Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

**HALLAM AND SOUTH COMMISSIONING LOCALITY**

**Local Executive Group (LEG) Meeting**

**Thursday 12th June 2014 at Charnock Health Centre 2-4pm** Item 12h

**Minutes Part A**

Members: Dr C Heatley (Chair), Dr M Boyle, Dr S Davidson, Dr A McGinty, Mr G Osborne, Mrs J Coakley, Mrs M Smith, Ms L Butler Mrs J Hoskin

Apologies: Dr G Wood, Mrs S Nutbrown

Note taker: Julie Hoskin

Declaration of Interests – None. Julie and Laura need to be issued with a "conflict of interest" form
Minutes of last meeting accepted as a true reflection of proceedings.

Matters arising: Charles has spoken to the Clinical Commissioning Group (CCG) regarding the offer of a management trainee to assist with some of the project delivery and to help with bid writing.

1) FURS (Freed up Resources) Update:- Charles confirmed that he would write to the unsuccessful bidders. There is still money available to spend and so projects can still be submitted for approval until September. It was suggested that Tanya Tailor (management trainee) could help with this.

The Medicines Optimisation scheme has been chosen to go ahead but as Michelle is now on maternity leave Charles will meet with the Public Health representative and report back.

The discharge co-ordinator scheme had been evaluated and the report was supplied to the group for opinion. It was felt that there was merit in the scheme and it should be re-submitted to try and qualify for some support, especially if it could be made more "locality-wide". Gordon wondered if it may be able to tap into the "winter pressures" funding. As the role taken by the discharge co-ordinator had similarities to that of the case manager role, a discussion developed around whether it would be possible for practices to obtain a list of patients previously cared for by the case manager so that data might be obtained to see how they had fared after this role was lost. Laura thought that this information should be obtainable and Gordon said that Community nurses can read code patients under their care so that it can be searched for. The information would be useful for the Acute Portfolio work on unplanned admissions. It would be beneficial to know information on admissions and if there had been an increase in GP appointments

and or visits. Another piece of information required is the number of cases of pneumonia per practice and information re vaccination status.

2) Julie (H) reported back from a visit to the Primary care development nurses based at the CCG. This team of 10 are available to assist in a variety of roles. For example, case finding, register cleaning and assistance with running joint clinics. They are not covered by their role to run clinics without the practice nurse being present but are keen to "get into" practices. They are very skilled in the holistic care planning work and can assist staff in doing these interviews or can train by using test patients and scenarios. It was agreed that they should be invited to a clinical council soon (11th Sept ) to discuss what they can offer and then it is up to practices whether they choose to use the team. Laura also thought we could email practices to advertise this service on their behalf.

ACTION JH and LB to organise this.

3) Financial Plan:- Gordon reported that there is a balance of "set aside" money for projects, £6,000. He also reported that Gill Newman from the CCG financial team wondered if she should come to our meetings. He wasn't sure what the purpose of this was and he didn't think it was necessary. The group agreed.

4) Clinical council for 10th July. (also combines item 10 Quality Incentive Scheme – QIS)

The QIS requires that GPs attend 8 meetings per year, the group felt that by offering to host some of these combined with the regular clinical councils LEG would be helping practices to meet the target and qualify for payment. This means that the format of the Clinical Council (CC) will need altering slightly as these meetings need to last for 2-3 hours. Gordon suggested that we begin earlier to allow for material that needs covering to be covered and then have the clinical speaker at 3pm. It was agreed that if we adopt this format for the final 3 CCs of 2014 and the 2 arranged for 2015 this would contribute 5 of the required 8 sessions for GPs and PMs. Julie C and Michelle agreed that it would be very useful to have these things combined. The current speaker from the Weigh Ahead scheme will still attend as planned but Sue L will contact practices to inform them of the new timings for the CC.

Gordon also discussed the idea of LEG supporting Multidisciplinary Team Working (MDT) meetings arranged around admission avoidance work. This could also be a forum to discuss the audit of where the case manager patients have ended up.

5) GP Association Update. Julie C and Michelle gave a general update regarding GPAs, the main thing to report being that Nether Green has moved from its current GPA (Hallam)to South West.
6) GPPA met with the Local Medical Committee ( LMC) who wish to be present when the GPPA negotiate with the CCG. The CCG would be negotiating with the GPPA as a provider organisation instead of 88 separate practices. The

Locality Managers at the meeting pointed out that there needs to be a total buy in from all the practices, HAS locality has 24 out of 27 practices on board at the moment. Provider companies would not be eligible to attend this meeting. The group wondered if the LMC might be an obstructive element in negotiations but if GPs happy for them to be involved then this would be fine. There was some concern that GPs do not really understand the significance of the GPPA and the new calculations being made that might affect practice especially PMS practices.

7) Care planning update ;- 415 plans claimed for - 40% of these are from HASL. The Local Enhanced Service( LES) finishes by September although it is hoped it will be retained as a resource by CCG to help maximise the potential for the national Direct Enhanced Services (DES) to be achieved. The inclusion of Nursing homes and Residential homes in care planning was also discussed as if they scored enough on the tool did not that demonstrate that they were at risk of admission. Charles asked if NH and RH could be included and Gordon said they could if you could demonstrate that the practice had added value by including them. Gordon felt the view of the Local Area Team would be that they hadn't asked practices to report on many areas so that all would have to be completed. Gordon also had worries that practices would do the work as they had for the Patient Participation incentive scheme and not be paid.
8) Quality standard:- Being worked on at present so discuss next meeting.
9) Planning Guidance Everyone counts and Better Care Fund. Charles and Gordon attempted to explain that this would be a situation where Local Authorities and NHS work together to jointly commission services for local people. For Sheffield this would mean the Council and the CCG learning to trust each other initially with pretend/virtual money. Charles used the example of an elderly patient in hospital needs to be discharged but the care package means council becomes responsible for the cost of their care so in no hurry for this to happen. Patient stays in hospital which continues to cost NHS money. If all money came from same "pot" would encourage a more integrated approach. The Medicines Optimisation scheme is an example of this idea in practice.
10) Quality Incentive Scheme. Gordon explained that this will be tabled to practices even though he felt it was too early to send, but told to do so. He explained that the philosophy is that the Incentive Scheme will cover work that good practices are already engaged in anyway. The four portfolio leads had considered areas that practices should be able to audit easily too. There is a need for clarification for practices. There is a requirement for attendance at 8 meetings to take place between June 2014 –April 2015 (see above).
11) Unplanned Admissions : the meeting felt that if the data could be gathered from the practices as discussed earlier this could be a useful exercise. The template was discussed as it is portable and can be incorporated into the holistic care planning template. This will updated upon at future meetings. Charles wondered if this needed clarifying for practices holistic Care Planning (CP) versus Unplanned admission CP. Do practices understand what the Local Area Team have asked for.

12) AOB:- Michael asked if anyone in the group had a problem with the intended speaker on Atrial Fibrillation being funded by Bayer. The talk would be non - promotional. The group discussed this and it was felt it was not a problem.
ACTION:- Michael agreed to liaise with the rep and arrange a date for a future Clinical Council.

13) AOB:- Isabell Bancroft from the Medicines Management team wanted to attend every meeting. Charles suggested she let us know what areas she might want to be involved with but perhaps it might be better if she attended the CCs.
NB She is in diary to attend the LEG meeting on the 21st Aug?

DONM - 17th July 2014 at Charnock Health 2-4pm.

**NORTH LOCALITY**

**COUNCIL MEETING AT ST THOMAS MORE COMMUNITY CENTRE**

**25th June 2014, 8.30am – 11am**

| Agenda Item | Action |
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| **Welcome, introductions and apologies**<br>TE welcomed two registrars; Nicola Finn From Buchanan Road and Alena Sileka from Chapelgreen Practice<br><br>***GP Attendees***: Dr M Ainger, Dr D Chatterjee, Dr R Corker (RC), Dr L Cormack, Dr R Deslandes, Dr K Donaghy, Dr N Field, Dr E Gabrawi (EG), Dr A Grover, Dr P Johnstone (PJ), Dr D Keating, Dr R Kemp, Dr H Key, Dr S Lupton, Dr P Mooney, Dr C Nwafor, Dr R Panniker, Dr A Rosario.<br><br>***PM Attendees:*** J Burgar, D Emmas, B Foster, K Green, S Grundy, P Hardy, A Hartley, C Hitchmough, L Houldsworth, J Jude, J King, M Payling, L Platts, M Neville (MN), C Stocks (CS), T Tate.<br><br>***North LEG Members:*** Dr T Edney (TE), S Kirby (SK) & Dr L Sorsbie (LS)<br><br>***Other Attendees***: Nick Allan-Smith (SCI Manager) (NAS)<br>Rachel Dillon (West Locality Manager) (RD)<br>K Dunne (SCCG) (KD)<br>L Liddament (SCCG) (LL)<br>Dr Alena Sileka (Registrar, Chapelgreen Practice)<br>Dr Nicola Finn (Registrar, Buchanan Road)<br><br>***Apologies from:*** N Alneami, Dr W Carlile, M Richards, C Normington, N Normington (NN), J Stevens, M Tindall, Dr A McCoye, Dr S Lupton, Dr T Turner.<br><br>Minutes of the last meeting were accepted. There were no matters arising. | |
| **Conflicts of Interest**<br><br>TE advised the group that until now the GP Provider Assembly update had been incorporated with the commissioning part of the meeting but it was decided to split the meeting. Once the commissioning side is closed PJ and CS will take over to give a provider update. | |
| **End of Life Care Pilot**<br><br>TE advised that there will be a new pilot that will start in Autumn. Jackie Gladden from the CCG will be attending the September Council meeting to | |

**Future PLI events:**

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| 9th July 2014 | Respiratory Disease (including COPD & asthma) |
| 3rd September 2014 | Mental Health/Learning Disability |
| 1st October 2014 | Infectious Diseases/Infection Prevention & Control |
| 5th November 2014 | Long Term Conditions, Care Planning & Self-Care |
| 26th November 2014 | Adult Safeguarding |

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| explain further but TE wanted to give the group the basic information. The project will co-ordinate care for palliative care in patients' homes. Care can be stepped up or down according to need. This will involve the palliative care team and District Nurses along with care providers into one care package. These carers and co-ordinators will receive training with the expectation that they can agree to look after a patient if they choose to stay at home. The pilot will be set up in the North Locality with the hope to spread citywide if it is successful. | |
| **Practice Visits**<br><br>The Exec group felt that they were losing contact with individual practices and were not seeing the other members of practice staff by attending GPA visits instead of practice visits. PJ responded that the practice visits were good for engagement. MA responded that the practice visits are a good idea and they promote engagement and added that feedback from the Council meetings should be altered too. It would be good to have a newsletter before the minutes with summaries of what was spoken about to feedback to practice staff. The group agreed. KD will start writing a Council Bulletin which will include a brief summary of topics discussed.<br><br>TE asked for dates from practices for the practice visits which will start in Autumn. Practices should send their availability to LL to organise. The visit will last 30-45 minutes. LS wanted to reemphasise that practice visits are good as the GPA visits felt like the Exec Group were losing contact with practice staff who do not attend the CCG meetings. The summarised minutes are also a good idea. | KD<br><br>All |
| **Care Planning LES**<br><br>LS congratulated all practices on their engagement with the LES. The final quarter ends on the 30th June and all practices need to have obtained the 75% target by then. NN will be collating the data and if practices hit the target they will receive their final payment.<br><br>LS wanted to reiterate that this is not the end of the LES. Practices have been given funding for two visits for each patient. The second visit which reviews the patient's progress is needed to evaluate the LES. Hopefully the initial results will be ready by September and by this time patients will have been seen twice. The LES should be discussed in GPA meetings for individual practice feedback. The evaluation will look at whether there was a decrease in A&E attendance, decreases in practice and pharmacy visits along with patient feedback. In late December or early January the final report will be completed. LS advised that the Exec Group worked hard to get the funding up front instead of per Care Plan. The Exec Group argued that if practices were given the money first then it gives opportunity to plan. The concern is if patients are not seen for the second visit and if practices stop after they receive the last bit of funding then this method of funding | |

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| will not happen again. LS urged the group to carry on with the scheme to keep to professional standards and show the CCG the evidence based work.<br><br>Practice Managers have agreed that if patients actively declined then they would be taken out of the cohort, as they are in QOF. The DNAs will still be counted in the cohort<br><br>MN asked whether practices will need to collate patient questionnaires. LS responded that this is needed and the GPAs need to summarise the feedback.<br><br>TE asked the group for progress with the citywide scheme. Some of the group responded that they are not doing it as there is too much work but others are able to do both the citywide and Locality LES. | All |
| **Learning Disabilities DES**<br><br>Heather Burns from the Long Term Conditions Portfolio has raised concern at the level of sign-up to the Learning Disabilities DES. The CCG are aware that there have been administrative problems and would like to know whether practices have voluntarily not signed or if this is a mistake. There are four practices not signed to the DES; if this is a mistake please contact Heather Burns ( heather.burns@nhs.net ). They are Wincobank, Page Hall, Crookes Valley and Dunninc Road. | |
| **Governing Body Update**<br><br>There is a need to improve communications from the Governing Body to practices so if the group has any thoughts, ideas or innovations it would be good to feedback to the Exec Group.<br><br>The two main areas being discussed at Governing Body are Co-Commissioning with NHS England and the Better Care Fund. LS gave an overview of co-commissioning. The 5 CCGs within South Yorkshire and Bassetlaw (Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield) have been working together on an Expression of Interest to co-commission with NHS England. The core contract would not be affected so it would be more of a GMS+ contract with relevant services to Sheffield. The expression of interest is South Yorkshire and Bassetlaw wide as this is a consistent area and there would be local CCG variations. It is ambitious and not without risk. Co-Commissioning presents an opportunity for flexibility. The deadline is short with the final Expression of Interest to be sent before the end of June. Because it is just an expression of interest, the CCG can still back out. The opportunities available can be seen when looking at initiatives such as the Roma/Slovak work. The current health inequalities across the city can be tackled and there could be an increase of services in primary care. TE added that, for example, with Winter | |

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| Pressures last year the CCG had problems paying practices extra for core contract work (surgery time) so this would give the freedom of putting on additional surgeries to provide additional services.<br><br>NF asked whether the impact of the Winter Pressures funding has been evaluated. TE responded that it is currently being evaluated. Compared to the previous year attendance at hospitals did not increase but with the warm weather it is difficult to prove that the Winter Pressures funding affected hospital attendance. It could be implied that it made a small difference and hopefully it helped practices. SK added it would be good for the group to remember that last year's Winter Pressures initiatives were a bit rushed but this year the CCG are already holding discussions on how to impact A&E attendance over the winter. Feedback from practices is welcomed if they feel that the money is useful.<br><br>TE advised that from a national perspective some CCGs are unconcerned about co-commissioning with NHS England and some want to be able to alter the GMS contract but there is no appetite for this in the South Yorkshire CCGs. The group may read press articles regarding the actions of other CCGs but this would not necessarily apply to Sheffield.<br><br>A query was raised as to whether the additions on the contract could be tendered to AQP. LS responded that the CCG want to keep services in primary care and recognises that practices are the heart of care in the community. There are restraints and there needs to be motivation from practices to make this work.<br><br>LS advised that the Governing Body have also discussed the Better Care Fund which is joint commissioning with Sheffield City Council. This would increase joint working with the Local Authority and Sheffield City Council. It is a challenge with governance as well as cultural gaps but the understanding is that it will be a great benefit. Social care issues cost healthcare so if the two bodies are investing money together it would improve outcomes for patients. The focus is to treat patients at home instead of the hospital or ensuring that patients do not need to go to hospital in the first place. Unlike co-commissioning with NHS England there was no choice but Sheffield CCG could decide on how much money would be invested. Instead of the minimum amount, which would not enable the outcomes Sheffield CCG wanted, more money has been pooled. TE advised it is complicated work as the Local Authority commission differently and even the language used is different. There is also risk that the Local Authority could change near the election which would need to be watched carefully. There are benefits and risks. RD will be able to explain further. | |
| **CET Update**<br><br>There has been work on the COBIC model of commissioning MSK services which would switch to outcome-based commissioning. This work | |

would ensure there would be only one provider for the different services such as physiotherapy, orthopaedics and rehabilitation.

SK explained that the Quality Incentive Scheme (QIS) has taken over from Q+P. Practices will be updated when more information becomes available. In the recent Connect magazine there is a good introduction to each Portfolio. The CCG has been looking at elements that practices can do to help the Portfolio's objectives. The draft paper of the main elements has been sent to Practice Managers but this does not contain a lot of information. The CCG are currently having conversations on the QIS and working out the finer details. A previous meeting discussed the final version of the QIS paper and hopefully the document will be available next week. It is difficult to ask the group to hold conversations on how to meet the QIS objectives without knowing what these objectives are. One thing that has been made clear is that the practices to not want a large workload with a lot of audits.

SG explained that one problem is that the deadlines start in September and the initiatives have not yet been released. TE responded that the deadlines have now been pushed back to the end of October and February. SK added that the deadlines have been discussed at length as originally the CCG wanted to have monthly deadlines. There has also been an idea to produce templates for practices. This is why there has been a delay in sending out the final document; there has been response to the feedback given from practices.

MP asked when further information for the QIS will be released as doing 12 months' work in 6 months is an impossible task in a practice which never has a quiet moment. TE responded that hopefully the papers will be sent next week but could offer no promises. The QIS funding is new and replaces the GPA money given last year with a top-up. The initiatives have been given from the four Portfolios and Medicines Management. One difficulty has been that each Portfolio has decided the initiatives individually instead of thinking of the whole workload of the full scheme but the CCG want the practices do all of the initiatives and not be over faced. The Portfolios set the criteria. If there are problems with the Children Portfolio initiatives, for example, practices can come to that portfolio to feedback. MA added that she contributed to the two items in the Children's Portfolio regarding Vulnerable Families and Asthma. Some of the group may feel that feedback is sent to the CCG and is not looked at but MA assured the group that she does look at it and wants to know any negative feedback to be discussed during the weekly Portfolio meetings.

A query was raised as to whether there will be work towards an approach for next year. TE responded that there is a hope that the QIS will continue and grow. There would be support available for practices in certain areas.

Most of the initiatives in the QIS ask for practices to discuss that clinical area with their GPAs and there is an expectation that practices will share information and problems with each other. MA advised that the money is

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| split between initiatives for individual practices and working within a GPA. | |
| **Select Committee Inquiry into the Sharing of Patient Data**<br>SK advised that the summary of the CCG Select Committee Inquiry (SCI) has been sent to practices with the agenda. The full document is available online at: http://www.sheffieldccg.nhs.uk/our-information/select-committee-inquiry.htm .<br><br>NAS introduced himself as the Manager of the SCI. Stage 1of the SCI was held during Spring earlier this year. An interim report was submitted which has been approved by the CCG Governing Body. Stage 2 which will explore actions will start in August. The recommendations will affect practices; hopefully in a positive way. It will make sharing data easier and improve the patients' experience and their safety. NAS asked for the group's views on the best way to ensure that practices are updated with the progress of the SCI. As background, the committee consists of GPs, patients and representatives from secondary and social care. There were 14 witnesses from a range of organisations plus patient representatives. The most urgent action that came from the SCI meetings was to organise an approach for GP engagement. The possible recommendations could be improving the consent process and how this effects patient visits, changing communication and guidance, support on the methods of sharing, increased security and confidentiality and increase of information available to patients.<br><br>A query was raised as to whether research into patient safety has been done by the SCI. NAS responded that the recommendations will improve patient care including safety. NAS explained that all care professionals, possibly including social care, would be given access. The SCI discussed the integration between health and social care to improve a patient's pathway.<br><br>A question was raised as to why social care would need medical records. The practice holds the information and if it is shared out this may give a negative public reaction. Patients would be sceptical about who else besides immediate care would be able to access the information. If the SCI could produce a single sheet of A4 paper with a list of organisations then patients could decide.<br><br>A query regarding selective dissent was raised. Patients should have the option of sharing their records with certain places such as A&E and Out of Hours services or opting out of all. NAS responded that this is being investigated. The view is that the whole record should be shared for holistic care and this would only be shared with those that need to know. The key phrase of the SCI was sharing should be safe and appropriate.<br><br>RC raised the point that a lot of patients work at the hospitals and there would be a worry that they could login and view the records of friends and family. NAS responded that this was raised during the SCI meetings. The | |

example given was of a celebrity attending hospital which led to 27 employees inappropriately accessing their record. The access had an audit trail and these employees were fired. LS responded that although these employees lost their jobs they had already accessed the information. There is also the issue of informed consent. How can a GP be sure that the patient is informed about what happens to their records? LS gave an example of when she was in hospital and was asked for her consent after receiving her pre-meds. NAS responded that the guidance needs to be clearer. There needs to be better communication and support regarding informed consent.

CS added that there is also a significant PR problem as earlier this year there was a lot of negative publicity surrounding care.data. CS explained that practices are now asking patients to trust them when there would have been no trust issues before due to the ill thought-out process of care.data. NAS agreed and added that the SCI need to explain that the records are for direct care.

EG added that the patient has the right to exclude one organisation or certain incidents in their record. If they are explained their rights then the uptake on sharing records would be higher. NAS responded that this could be done and has been looked at by the SCI. But the view on partially sharing records is different as it is difficult to predict what information is needed further down the pathway to treat the patient holistically. For example, if the hospital does not have the mental health history of the patient.

MA added that the Lloyd George notes were the property of the Secretary of the State. That was clear ownership but this is no longer the case. When SystmOne was introduced the model of GP ownership became established and the GP was assigned as the arbiter of access. The patient is asked with each new provider (for example, District Nursing) whether they can access their records. The new sharing model has been grappled with ever since. There needs to be a change of thinking of the outdated 'NHS record' as there needs to be multi-disciplinary input. MA added that for children's records the health visitors being able to use SystmOne has made their input more visible. There was no problem of block sharing the health visitors' data with the GP but not vice versa. For the under-5's this way of working is daft. The CCG are developing a new model of safeguarding with the SCI so that softer concerns are picked up more effectively. MA added that her practice is not waiting until the recommendations come out in August but they are opening up the records to the school nurses on SystmOne. A query was raised whether the parents of the children would have their records opened too. MA responded that the health visitors also give care to post-natal women to screen for depression. There is a limited time period for the record sharing; during the time the provider is caring for that patient.

NAS asked the group how to give information to practices. Whether it should be a similar session, written, or via a PLI. TT responded that a PLI

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| would be a good way to get mass debate. The problem with PLIs is that the admin staff would also need to attend so the venue would be an issue and there would be no way to organise a PLI event before Stage 2 in August. TE added that with summer holidays the practices will be short staffed so it would be impractical to get true participation from practices.<br><br>NAS advised that going into the next stage there will be further debates. The SCI are currently working on patient engagement and different consent models. If the group are interested they can keep updated via the website. | |
| **Better Care Fund**<br><br>TE advised that the next meeting in July will be a Keeping People Well Workshop as part of the Better Care Fund. This will include conversations with organisations to bring the community network together, similar to the Marketplace held previously but with more definite outcomes to form and formalise arrangements with community organisations. The venue is to be confirmed.<br>***Post-meeting note: The venue will be St Thomas More Community Centre.*<br><br>RD introduced herself as the West Locality Manager and gave a presentation regarding the Better Care Fund.<br><br>  <br>Better Care Fund presentation.ppt<br><br>RD advised that the Keeping People Well Workshop would focus on developing outcomes. It sounds easy, and is common sense, but there are huge challenges. Out of the work streams this one is developing a new service out of developed ideas. There is only emerging evidence that this way of working would be a benefit. There are also data sharing issues. This is an opportunity for practices to be included in discussions.<br><br>TE asked for practices to think about who they would like to invite, for example SOAR or the Citizen's Advice Bureau and to think of the gaps in community services.<br><br>The group responded with a list of organisations:<br><br>• Social Services Home Care<br>• Drugs and Alcohol Fitzwilliam<br>• Women's Abuse Service<br>• SADACCA<br>• Yemeni Centre<br>• PACA | |

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| • SOAR<br>• Activity Sheffield<br><br>SK added that practices will be reimbursed for their time as the Workshop is within Council time and it is open to all practice staff. | |
| **Date and Time of Next Meeting**<br><br>**Keeping People Well Workshop**: 16th July 2014, 8.30 – 11am at St Thomas More Community Centre<br><br>**Council Meeting**: 10th September 2014, 8.30 – 11am at St Thomas More Community Centre | |

# SHEFFIELD CCG WEST LOCALITY
# Executive Team meeting Public minutes
# Wednesday 5th June 2014
# 8.00am Fairlawns

**Members Attending:** Dr Nikki Bates, Rachel Dillon, Dr Julie Endacott, Dr John O'Connell, Emma Reynolds, Dr Steve Thomas, Susie Uprichard (Chair).

**In attendance:** Richard Crosby, Kerry Dunne, Tania Tailor.

**Apologies:** Kate Carr, Diane Dickinson, Dr Michael Jakubovic, Lynda Liddament, Dr Tim Moorhead, Dr Jenny Stephenson, Jayne Taylor, Fiona Walker.

**Welcome and Apologies:**

1. The apologies above were noted.

**Conflicts of Interest**

2. Rachel mentioned that from now on the Exec had to raise any conflicts of interest at the start of the meeting, given that we are a sub group of the CCG CET. The group discussed how we should do this, and Rachel agreed to seek clarification of how this should be done. For today's meeting, there were no conflicts of interest.

**Minutes of meeting 3rd April 2014 and Matters Arising:**

3. There were no amendments from the previous minutes.

4. With regards to the West Locality Business Plan, Ian Atkinson is keen for the plan to include improving the quality of Primary Care.

5. Advertisements for the Commissioning GP will go out to practices soon with a deadline in June. Rachel asked whether anyone would be interested in mentoring the new Commissioning GP. Steve responded that between himself, Julie and Mike there should be enough time and asked whether there is a benefit from having a single mentor. Julie responded that there is a huge benefit and advised that it might be best to build the mentoring around the person who gets the role.

6. Rachel advised that she has received comments from Devonshire Green regarding the healthcare for the homeless from Paragraph 4 of the previous minutes.

7. In regards to paragraph 9 of the previous minutes, Jenny has been in contact with Paul Wike and Maria Read regarding citywide District Nursing discussions.

8. In regards to seeking an answer to the question about whether the new initiative within A&E will liaise with GPs, Steve has not been able to establish any answers yet. Rachel agreed to take it forward and the item to be brought forward for the next meeting.

9. All other action points have been completed.

**CRG/CET/CCG Update**

CRG Update:

10. Dr Mike Tomson from the Mathews Practice has been asked by Zak McMurray to provide an objective overview of the structure and function of the Clinical Reference Group. He will look at and critique the Terms of Reference and see how the group is working including linking the group into Planning and Delivery.

CET & Planning and Delivery Update:

11. The key points were a discussion around the challenges with co-commissioning and analysing the Quality Improvement Scheme thoroughly.

CCG Governing Body Update:

12. Nikki explained that co-commissioning was on the agenda for the CCG governing body meeting later that day. Nikki has started working with the Children Portfolio as the Governing Body representative and has been attending meetings with Trish Edney, Margaret Ainger and Kate Laurance.

**Better Care Fund and Keeping People Well in the Community:**

13. Rachel gave a presentation on the national initiative to encourage joint working between CCGs and Council called the Better Care Fund, and went on to describe the keeping well in the community theme. Key points from the group were:
    - John advised that early intervention at a young age is often missed in current culture. Rachel will raise this point but the focus will be on emerging and high risk patients.
    - Julie added that there is encouragement in schools regarding healthy eating however, there is a cohort of young adults who have not had any early interventions. Rachel added that this could link with the Move More campaign.
    - Steve raised the service called 'Help Yourself' which informs and advises. Rachel agreed and would note that, but added that there needs to be other options, for those who do not have access to the internet for example.
    - Mental Health was not mentioned specifically and how hard to reach groups would be included. Rachel advised that the service was inclusive and people would be identified through a widened risk stratification process, but offered that perhaps more could be done to mention that this service had to be inclusive.
14. Rachel concluded that the contract for the service would be outcome based. Next step was to hold workshops in each locality for GPs and VCF organisations. Rachel proposed to use the Council meeting in July as West's workshop. The Exec agreed to this proposal.

**Co-Commissioning with NHS England:**

15. Nikki explained that all had seen the paper in May where Simon Stevens was seeking expressions of interest from CCGs to co-commission primary care. If the CCG wanted to

work on this idea they would have to apply by June 20th 2014. It will not be one size fits all.

16. Katrina Cleary will lead the bid on behalf of South Yorkshire and Bassetlaw CCGs. Co-commissioning options could include enhanced services, discretionary payments for premises, sanctions and mergers.

17. John asked why Sheffield CCG has decided to do this. Rachel responded that the flexibility given would contribute to integration. Steve added that the CCG commission small parts of local contracts and often the CCG would like to influence more so that whole clinical pathways could be commissioned from secondary care to primary care.

18. The group agreed that it was advisable not to include performance and contract management as it would be no different to a PCT and conflicts of interest would be difficult to manage.

19. Nikki added that part of the request states that the CCG needs to prove that the practices have been involved so this could be done through the Localities.

**Medicines Management Update:**

20. Richard gave an update from the Medicines Management team which is attached to the minutes.

**GPPA Update:**

21. Julie advised that the GPPA will be meeting with the LMC to discuss the mandate which will then be sent out to practices. Further meetings for the GPPA have been planned with Ian Atkinson and members of the Foundation Trusts to discuss contracts and tenders.

**AOB:**

22. Steve advised the group of the NHS Apps store available through the NHS Choices website. Most of the apps are free, useful and available for both Android and iPhone.

**Date and Time of next meeting:**
**3rd July 2014, Boardroom, Fairlawns**