the boundary is considerably larger compared to the first submission. Magna raised concerns re the distance for the on call GP for home visits. Therefore, the proposal is that the Brookfield boundary becomes an outer boundary and existing patients would be included and any new patients would be advised to register with an alternative practice within a mile of this boundary. There are no care homes in this area. Due to the timeframe of the patient engagement and the submission of the business case, the practice is still collating the patient engagement data. **Request for PCC approve this merger.**	

	HW left the meeting at this point. **GPs and Rotherham Connect Healthcare left the room at this point.** All the information presented to the committee supported the merger and it will lead to a more sustainable service for patients. However the committee were concerned that the practices have not yet submitted the patient opinion data. It was decided to delay a final decision until KH had seen the patient opinion data. **GPs and Rotherham Connect Healthcare returned to the room at this point.** **PCC agreed the paper subject to the patient engagement being signed off by KH Lay member.**	
6c.	**MJOG** **The GPs will be bound by the details of this paper, should they make any appeals; as such they will remain in the room for the discussion but will be asked to leave before a decision is made.** SH gave an overview of the system. Uptake was quite slow initially and since has really taken off as a communication tool. However this comes at a cost. There is an app which can be used for i-message smart message where no cost is incurred, however patients have to download the app and uptake on the app is still low. If everyone who has a smartphone uses the app would create a saving of £25k. Also restricting FFT messages would also reduce the current costs. MJOG have agreed to provide digital materials for use in practices and provide larger posters etc. and are happy to provide further training with practices and promote the benefits of this system. If PCC agree to a licence for 3 years in advance MJOG have agreed to reduce this by £2000 per year. **Post meeting note: SH has secured a reduction of £8606 over the 3 years which gives a further yearly reduction of £2868.** Group discussed the following:- • What would be a reasonable patient response to show if the practice is meeting the FFT satisfaction and limit the numbers of responses required. • Restricting FFT messaging and reviewing where other restrictions could be put in place to reduce cost. • If non-recurrent money available to promote greater use of the app. (Apprentices have been offered to the practices to provide support, however this has been declined). • Only using MJOG for patients with smartphones where no cost is incurred, and move to encouraging more patients via PPG groups promote downloading the app and the associated benefits to the patient, save money and reduce DNAs. **GPs and Rotherham Connect Healthcare left the room at this point.** **PCC agreed extra support to promote the app until end of March**	

	2018. From April to June MJOG will only be available to those with a smartphone. Usage will then be reviewed to make a decision on usage after June 2018.	
6d.	**Primary Care Dashboard** RG advised that recently visited practices are safe and effective, however further work is required with Greasbrough as there outliers have significantly increased. Wickersley had their Quality and Contract visit recently and although they are outliers, a new practice manager is now in post and measures have been put in place to improve the data quality and RCCG anticipate that improvement will show in the next performance dashboard. Workforce is an outlier for some practices which have high admission rates and RG advised that this is raised at the Quality and Contract visits along with other key lines of enquiry within the dashboard. Group discussed the cost of admissions verses' a business cases for e.g. ANPs to provide cost savings in this area. There was discussion of the desirability of flagging up the information in the dashboard as often as possible e.g. PLT and at GPMC. **PCC encourage as much dissemination of the dashboard as possible.**	
6e.	**Appeals Process** **The GPs will be bound by the details of this paper, should they make any appeals; as such they will remain in the room for the discussion but will be asked to leave before a decision is made.** RC suggested in the steps of the appeal that the following amendment be made: 'removed from process' be replaced with 'removed from the decision making'. NT enquired about the 30 days rule and RG clarified this. **GPs and Rotherham Connect Healthcare left the room at this point.** **PCC Agreed the paper subject to amendment 'removed from process' be replaced with 'removed from the decision making' in the steps of the process within the paper. The appeals process will be reviewed again after a further batch of appeals have been heard.** **Action – RG to make the amendment to the paper as above.**	**RG**
7.	**Quality** ○ **Quality Contract update** Surveys have been issued to ask GPs to advise if there are any areas of concern within the Quality Contract otherwise this will be rolled over to 2018/19. Leads have been asked to update the standards and a meeting is due to take place on the 31st January 2018 to discuss the 2018/19 contract further. Quarter 3 2017/18 data is due in by close of play today and	

	RG/AG/JMu are going to review the data in detail prior to sending out on the 10th February 2018. One area raised was Outpatient follow ups which GPs are unable to influence but they can influence the initial referral. RC reiterated the need for GPs to notify the RCCG of any areas of concern with regard to indicators. RCCG do not want to penalise practices however, evidence is required via a very short report to demonstrate what you have done to try and improve e.g. A&E indicators. **Action for GA to reiterate to the GPs in Rotherham the need to advise the CCG on indicators and suggestions where an indicator is not appropriate what could it be replaced with.**	**GA**
8.	**Terms of Reference** Membership: clarity required with regard to Lay Members and duplication in the document to be removed. None voting members: to have representation from Rotherham Connect Healthcare and LMC. Abbreviations:- initial abbreviations be in full then abbreviations in the brackets can then be used throughout the remainder of the document. e.g. Patient and Public Engagement (PPE) Minutes: to be published on the website and draft minutes to Governing Body. **Action - JMu - to make amendments and forward to RC & JT**	**JMu/JT**
9.	**Any Other Business** None raised	
10.	**Forward Programme** all due in February - Dementia - Full LIS review - Full LES coverage - Care Home update - Waverley - Review Appointment figures annually	
10.	**Items for escalation / reporting to the Governing Body**	
12.	**Date and time of the next meeting** 14th February 2018, 1pm, Elm room, Oak House. Please note this meeting has been extended.	

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Minutes	**Title of Meeting**:	Rotherham CCG Primary Care Committee
	Time:	1:00pm
	Date:	14th February 2018
	Venue:	Room 2.03 Willow Room, Oak House, Rotherham
	Reference:	JT / RCa
	Chairman:	Robin Carlisle

Present

Robin Carlisle	RCa	Lay Member (Chair)	Member
Avanthi Gunasekera	AG	SCE Primary Care GP	Non-Voting member
Chris Barnes	CB	Rotherham Connect Healthcare (Federation)	In Attendance
Chris Edwards	CE	Chief Officer – RCCG	Member
David Clitherow	DC	SCE GP	Non-voting member
Emily Hague	EH	Student Nurse –accompanying Sue Cassin	Observer
Geoff Avery	GA	GP Members Representative	In Attendance
Jacqui Tuffnell	JT	Head of Co-Commissioning RCCG	Member
Julie Murphy	JMu	Senior Contract & SI Officer RCCG (Minute Taker)	In Attendance
Kathryn Henderson	KH	Lay Member	Member
Keely Firth	KF	Deputy Chief Finance Officer RCCG	In Attendance
Lee Eddell on behalf of Carolyn Ogle	LE	NHS England	In Attendance
Neil Thorman	NT	GP LMC	In Attendance
Rachel Garrison	RG	Senior Contract & SI Manager RCCG	In Attendance
Sue Cassin	SC	Chief Nurse – RCCG	Member
Wendy Allott	WA	Chief Finance Officer	Member

		Action
1.	**Apologies** Nichola Barnes – Healthwatch Councillor Roche – RMBC	
2.	**Declarations of Conflicts of Interest and Pecuniary or Non-Pecuniary Interest** **The GP members of the committee are partners in different practices across Rotherham. They have a direct interest in items that influence finances, resources or quality requirements for general practice in Rotherham. This applies to all items discussed in Items on the agenda. Any additional specific Conflicts of Interest and how the Committee addressed the conflict of interest will be noted under individual items.** None declared The agenda items with a conflict of interest are grouped together and the GPs and Connect Healthcare Rotherham are requested to leave the room to enable decision making.	

3.	**Patient & Public Questions** There were no public questions raised.	
4.	**Minutes of the last meeting and action log** The Minutes of the last meeting were agreed as a true and accurate record with the noted amendments to the following:- **Item 6a – Patient Questionnaire** *KH advised that the NHS PPG event is **next week**. KH and NHSE Lay member will be in attendance and will provide feedback at the February meeting.* **Should read** *KH advised that the NHS PPG event is **next month**. KH and NHSE Lay member will be in attendance and will provide feedback at the March meeting.* **Items 6b, 6c, 6e, Standard statement** *The GPs will be bound by the details of this paper, **should they make any appeals;** as such they will remain in the room for the discussion but will be asked to leave before a decision is made.* **Should read** *The GPs will be bound by the details of this paper, as such they will remain in the room for the discussion but will be asked to leave before a decision is made.*	
	Matter arising:- **Magna/Brookfield merger** KH worked through the information and felt happy that the practice has tried to engage with patients in a number of ways. Where patients have stated any issues are within the public domain. No concerns were raised in relation to the merger going ahead. RG advised that there will be a delay as the merging practices have not booked the IT department to make the necessary IT changes. Apologies received from Sara Hartley therefore, no further updates from Sara Hartley	
	Action log:- Group agreed that the items marked green be removed from the action log, then went through the remainder of the action log as below. • Estates strategy – Officer's Estates Group is in place. Agreed to change to green and report back as required. • Dementia LES is on agenda, agreed to make green. • LES Coverage – Care home LES data is due be received by PCC	

	in April 2018 therefore to remain amber. • MJOG on agenda today. • Finance – report due in March 2018, agreed to make green • Case management is to remain on the action log and to be received by PCC in March or April 2018. • Waverley is on the agenda today, agreed to make green. • JT to inform of conversation with Richard Cullen. • GPFV as strategy will be going to Governing body and any further comments to JT prior to Governing Body receiving this report. Agreed to make green. • Magna Brookfield agreed to make green. • Quality Contract indicators, GA to relay information with practices.	
5.	**Finance Report** **The report sets out CCG funding that is spent on General practice. The GP members have a direct financial interest in this item. As the item is primarily about understanding the CCG's financial treatment of primary care the chair proposed that all members could participate fully in the discussion and would be asked to leave for the decision.** KF gave an overview to inform members of the financial position at month 9, proposals for achieving the 2017/18 plan and principles for the 2018/19 budget which had been supported at the December PCC. KF drew attention to the following:- ○ the PPV assurance work was now complete and the report provided for information ○ A review of the primary care budgets had been undertaken following receipt of Q3 returns and the 2018/19 proposed plans were being drafted. ○ With regard to 2017/18 underspends, plans for reinvestment were highlighted in section 2 and, in addition, non-delegated money (from CCG commissioning funds) is to be invested into Primary Care in 2017/18. GA asked about the quality contract money and for practices who are under these figures, is this included in the report. KF advised that the underspend will be managed via federation with stipulations on how the money is used e.g. to provide staffing for practices. KF advised around the growth and that further uplift guidance/notification has been delayed until June 2018. KF proposed that a 1% uplift be applied to preserve the budget and to cover any future increments dependent on the outcome of the guidance whilst CCG colleagues await further advice at regional level. NT was if the LMC had expressed a view on the delay. NT advised that national negotiations appeared to be taking a long time to conclude possibly due to other national priorities. **Later in the meeting the GPs and Rotherham Connect Healthcare left the room for a decision to be made, this decision was as follows:** After discussing the options members agreed to a 1% uplift on account	

	as a pragmatic solution subject to any other instructions from NHSE with corrective payments be made accordingly. RCa advised that AG should lead on a lot of these areas as GP Primary Care Lead. **Action – JMu to add AG to the papers on future agendas.** **GPs and Rotherham Connect Healthcare returned to the room at this point.** Members of the Primary Care Committee noted the latest analysis of expenditure in Table 1 and supporting information and acknowledged the action taken to understand the expenditure trends particularly around the LES schemes and the consequent realignment of budgets for 2018/19 with the balance being added to the Primary Care Central Budget. **PCC agree with the initial proposal and the recommendation to apply a 1% uplift.**	**JM**
6.	**Strategic Direction**	
6a.	**Dementia** **The GPs will be bound by the details of this paper; as such they will remain in the room for the discussion.** JT gave an overview:- 25 practices signed up to deliver however, not all are delivering this service. JT has been in discussion with the Federation for sub contract arrangements to be in place to make this work and have equality of service across the Rotherham footprint. Currently where patients are going to the memory clinic, RCCG are aiming for a 1/4/18 start date with sub contract arrangements in place for those not providing the Dementia LES. Group had a wider discussion on how this will work for patients:- CB advised that the federation are hoping to have 3-4 hubs in place and the group queried if this would be sufficient coverage. CB advised that the biggest distance is 4 miles away from the patient's practice to the nearest hub. DC advised that patients have reported that travel does not come into this as patients would prefer a quality service which is being provided by the GPs. KH would like assurance that patients are attending appointments in the hubs. JT advised that the Federation will be reporting back to the RCCG with data on how the service is working. GA asked how this affects follow ups as they have been chasing follow ups in a timely manner compared to the memory clinic service. NT advised that there is history on how this service was perceived in line with diagnosis and new medications, and advised being mindful of increased activity against costs of medications and to have pragmatic approach. Group agreed that this LES needs to be under close review on how this service is accessed and works in practice to provide assurance and is to	

	be evaluated when it is up and running. **PCC noted the paper and JT to provide a report as and when appropriate.** **Action - JMu to add to action log for a revised Dementia report to be received around July 2018.**	**JMu**
6b.	**Proposed LIS 2018/19** **The GPs will be bound by the details of this paper, as such they will remain in the room for the discussion but will be asked to leave before a decision is made.** **Conflict of interest raised by GA the that he and Simon MacKeown the Vice Chair of members committee that they are already receive payment for attendance within these roles.** RG gave an overview of the paper and key issues:- *1. **Amendments to reflect the new locality structure:** The document has been reworded to ensure payment is made for engagement with the new 7 locality structure.* *2. **The inclusion of an additional requirement under 2.1 - Electronic Survey / Feedback on Discussion Items:** Following the success of the recent patient engagement process around Access it is recommended that practices are incentivised to engage in future such activities to provide full Rotherham coverage. In order to fairly reflect this change, the number of practice questionnaires has been reduced from 24 to 20 per year.* *"In addition, the CCG may request that practices facilitate Rotherham wide patient engagement exercises via their access to MJOG and the patient list. Rotherham CCG will request a maximum of 4 such exercises per year".* *3. **The setting of the Engagement into the Quality Agenda under 2.2:** Traditionally this section has contained a number of pre-defined clinical audit projects. However in the last year a project (cancer reviews) was determined in year to reflect a CCG priority. It is recommended that this approach is taken in 2018/19* CE advised that members committee are maintaining 8 localities for commissioning purposes, however, within the paper only 7 will be paid for the provider function. Members agreed for 7 locality provider networks and this is to be revisited in 6 months' time. NT suggested funding engagement and this be spread across the practices and they decide how they function within this cost and RCCG monitor attendance. JT advised nationally requirement is to have geographical localities and does not cover the extra meetings and this is to ensure that the meetings are not duplicated.	

	When the GPs and Rotherham Connect Healthcare left the room the following was agreed: **RG queried the amount of money to be paid per meeting. The committee requested that the budget should be divided out by the 7 to encourage attendance at 7 instead of 8 and those practices that attended 2 meetings would receive less money per meeting.** **PCC are noting the two different structures identified within the paper and for the next 6 months agreed to maintain both structures and that existing funding is pro-rated across the groups. RG to work this into the LIS**	**RG**
6c.	**LES Coverage** **The GPs will be bound by the details of this paper; as such they will remain in the room for the discussion.** JT gave an overview on SH behalf. The paper showed which practices had a '0' return for the specific LES' from this several practices stood out and the committee discussed this in further detail. For practices that have a small amount of activity or nil activity this may indicate that there are little or no patients who require this service e.g. ring pessaries. GA gave an example that Blyth Road have sub contract arrangements in place and the service is offered and covered under these arrangements but still do not have any activity, and the report does not reflect this element in how it has been presented. KH asked what evidence is there if the service is offered and not used by patients, as Broom Valley stands out on the report. RG advised that they are the only practice, who do not deliver anti-coagulation monitoring and RCCG have made several attempts to tackle this in year and have requested the practice put in place sub contract arrangements for the monitoring of stable anticoagulation patients from January 2018. SC recommended changing the report to service provided against practice and where sub contracts are in place and if there has been any activity. RCa stated that this paper is a good and positive reflection of activity and agreed that it needs to show a full LES service overview provided against practice activity and sub contract arrangements. **Action – SH to amend the report to reflect where sub contract arrangements are in place but no activity and present slightly differently.** **PCC note the paper and the picture is positive overall and amendments to be made as discussed.**	**SH**
6d.	**Waverley**	

	The GPs will be bound by the details of this paper; as such they will remain in the room for the discussion. RG advised that this paper is to inform the Committee of the outcome of the Waverley procurement process and Award. The committee discussed the process and the award, paying particular attention as to how the decision and % distribution for the scoring are devised. RG advised that there are questions that sit behind the data which equate to a % allocation per question which make up the result, and some questions were also disqualification questions. The committee asked if standard questions were used. RG advised that standard questions were used and adaptions made to meet the Waverley requirements. RG is happy to provide the underlying information. GA enquired about Treeton as they are close to this site and there are issues with their building. JT assured the committee the full procurement process was followed and that Treeton have received significant assistance for their practice estates capacity issues. The committee requested that once the contract has been awarded that RCCG receive a mobilisation plan. KT thanked the team for the patient experience received. **Action – RG to provide the mobilisation plan and regular updates. Committee to receive an overarching update in April 2019 on how this practice has worked and to add that KH was part of the moderation.** **PCC noted the decision.**	**RG**
6e.	**MJOG** **The GPs will be bound by the details of this paper; as such they will remain in the room for the discussion but will be asked to leave before a decision is made.** JT advised that since the last committee the Primary Care team have received some feedback from practices and on behalf of patients. RCCG are aware that patients and practices like MJOG. Concerns were raised from a practice point of view around those patients who are from more deprived backgrounds, that are potentially without access to the internet being unable to download the app and general disagreement with the loss of the use of this service even for a short period. The committee discussed, rather than remove the service for 3 months that we limit the length of message to 3 strings and use links and still promote the use of the MJOG app during the next 3 months. GA agreed this was positive and that lot of people will use the app. FFT is a concern re cost, response rates and reporting. GA would like to know what the threshold to achieve an appropriate and relevant response rate would be for his practice. GA suggested further restricting FFT as an alternative.	

	JT advised that RCCG are restricting FFT so that no duplicates are sent out. RCa - Proposals are in place for the next 6 months and a review is to be undertaken with a view to capping if there has been no reduction in costs. **PCC direction of travel is to support MJOG for the next 6 months and review** **When the GPs and Rotherham Connect Healthcare left the room the following was agreed:** Group agreed the paper with a 6 month review. Following on from this the committee members discussed at what point remedial action if any should be taken for those practices not responding to FFT, if this is a contractual requirement and if no further acceptable response received a remedial breach should be issued and sanctions could be stated in the breach. LE explained that this was a mandated return from 2014 and advised a 3 step process for this. RG advised that this needs to be reviewed in context and review how our peers address issues. WA agreed with RG's approach. It was identified that a paper detailing all contractual compliance issues should be prepared. JT's concern is that this particular issue has been on the radar for some time and needs addressing. **Action – RG to provide an up to date paper on the data received** **Action - Group agreed that a discussion paper is provided relating to compliance and what the options are for breaches. Paper to be received in April 2018.** **GPs and Rotherham Connect Healthcare returned to the room at this point.** **RCa gave an overview of discussion and link in with our peer CCGs. and then review our approach on having practices meet the objective of achieving full coverage.** Committee considered writing to the practices again but felt this had already been undertaken NT advised notifying Greg Pacey at the LMC of who the practices are and a conversation will take place between LMC and the individual practices. **Action – SC to follow up and have the discussion with Greg Pacey at LMC**	**RG** **RG** **SC**
6f.	**Transformation Funding for Primary Care Locality development** **The GPs will be bound by the details of this paper; as such they will remain in the room for the discussion but will be asked to leave before a decision is made.**	

Conflict of interest noted for GA and NT who sit on the Federation Board.

Background from paper:-. *As we have developed the provision of healthcare within Rotherham and have begun to develop our community services it has become apparent that the localities that are needed to provide an integrated service at a size that is suggested by NHS England (30-50,000 patients) and GP Members Committee have now agreed a proposal to create seven localities for provider purposes. The existing locality structure of 8 will remain for the commissioning function.*

The CCG would also continue to organise meetings to improve the quality of general practice which is why we would want to continue the clustering of practices as per the quality contact to allow learning amongst practices that have similar practice demographics.
An integrated pilot of multi-professional working has been in operation since July 2016. Following evaluation, the intention is to replicate this model across Rotherham.

£1 per head has been identified in the ACS allocation to support the development of these localities (or primary care networks as officially titled).

JT advised that the report identifies non-recurrent funding for consultancy support, IT support, legal advice, backfill for GP and Practice Managers release and a Programme Lead to enable this project to move forward. The intention that the localities will hold the locality meetings in house, however there is are some funds for larger venues for all to attend network meetings.

The committee discussed in detail the funding, localities 7 and current 8 and that the direction of travel should be led by the localities and be pulled together by the Programme Lead, and that we need to invest time and space to make development of localities work. It was noted that previous localities were based on deprivation and relationships between practices. Going forward the revised 7 GP localities reflect geography and the LA localities and boundaries.
The funding is to be delegated to the federation to lead the programme of work.

GA had concerns about practice managers having the time to link in with this work, however, backfill has been accounted for.
NT noted that the funding appeared to be top down and asked if it would be possible to delegate more funds to make localities to deliver. Also what is in the paper cannot be contractually obligated as there is no money to commission this if practices are required to deliver information.

JT advised that experience to date has required an 'Officer' to pull work together and lead and whilst it would be really good if localities were able to lead delivery at this stage this was not considered feasible.

NT advised undertaking the organisational development consultation process first and KH enquired if this could be done at a lower cost of e.g. £50k.

WA asked about the heading of the recommendations and what the envelopes are and consolidate areas so it gives scope for delivery. It was

	agreed to link the consultancy support with backfill to increase the envelope across the areas. Recommendation:- to support the proposal for development of the localities and requires GP member involvement as it links into the locality discussions as there is an expectation from NHSE for us to have a plan for delivery in place. **When the GPs and Rotherham Connect Healthcare left the room the following were agreed:** Members discussed the 7 localities for delivery and agreed the priorities for investment. Committee agreed the federation will lead the recruitment and management of the programme lead. Agreed the overall package of funding available to support this programme and the priorities to be delivered. **GPs and Rotherham Connect Healthcare returned to the room at this point.** **PCC agreed for the federation to lead this programme of work and work within the budget to deliver the priorities.** **Action - KH in the absence of RCa to report up to Governing Body re the localities for commissioning and development.**	**KH**
7.	**Quality Contract update** AG advised that the Quality Contract year end performance and supporting information haves been sent to all GP practices, and 3 requests for appeals paperwork have been received so far. A revised Quality Contract for 18/19 is to be received by LMC officers a week on Monday. Key areas of amendment:- o Secondary care outpatient follow-ups which are out of GP practice control. o Access - NHS 111 having access to bookable appointments within practices. o Core hours in standard 1 has been amended to reflect that practices have to be available till 6.30 before moving to extended hours services. AG/RG to provide a detailed paper for next PCC. RG advised that there is currently approximately £100k underspend and that the CCG are aware of some areas within the self-declarations which are incorrect and we anticipate that appeals will be received to evidence for payment. GA queried the Health Check data. AG advised that this is received by Public Health from the GPs and is then received by RCCG. RG advised that she was disappointed that this data has been sent out regularly throughout each quarter and is only now being scrutinised by	

	practices and that this should be reviewed quarterly and not at the end of year payment point. **Action – AG/RG to provide Quality Contract paper for PCC in April 2018.**	**AG/RG**
8.	**Terms of reference** **Terms of reference** **The GPs will be bound by the details of this paper, as such they will remain in the room for the discussion.** SC queried the layout of the members titles and should read:- o Lay member Primary Care (Chair) o Lay member Governance attends only if one of the lay members unavailable o Lay member Patient and Public Engagement (Deputy) **Action – JMu to make the amendments as above. JT to discuss with Ruth Nutbrown re governance arrangements for amending the ToR.**	**JMu/JT**
9.	**For information only** • **PPV combined paper** KF advised that lessons learnt feedback has been provided to Practice Managers. RCa stated that proposals for case management are to be advised. South Yorkshire & Bassetlaw CCG's Primary Care Priorities are to be received in March/April dependent on size of agenda **Action – JMu to add to the action log**	**JMu**
10.	**Any other business** Nothing at this time.	
11.	Forward Programme - Care Home update – April 2018 - Review Appointment figures annually – April 2018 - Performance Dashboard – March 2018 - FFT update – April 2018 - Finance Plan – March 2018 - SY&B Primary Care Priorities – March 2018 (dependent on agenda size) - GPFV work plan – April 2018	
12.	Items for escalation /reporting to the governing body Localities discussion	
	Date & time of the next meeting: Wednesday 21st March 2018 commencing at 1pm in Willow Room, Top	

	floor, Oak House.	