NHS
Rotherham
Clinical Commissioning Group

Minutes of the NHS Rotherham Clinical Commissioning Group

GP Members Committee Meeting

Wednesday 31July 2019 at 12.30 -3.30 pm

G0.4 ELM Room, Oak House

QUORUM

COMMITTEE have 7 voting GP members
Quorum is at least 5 GP Members (or their respective deputies)

Members or Deputies Present:

Dr Geoff Avery (GA) – Chair	Blyth Road
Dr Simon MacKeown (SM)	St Ann's Medical Centre
Dr Subbannan Sukumar (SS)	Wentworth 1
Dr Simon Bradshaw (SB)	Crown Street Surgery
Dr Neil Thorman (NF)	Deputising for Tim Douglas
Dr Tariq Ahmed (TA)	Wentworth 1
Dr Richard Fullbrook (SF)	Maltby/Wickersley

In Attendance:

Dr Richard Cullen (RC)	Chair Rotherham SCE
Dr Jason Page (JP)	Vice Chair Rotherham SCE
Mr I Atkinson (IA)	Deputy Chief Officer
Dr Gokul Muthoo (GM)	LMC/Stag Medical
Mrs W Allott (WA)	Chief Finance Officer
Mrs Catherine Hall (CH)	Deputy Chief Nurse
Dr S Rao (SR)	Parkgate
Mrs Ruth Nutbrown (RN)	Assistant Chief Officer
Dr A Qureshi (AQ)	GP/CD Raven
Dr V S Churitale (VC)	Brinsworth
Dr T Ahmed (TA)	Wentworth 1
Dr Sam Sukumar (SS)	Dinnington
Dr N Ravi (NR)	Greenside
Ms Lindsey Hill (LH)	Minute Taker

Apologies:

Mr Chris Edwards (CE)	Chief Officer
Mrs Sue Cassin (SC)	Chief Nurse, RCCG
Dr Bipin Chandra (BP)	Treeton Medical Centre
Dr Tim Douglas (TD)	Dinnington Group Practice
Dr Simon Langmead (SL)	Central North
Mr Barry Wiles (BW)	Practice Managers' Rep

No.	Item
1.	**Present and Apologies:**

Apologies were noted for Dr's Chandran, Douglas & Langmead, Mr Wiles, Mrs Cassin and Mr Edwards

2. Quorum

Dr Avery declared the meeting as being quorate.

3. Declarations Interests

The Chair reminded members of their obligations to declare any interest they may have on any issues arising at meeting which might conflict with the business of the NHS Rotherham Clinical Commissioning Group.

Declarations declared by members are listed in the CCG's register of interests. The register is available on the CCG website at the following link:

http://www.rotherhamccg.nhs.uk/about-us/declaration-of-business- interests_2.htm

Conflicts of Interest were declared for attending LMC members, Dr Avery and Dr MacKeown relating to Governing Body attendance, Dr's Avery and Muthoo relating to Federation membership and possible conflicts for all Clinical Directors attending today.

4. GPMC Draft Minutes 26 June 2019

As a standing item, Dr Avery shared the contents of the minutes dated 26 June 2019 for information adding that the focal point of the meeting is to discuss the future of the GPMC Committee going forward.

5. Future GPMC Meetings

- Dr Avery shared the proposal in order to review governance arrangements as discussed in the previous June meeting and gave a brief overview on the background of members committee, membership involvement and what the function of the GPMC is adding that some localities do not have a GPMC but it has worked very well in Rotherham.

  The June GPMC meeting was a starting point for discussions which looked at more locality representation and the proposal to hold bi-monthly meetings with 2 representatives from each network.

  Dr Avery shared concerns about of conflict of interest relating to Governing Body attendance for Clinical Directors attending this meeting going forward, suggesting replacement roles as chair/vice chair should also be considered and commented that initially, bi-monthly meetings may not be enough to finalise the structure and meeting format suggesting a further review of the bi-monthly schedule in 6 months.

- Dr Cullen stated that the upcoming months gives flexibility to work out how the CD's will meet/interact with GP's and CCG's locally anticipating the structure of future meetings will be governed by a further general 'instruction' document on how things are to be done.

- Dr Muthoo suggested a decision should be made on how the meeting will be quorate, adding that CD's need time to meet and discuss options, adding that if members require LMC or Federation involvement, he would then take the request back accordingly.

- Dr Muthoo went on to say appointed representatives for PCN (as former representatives of the GPMC) are vital as they know the processes.

- Dr Sukumar shared a view that the two different sectors, commissioning and providers, will always have conflicts of interest which constantly overlap but both are equally as important. Dr Sukumar went on to say that the CCG deals with this is by passing back to GPMC and to grass roots level to gain feedback on direction of travel for the CCG. We have to continue with this process as the new PCN has more power, responsibility and financial involvement. Dr Sukumar also shared concerns that even at monthly meetings we are not able to catch up with the speed of things that are happening, bi-monthly meetings are not enough.

- Dr MacKeown added that CD's are providers but also have commissioning/monitoring care roles and so needs consideration to formalise how it is done.

  Dr Thorman commented that as CD's roles are evolving it is not clear how the local CD's will carry their roles forward. He agreed that the GPMC membership needs to change due to the 8 localities/6 PCNs but there is no reason at this stage.

  There is an option have 1 representative from each PCN on this members group, reflecting the current structure but with open invitation for CD's to attend, but to review in 3-4 months.

- Dr Nalliagounder shared a view that historically, members have represented locality members at GPMC holding the CCG executives to account. As localities no longer exist, and have morphed into PCN's, CD's are now the leaders for the PCNs and therefore should not be left out of the decision making process.

- Dr Avery went on to give examples of recent pharmacy and VAR baseline discussions, bounced around emails/telephone calls for weeks , but if we had this platform already working, then these issues would have been discussed.

- Dr Muthoo shared an understanding that both CD's and former GPMC were required so that the GPMC continues to have the filtration mechanism of the executive decisions and then being passed on to the PCN's. The CDs role is to understand what is happening in a leadership role, and to lead a strong unit of GP's both as commissioners and providers.

- Dr Sukumar added that timing for each CD's is variable for the amount of work required, will they have time to attend the full meeting?

- Dr Thorman asked Dr Avery if the CCG has indicated if they would view CD attendance at this meeting as part of the CD role for remuneration purposes? To what extent does the CD attendance at this committee fulfil a CCG purpose as well as a .PCN purpose.

- Dr Avery responded that the CCG and CDs need more communication to define the details about this and also the roles of chair/vice chair/locality representation relating to remuneration.

- Dr Page commented that it is important to have a good active deputy for each area. Firstly to have somebody there who knows what is happening and secondly for succession planning adding that relating to being quorate, caution should be taken about making it 'too tight' and not to rely on a vital person attending/not attending rendering the meeting as not quorate. We have to get quorate membership right.

- Dr Cullen added that the other advantage is that as a CD wouldn't have to attend

every meeting due to time pressures by delegating a representative from their network.

- Dr Nalliagounder recommended two people from each PCN would be better option than one person. Regarding voting rights, he proposed a PCN vote rather than a member/CD vote adding that quoracy would be one person from each PCN with four out of the six PCN's having representation if required.

Members discussed the option to have bi-monthly meetings was purely to reduce GP workload pressures. Dr Cullen assured members that it is not a cost issue which was also confirmed by Mrs Allott who stated that the final decision made would be fully supported by adjusting the financial plan accordingly.

- Dr Avery asked Mrs Nutbrown what proportion of attendance is required to be quorate, if twelve people are invited and at least one person from each locality attends. Would it work if we have five out of six PCN's represented?

- Mrs Nutbrown responded that from a HR perspective, 85% is required.

- Dr Thorman asked if this refers to quoracy of people representation or PCN representation.

- Dr Avery offered the earlier comparison relating to a proportion of twelve people attending, against five out of six networks having representation which would work to the 85% rule.

- Dr Muthoo interjected that rules are very different for GPMC members who have provided for the CCG, GP's and Primary Care in general having very different roles, adding that CD's are coming with a very different 'leadership' hat on. The reason for the meeting will cover aspects of the GPMC meeting as well as the leadership meeting.

- Dr MacKeown stated as the CD role represents the PCN, each CD has responsibility for managing their own conflicts of interest.in the best interest of the PCN and the patient.

- Mr Atkinson added that this discussion has been really positive. When GPMC was set up it had two functions - to establish the strategic plan, and how members create and hold to account the SCE delivery (no routinely voting) adding it is more about how we create the headspace of the CDs and SCE.

- To clarify the proposal, Mr Atkinson informed members that the intent is that month on month, the system will be held to account for delivery of the CCG's plan. Mr Atkinson went on to say that alongside primary care issues within the system, 50% of the time will be look at how to engage with the CD's for their part of the plan, so that a few months further on when papers come through CCG governance everything will be aligned and ready to work within the system. Mr Atkinson added that the where SCE clinicians present a case to members, if there is strong feedback questioning a process requiring different thinking, the lead GP would take it back into the CCG the following month. There may be rare occasions where a vote is required to sign off the commissioning plan for the coming year.

  Mr Atkinson gave an example of the Commissioning Plan review of respiratory pathways and the on-going live discussion between the CCG, GPMC, SCE and how it links in PCN directors and to create that opportunity to offer influence and direction.

Members discussed the benefits of more early input and the opportunity to discuss and manage the Rotherham Plan in a different format.

- Dr Muthoo - no real data is available for the PCN role. Rotherham is way ahead of the pack and CD's will now represent all providers being pro-active and leading the commissioning.

- Dr Sukumar commented that CD's will filter duties due to workload pressures.

- Dr Thorman queried quoracy, asking if being quorate means the CD's are welcome to attend, with 5 of 6 PCN's represented, would the CD's look at the agenda and own workload and come as often as possible. Does this offer the best representation.

- Dr Muthoo stated that it cannot be that simplistic. As an LMC representative, GP Member and GP, why should a GP not be able to vote.

- Dr Thorman stated the vote would be through the PCN.

- Dr Muthoo stated that he would like the GPMC to take issues back to each PCN and ground rules have to be set, with dependence of GPMC members to retain the value of real thinking.
  Dr Muthoo gave the example of Dr Cullen sitting on CCG Board decisions, then coming to vote on a GPMC decision.

- Dr Cullen added that GPMC is an important part of the governance process but it is not 'the' governance process. The initial discussions will have been developed with full GPMC knowledge through various meetings, which would not require a strict quoracy as it is more of a consensus of opinion.

- Dr Sukumar asked about doing the same job and getting paid twice e.g. as a CD and GPMC chair, will the two roles run simultaneously. Papers are the same for both meetings, it is complicated as there is so much work to do.

- Mr Atkinson stated that GPMC endorse decisions for the direction of travel to the CCG, they rarely make actual decisions. Mr Atkinson suggested that space is created in the second half of the meeting for commissioning business, that becomes a forum where the CD's are invited to a more grounded meeting.

- Dr Avery referred to the paper circulated.to ensure all points have been covered.

- Dr Suku stated we have covered the GPMC, CD's meetings, PCNs – what happens in CCG. If CD's are invited to the decision making process, what happens to SCE members.

- Dr Cullen responded that SCE members provide weekly clinical input e.g. respiratory pathway. The CCG listen to feedback on what changes are required to liaise and develop the pathway as a CCG team on behalf of the GPMC. The offer is that CD's can attend or identify a representative to any meeting we have organised relating to development of clinical pathways.

- Dr Sukumar asked if CD's would attend as they have a set pattern of daily work. Would they also get paid to attend other meetings.

- Dr Thorman shared concerns that if CD's attend other meetings, is it another tick in a box which should be provided by the GPMC.

- Dr Cullen responded that historically, GPMC provide the clinical view in meetings as additional clinical input i.e. non-members group GP's and members have contributed and feedback. If a CD has a specific interest they are offered the opportunity to attend as clinical leaders, in order to contribute to areas where they have decided change is required.

- Dr Thorman shared concerns that if a group of CD' s nod very firmly at something the SCE is doing, the CCG then get the idea it has been agreed

- Dr Cullen stated that is exactly why CD's and other members are present at this meeting so that an agreement can be reached. Dr Cullen will ask for a list of meetings where clinical input will be of benefit to allow CD's to identify where, as CD's, we might need to consider wider clinical input for areas of specific interest.

- Dr Sukumar commented that there is no 'top down' directive on how CD's will work.

- Dr Muthoo asked if CD's can challenge an executive if they are not happy with the way a service is being provided, adding that a CD as a leader, would not be able vote in the same way as a GPMC member.

- Dr Cullen responded that GPMC have an issues log to address this adding that there is a commitment from SCE and GPs to attend when requested, a finite budget and management work plan if GPMC identify an issue which needs addressing.

- Dr Thorman shared a nervousness that CD's could 'use' the GPMC and become a cabal making decisions and pushing things through GPMC.

- Dr Cullen stated that this is not the decision making body, it is recommends to the board so there is the opportunity for lay members and independent GP to ask questions.

- Dr MacKeown commented that CD's need to have discussions and include everyone in the decision making process.

- Dr Sukumar asked for clarity relating to the new CD leaders representing the practices and the 8 SCE members leading the CCG, and how the future will unfold if we have 6 CD's, 6 PCN reps, LMC and SCE members.

- Dr Avery added that Dr Douglas also shares concerns that CD's will also have a 'dual' CD/SCE role made more difficult to define due to lack of guidelines or rules.

- Mr Atkinson suggested we agree on a 6-9 month interim plan and work through the financial risk with further review by the end of the financial year, as a Rotherham Place as it will allow enhanced engagement, putting the service first.

Appendix 1

Mrs Nutbrown asked members if they wanted changes to be made in the content of Appendix 1,

- Title
  Do members wish the title of the meeting to remain as GPMC
  Dr Avery confirmed **GPMC** is the agreed title for the future meetings

- Purposes
  1st paragraph - strengthening of text
  Third line to read '**involved with /part of**' rather than 'linked'.

- Responsibilities
  Details to be reviewed in 6 months
  Change bullet point 1 to read **PCN** rather than locality
  Second bullet point to include **locality/objectives**
  To add a bullet point to read **'to present the view of the PCN's'**

- Composition of Group
  Currently listed as 12 people - to be changed to **2 people from each PCN of which 1 is the clinical director or clinical representative**
  Mrs Nutbrown asked for agreement that those 12 people are the voting members if required.
  Each person has an individual vote.

- Quorum to be changed to 1 person from each PCN **with the first sentence removed.**
  Dr Page asked who has the vote if both the CD and clinical representative are attending. Is it one vote per PCN.
  To include **If a PCN is not represented and they are unable to attend, a proxy vote can be submitted to the chair.**
  Mrs Nutbrown confirmed there will be 12 members, each PCN has the mandate for 1 vote should it be required.
  Dr Muthoo stated it cannot be quorate if all CDs attend with no other reps or all reps with no CDs.

- Accountability
  Dr Cullen shared the view that long term, to be able to get more GP full involvement with the CCG Board, it would be wise not to have the chair and vice chair as CD's. This needs consideration of succession roles over the next months. The Board is the final assurance check that everything has followed process and the final point of sign off.
  In principle members agreed but that there should be a review in 6 months.

- Frequency - to read **a minimum of six meetings per year**
  The next meeting is scheduled for September and will be required to sign off the TOR.

- Attendance - Mrs Nutbrown suggested that the attendance be changed from 100% to **85% per PCN.**

- Next Review - **6 months**

Appendix 2

Members agreed that they would commence arrangements for the first half of the meeting and progress this TOR as the process develops.

- Dr Avery added that the CD's, LMC and general feedback would then influence what is in the TOR.
- Mr Atkinson added that the second meeting would involve the CD's as providers on development of plans to implement the strategy.

- Dr Thorman expressed a concern that if decisions are made in the second meeting, what is the point of the first meeting?
  Dr Cullen responded that it is about what the PCN might contribute to the item.

- Dr MacKeown commented that as a CD, it feels more like a 'mini PCT', having a provider role, commissioning role and a monitoring role. With that in mind, where would the co-commissioning type discussion take place.

- Mr Atkinson responded that in the first meeting, a paper is received in the first meeting, fully worked up with finance detail attached, and recommendations to endorse the direction of travel as in the past few years with added input.

  The second half of the meeting will look at how to get CD input prior to the formality i.e. respiratory pathway having enhanced model in the community.

- Dr Thorman asked why early feedback cannot be given in the first meeting and why it is exclusively CD's
- Dr Avery stated that the discussion needs to take place between CDs and the CCG as it is different to GPMC.
- Dr Thorman asked why the CDs views are needed and not GPMC if we need grass roots level feedback.
- Dr Muthoo suggested contacting the GP's to establish who is interested.
- Dr Avery added that to follow the discussions taking place at GPMC, the second meeting will look at opinions and a secondary discussion with CD's and CCG to discuss further.
- Dr Thorman shared a concern about who defines what is discussed at either meeting and why the CCG would ask for a 'just' CD opinion.
- Dr MacKeown added that a CD job description is to represent the network at CCG level clinical meetings.
- Dr Avery stated that the second meeting is an opportunity to discuss if required as the space and time is allocated. The meeting is all about communication rather than making decisions.
- Mrs Nutbrown added that is also about interface with the wider Rotherham Place system for e.g. public health.
- Dr Sukumar stated that GP issues do not get enough attention at this committee and dedicated time is needed for it.
- Mr Atkinson stated that this forum would give the chance to discuss issues.
- Dr Bradshaw commented on the viability of attending the first part of the meeting being more difficult for practices to release staff for 90 minutes.
- Dr Avery suggested a time commitment for six months to see what works/does not work and too look at whether people struggle to meet this commitment. By being here for 90 minutes then members may as well stay for the second meeting.
- Dr Nalliagainder suggested an **addition to the Priorities section about day to day issues in Primary Care.**
- Dr Sukumar commented that sending an email to SCE members would be delegated to other staff, and staff shortages/sickness/lack of cover would delay responses.

Forward agenda items.

Respiratory Update

Performance Report

Permanent Medical Director invitation.

Next Meeting: Wednesday 25 September 2019, 12.30 – 3.30 pm, Room G0.4 Elm Room, Oak House

No Lunch Provided