NHS
Rotherham
Clinical Commissioning Group

Minutes of the NHS Rotherham Clinical Commissioning Group

GP Members Committee

28 April 2021

Via zoom

Quorum
Quorum is one member or deputy from each Primary Care Network
Committee members have 1 vote per Primary Care Network

Present:

Primary Care Network	Clinical Director	Representative
Maltby/Wickersley	Dr G Avery (Chair)	Dr R Fulbrook
Health Village /Dearne Valley	Dr S Mackeown (Vice Chair)	-
Raven	Dr A Qureshi	Dr B Chandran
Rother Valley South	Dr T Douglas	Dr N Thorman
Rotherham Central North	Dr N Ravi	Dr S Langmead
Wentworth 1	Dr T Ahmed	Dr S Sukumar
Participating Observers		
Practice Manager Rep	Mr B Wiles	
Nurse Representative	Mrs S Cassin	
CD of Connect Health Rotherham	Dr G Muthoo	

In Attendance:

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Chair of SCE	Dr R Cullen
Vice Chair of SCE	Dr J Page
CCG Chief Officer	Apologies
CCG Executive Place Director	Mr I Atkinson
CCG Chief Finance Officer	Mrs W Allott
CCG Assistant Chief Officer	-
Administration	Ms D McGarvey
SCE GP Lead	Dr D Clitherow -item 9 Long Covid Pathway

1	**Apologies** Mr C Edwards
2	**Quorum**
	Dr Avery confirmed the meeting quorate

3	**Declarations of Interest**
	The Chair reminded members of their obligations to declare any interest they may have on any issues arising at meetings 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
	Declarations of Interest from today's meeting
	No conflicts of interest were declared
4	**Draft minutes of the GP Members Committee meeting dated 31 March 2021 and the matters arising**
	Members agreed the minutes were and true and accurate records of the meeting with actions completed or underway
	Actions: For discussion Vote of Confidence Term of Reference Proposed Legislation for Clinical Commissioning Group transitioning to Integrated Care System Communications for the Integrated Technical guidance awaited May agenda- Dr Anand and Mrs Tufnell Mental Health update Members are to discuss the role of the GPMC meeting and GPs forming new meeting to be represented at Integrated Care System
5	**COVID update**
	Mr Atkinson informed members, the covid infection rates for Rotherham have reduced to 55/100000. No significant impact on the infection rates have been identified over the Easter holiday period or with children returning to schools. Rotherham are in a positive position with the rates of prevalence and delivery of vaccination programme for first and second doses and have ability to look at the system as one across Rotherham Place. The expectation is that 70% of the Rotherham adult population will have received their covid first vaccination. With the current high covid infection rates and death rates in India, they are expected to use their manufactured supplies of the Oxford Astra Zenca vaccine for their population. England with continue with the delivery of the vaccination programme with the moderna and pfizer vaccines. Rotherham have a good system in place for delivering the programme. Dr Fulbrook asked were Rotherham are at, to move from the National push model of delivering the vaccination programme which is driving the numbers forward in Rotherham. The push model is causing problems from a staffing perspective when

	such as a weekend covid clinic is cancelled and re-arranged to take place mid-week at short notice and practices expected to manage. Could Rotherham revert to a pull model to control the covid clinics to deliver the vaccine programme to help with the moral of the teams. Mr Atkinson informed members the aspiration nationally for a pull model would be when the vaccine can be supplied in abundance. Currently there is not enough supply for all the first doses of the vaccines, the national narrative does not always deliver the vaccine as agreed and then clinics are arranged when the supply of vaccine is received. Rotherham will use the moderna and pfizer vaccines as they are allocated, and the level of vaccine managed as the amounts of vaccine will not be coming through the system in large numbers over the next six weeks. Management of the second dose of the astra zenica vaccine there is more flexibility and offers to get the balance right for available workforce versus the core work in Primary Care. Dr Avery informed members of the covid expansion fund available to help back cover for shifts and agreed is it not easy to organise and difficult with changes brought with the relaxing of the lock down restrictions socially and work wise and keeping up the momentum of delivering the vaccine programme. Dr Sukumar informed members for the second phase of the vaccination programme Primary Care Networks agreed to work together, the plan was to deliver the astra zenica vaccine which can be controlled and utilise to the practice's timescale. And for the pfizer vaccine to be delivered at different vaccination centres as there is no control and needs to be dispensed of to the public quicker. Vaccination sites are becoming busier, staff are requesting holidays and the is a lack of staff for the practice core service work that is still expected to be carried out. Mr Avery informed members it has been agreed for other staff members to be brought in to provide support with the programme for the administration, vaccination programme and locums. Dr Muthoo informed members the astra zenica vaccine is expected to be in short supply due to the situation in Indian and who are a main supplier of the vaccine. Mr Atkinson informed members indication from NHS England is that the next supply for first doses will be the moderna and pfizer vaccines.
	Actins None
6	**Finance Update**
	Mrs Allot informed members The 2020/21 financial year closed month 12 with £1,078000 surplus and has been agreed with the Integrated Care Sysytem and declared. Finance have prepared the first draft of final accounts and are the with auditors to be reviewed. The draft financial plan is due in on Thursday 29 April 2021 and is going to the Governing Body meeting for approval on Wednesday 5 May 2021. The features of the financial plan for 2021/22 is for the first six months from the allocations with working assumption for underpinning the plan with CCG

	assumptions of what twelve months would look like with only six months financial allocation guaranteed. Systems must submit balance plans and CCG have a draft balance plan which support CCG submitting balance plan being submitted. Once the financial plan is approved in Governing Body then detailed conversations will take place of what it means internally, the financial plan will be taken to Primary Care where the risks will be discussed and what can and cannot be said for definite. Mrs Allott informed members it is not known how the transition path will appear for the role of Place or role of Financial Place and how the allocations play through are part of the design process that is not there yet. Dr Sukumar asked Mrs Allott the Rotherham CCG surplus is £1,078000 declared to the Integrated Care System what are the stances of the other CCGs balances and are the funds protected? Mrs Allott informed members of an artifact of the current financial regime is that the surplus is a technical surplus due to the changes made to the financial regime predicated on assumptions. The true CCG surplus for 2020/21 was underspend on prescribing projects tied in with and run with the Acute Trust where the funding were protected through a block system and the narrative has been updated in CCG annual report for 2020/21, to explain the CCG financial year. Dr Sukumar asked Mrs Allott if the Quality Care Contract in Rotherham is the payment ring fenced and protected, or with the bigger budgets will it be lost? Mrs Allott informed the meeting the Quality Contract funds is a delegated budget and the situation has not changed and is the only part of the CCG portfolio that is in line with the NHS Long Term Plan and is protected and re-provided for 2021/22. Dr Sukumar raised the concern of duplication of payments for work carried out in Primary Care Networks. Mrs Allott agreed funding is morphing due to the changes of where funding is sourced such as CCG, ICS, delegated, primary care networks, GP national contract and quality outcomes framework. As commissioners the CCG seek not to double pay for anything and amendments have been made to the quality contract and the delegated budget is protected. Mrs Allott informed members for transparency in the details in the CCG financial plan going to Governing Body for approval CCG have had a national settlement in Primary Care that is over and above the growth funding that CCG are given to fund it, there was a shortfall, mechanism has been used ways for the first six months of the year and making all other thing being equal CCG will use the same mechanism for the second part of the year. Dr Thorman asked Mrs Allott about contingency monies given the presented surplus at the end of the financial year would it lead to a review of the amount of monies that cannot be spent to general practice as contingency and in relation to that would it be possible if Dr Avery agrees for members to receive a report for the monies put aside last year for contingency and what was spent and what it was spent on?

	Mrs Allott informed members the concept of contingency disappeared in the financial year 2020/21. It is CCG business rules to keep a contingency, so when the new emergency financial regime came in for months one to three then changed in month four, again on month six and then months seven to twelve. None of the regimes required contingencies, because nationally they moved to a funding regime to provide funding for anything required to deal with the covid pandemic. A new financial plan was brought in based on a different set of scenarios and finance were managing the in-year financial position against national assumptions. Finance are unable to produce a report for 2020/21. For the financial plan for 2021/22 the Primary Care contingency is half a percent out of the delegated budget and the remainder of the CCG portfolio has a contingency of half a percent details are defined in the financial plan. Dr Ravi asked Mrs Allott what happens to the surplus monies? Mrs Allott informed members the surplus is added to the previously banked historical surplus's and noted against the Rotherham system. Rotherham have £15 million in surplus funds and CCG can request drawn down from surplus monies. It is expected that drawn downs will not be included in the 2021/22 financial year and drawn downs will possible be discussed again when the talks start about the new financial regimes associated with Integrated Care Systems. Dr Ravi asked Mrs Allott regarding the confidence of the delegated budget were do the Quality Contract monies and PMS investment funds including the innovation funds sit in the delegated budget available for Primary Care next year? Mrs Allott informed members they all sit on different lines of the delegated budget and came from what was originally PMS block. Where things have moved out of being a contract payment under PMS, of the nearly £2million monies CCG had to re-invest back via PMS reinvestment local enhanced schemes, inflation uplifts extra and monies in the innovation fund make up the delegated budget. Discussions will take place of where the funds can be drawn from for the shortfall. Dr Muthoo asked Mrs Allott could the local Place Integrated Care System decide to stop the Quality Contract and pass monies to the Integrated Care System or will Primary Care be an independent subsidiary and funding cannot be taken away and whether Integrated Care System new direct enhanced services duplicate specifications of the Quality Contract? Mrs Allott informed members the link of what the ICS may be able to do is unknown until any delegation agreement might look like with the ICS, it is unknown what will be delegated to Primary Care. Mrs Allott informed members she does not have the answers to these questions yet.
	Action
7	**National Planning Guidance**
	Mr Atkinson provided members with an overview of the National Planning Guidance and the NHS England's priorities for over the next 6 to 12 months are: • Recovery • Elective - 52 week-waiters • Urgent priorities surgical treatments

	• Cancer services • Mental Health • Primary Care vaccination programme • Primary Care Network Development • Integrated Care System- agenda CCG process response to the National Plan are being sent Friday 30th April with a response expected in two weeks.
	Action Mr Atkinson agreed to share feedback to CCG process to the National Plan
8	**Primary Care and Secondary Care referral Process**
	Dr Cullen provided members with an update • Monthly meetings have been set up with Dr Davies, Dr Gardener and Dr Cullen • Survey carried out by (TRFT) junior doctors to find out what details are required in the discharge letters to Primary Care. • Process set up for Systone letters to be sent the right way from different departments • List produced of how to communicate by email to GP practices and TRFT departments • Requested for accurx - secondary care to primary care letters to be added to the system for GPs to – LMC to obtain the BMA agreement for the use of their standard letters- Dr Thorman informed the meeting BMA have agreed for BMA letter can be used. • Dr Gardner is feeding back to consultants and junior doctors directly who are sending inappropriate requests to Primary Care. Dr Muthoo requested for new doctors and consultants to be informed of the process used by Rotherham primary and secondary care who have the same access to patient details**.** Dr Cullen informed the members the Morthen Road Practice will carry out a pilot scheme of the new letter process on accurx for communications directly with consultants**.**
	Actions
9	**Post-Acute COIVD-19 -Follow up in Primary Care**
	Dr Clitherow informed members the Long Covid presentation has been super seeded by new national commissioning guidance received on Monday 26 April, there are no great changes for the pathway and clinical care and provides additional guidance to commissioning services which breaks down the pathway for patients who have been in acute services and for patients not presented to hospital services. The pathway has been renamed Post Covid Syndrome Assessments causing confusion as some patients are having post covid pneumonia assessments carried out who attended hospital and acute bed based with covid pneumonia and receiving respiratory clinic follow up.

There are patients with different symptoms described as long covid, the data from the NHS Office of National Statics is changing while we are getting more knowledge of the syndromes from when England came out of the first wave of covid in 2020.
National data was suggesting that around 20% of patients may suffer from Long Covid syndromes, that has reduced and currently running at around 13 % and the figures are consistent with regards to the number of patients effected by long covid.

The National Institute for Health and Care Excellence (NICE) and the Royal College of GPs have written a case definition for patients who have had symptoms contributable to having an acute covid infection lasting beyond 12 weeks. The guidance gives a narrative description of what happens to patients after an acute covid episode and does not provide GPs with guidance of what to do making the commissioning of services difficult, GPs are learning on the job using experience of other systems. There has been a national drive from NHS England for long covid and post covid clinics being set up for patients who have been in acute hospital bed based, who may have prolonged symptoms.

Briefly patients would generally present with long covid at around 10 weeks and see a GP before that if their acute symptoms have not settled down. Acute covid is thought to last between four and eight weeks and then there is a time lag for these symptoms to resolve. Some patients will present beyond their acute illness with significant symptoms which may require hospital admission such as persistent chest pain, acute breathlessness and may need to be seen due to thrombotic risks. The long covid patients may present different symptoms at around 12 weeks.

Rotherham have set up from the national guidance suggesting holistic needs assessments to take place to look at medical symptoms, non-medical areas such as mental health issues assessments are being performed by Voluntary Action Rotherham and the details are fed back to Primary Care to deal with the dispositions that may be required.
Some patients may have significant ongoing respiratory symptoms and from a medical viewpoint is most prominent, patients with ongoing breathlessness, shortness of breath and exertion even if the chest x-ray is normal should be referred into respiratory services at Breathing Space.
It has been acknowledged that GPs are having issues referring into the service. The other area identified is patients with mental health disorders which are far reaching for patient attending the acute hospital bed based and managed in the community. Referrals in the mental health services and improving access to psychological therapies are required initially although some patients have significant post-traumatic stress disorder.

The part of the pathway the requires resolving is the multidisciplinary team (MDT) requirements, initially mentioned in the last round of commissioning guidance for patients dealt with in the acute hospital bed base and managed in the community who may have multiple symptoms to help the patients care and prevent multiple referrals. Due to the multi nature of post covid a patient may need to be assessed by respiratory, neurology, cardiology, dermatology, and other consultants**.**

The plan would be to form a multi- disciplinary team (MDT) to hold some of the more complex patients that have more than one system involvement to prevent

	them being referred in a number of directions that would not be suitable patient and the currently stretch service. There are discussions taking place and there are different ways, some area are putting in to an acute provide area and picking up the patients through the hospital base and referring up in to secondary care from community or run it as a community model and de-medicalise some of the on-going issues which can be chronic. This is work in progress with the aim for the figures to reduce and treatments are developed for covid and the prevalence of the illness reduces over the next few months. Dr Thorman asked Dr Clitherow what are the changes for patients who had their covid experience in Primary Care or Secondary Care and the long term follow up? Dr Clitherow informed members, the thoughts in 2020 were that there would be a large potential of long covid prevalence and would be unchanged for patients having had covid acute or community bed based and for patients who have not attended hospital during the period and patients who were not admitted with acute covid The numbers of patients with acute covid the figures increased when the various waves have happened. The thought is that patients who had covid a year ago the levels of long covid are the same between those patients cared for in acute admissions and community managed patients. That might be changing with more patients going in to hospital there might be more long covid occurring in patient that come out of hospital there is no definitive information yet. Patients who have been in hospital with covid get a follow up phone call at 6 weeks and may have a second chest x-ray if they are still having respiratory symptoms and then a formal follow up at 12 weeks follow. Dr Clitherow informed the meeting there are no changes made to the national guidance regarding follow up for patients post hospital. Dr Douglas acknowledged the difficulty of the pathway as there is not perfect model and questioned if a communication could be sent out to GP practices regarding the initial assessments being carried by VAR as patient are expecting VAR to be the Long Covid Clinic- Dr Clitherow informed members the issue is being addressed. Dr Muthoo thanked Dr Clitherow for the comprehensive detail in the long covid pathway and asked, of the 13% post covid sufferers what are the figures in Rotherham and does all the investment need to be done at an ICS level rather than Rotherham Place? Dr Clitherow informed members the numbers for post covid sufferers in Rotherham are currently unknown the figures could be modelled out based on national prevalence and from what has happened since and he was involved with the long covid pathway at an ICS level as there are different models for the pathway, the ICS view is that the long covid pathway should be delivered at Place because of the services that maybe required vary between Places and there will be ICS involvement in the future.There will be a further analysis of where Places are struggling with sectors and this would be were an MDT would be required. Dr Clitherow informed members that smaller systems that have created the MDT part of the pathway.
	Action None

10	**Reduce GPMC meetings for Primary Care to form a new representative group during CCG/ICS transitional period**
	Dr Avery informed the members Primary are required to identify a Primary Care representative at ICS by April 2022. Dr Cullen informed the meeting the ICS/Primary Care Group model is of a one Primary Care representative from each Place to represent Primary Care at Primary Care Board or Sub-Group of the ICS Board. Of which one of those will become the Primary Care representative on the ICS Governing Body. A priority is for GP Members to identify a lead and how the Primary Care Directors, GP Federation and Practices would feel represented by the selected representative. Time is required to be set aside for this discussion, Dr Davies Chair of the LMC has sent out a survey monkey out to make sure the thoughts are in still in alignment with what the majority of the GPs in Rotherham are thinking. CCGs are being expected to transfer some of their decision making into the joint committee of the CCGs in a more structured way. Therefore, they will have less business coming through the CCG Board and more going through the combined Boards of the CCG in the joint committee and less business coming through the GP Members Committee to feed up to a Board. Dr Thorman informed members up to now 30 responses have been received to Dr Davies survey monkey and supporting the idea of having a reference type group within Rotherham Place to represent Primary Care, General Practice and GPs need to think what Primary Care means in its broader senses. Subsequently, the discussion that took place for the survey monkey were that this group would evolve into the reference group. Dr Thorman asked if the CCG Officers of the GP Members group and administration support are in agreement with the direction of travel and if so when would it happen and does anything need to be done to make it happen? Dr Cullen informed members that the Mr Edwards and Dr Cullen's roles are to provide support for the development of the Primary Care voice as it develops. There are no extra resources to fund people to go to other meetings, Dr Cullen and Mr Edwards will provide representation and admin support when needed. Members discussed and agreed for the GP Members meeting in May for this matter to be discussed and resolved. And in the meantime, the GP Members group perform the duties while the CCG exists on a notional basis, with the expectation that, the majority of the business that comes through the members group will be on the basis that it is the Rotherham super reference group and the membership will change accordingly. What is the process? Dr Cullen informed members with the new ICS there is not a process to follow, it is up to the members to agree to extend their role. Dr Avery agreed for members to discuss the options for the current GP Members Committee meeting to be held bi-monthly, for papers to be discussed and a further

	discussion of the new group to take place at the next GP Members Committee meeting in May. Dr Douglas requested clarification of what resources are available for the representative who attending the committee, representative at Place Board and representation at ICS level meetings. Dr Cullen informed members resources will be identified for a GP to be the representative for Primary Care. CCG will not fund a meeting for GPs to decide who the representative will be. When GP Members Committee comes to an end the funds will be released as CCG transition. Mr Atkinson informed members. in relation to a super reference group the system seems to be gathering up momentum regarding future architecture, functions and how it all plays out and CCG ability to influence it via the GP Members Committee Group in terms of the Primary Care aspect which is one aspect of the whole system which is vital and having part of the members committee dialogue that still sticks on the core of CCG constitutional business if it is required monthly or bi-monthly. Among the space using the group to feedback anything that is coming out of ICS dialogue around and how the local Place will interact and for the Place based work and broader Primary Care work to be managed Dr Avery agreed for one hour of the GP Members Committee meeting in May for members to discuss the future for the Primary Care representation and half an hour on papers. Dr Muthoo questioned who will be representing the dentists, optometric and community pharmacies at Place and to consider a collaborative representative with Primary Care Practices with agreement for a GP as representative? Dr Cullen agreed as Primary Care develop and to maintain a GP in the prime position and offer for dentists, opticians, and pharmacies to get involved in a Primary Care group with LMC representative. The National documents expect Clinical Directors to be strategic leaders for out of hospital care and to represent the community voice to develop services with the pharmacies, dentist and opticians. Dr Cullen agreed to provide members with a starter list for the GP Members Committee meeting in May
	Action Dr Cullen agreed t provide members with a starter list for the discussion.
	For information
11	C- the Sign
	Dr Page informed members the software will be delivered to practices from the 10th of May and provides: • Two week wait forms kept up to date • Safety net for cancer care reviews and follow ups • Set checklist for GPs -of which patients to refer for diagnostic

	Each practice is required to sign a data protection agreement Dr Thorman informed members historically Data Protection Agreements usually go through to the Local Medical Committee. Dr Ravi informed the meeting he has watched the demonstration video – to the new system and informed members it is vital for the correct data input of codes and notes must entered.
	Action Data Protection Agreement to go through to the Local Medical Committee
	For Approval
12	Strategic Clinical Executives Chair and Vice Chair
	Mr Atkinson informed members in line with the CCG constitution GP Members are asked to ratify the decision of the members of the Strategic Clinical Executive meeting. GP Members ratified the Strategic Clinical Executive members decision.
	Action None
	Standard items
13	Issue Logs TRFT RDaSH
	Action Not discussed -short on time for the meeting
14	**Any other business**
	Dr Ravi asked Mrs Allott and Mr Atkinson if there was any sight of the covid expansion fund monies of £120m for Rotherham and how it is going to be distributed. Mr Atkinson informed members the allocation has not been received and the agreed approach will be practice per head population when the allocation has been received. Dr Sukumar- requested for the minutes of the GP Members Committee to be circulated prior to the papers for the meeting being circulated. Dr Avery agreed to look into the GP Members Committee meeting minutes being distributed prior to the papers being circulated a week before the next meeting. Dr Mackeown informed the meeting of district nurses providing the wound care service not seeing housebound patients at the weekend and queried if there is a gap in the service? Dr Thorman informed members the issues have been resolved.

	Action Dr Avery - Draft minutes to be circulated prior to papers being circulated a week before the meeting
15	**Feedback from Governing Body March 2021**
	Dr Avery informed members everything has been covered.
16	**Urgent Issues and Appropriate Escalation and Risks Raised**
	None
17	**Date and time of next meeting**
	Wednesday 26 May 2021 at 12:30pm via zoom