Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Thursday 18 February 2016, 2.00 pm – 4.00 pm
Boardroom, 722 Prince of Wales Road

Meeting of the Primary Care Commissioning Committee held in public

Questions from members of the public should be put in writing to the Director of Delivery, in which case written answers will be provided on the day or will be sent within 7 working days and posted on the website (http://www.sheffieldccg.nhs.uk/about-us/GB-meetings.htm)

Confidential items are outlined in a confidential agenda below; confidential items will be considered in a closed private session

		Paper	Presenter
1.	**Introduction, Welcome and Apologies for Absence**		John Boyington, Chair
2.	**Declarations of Interest**		John Boyington, Chair
3.	**Questions from the Public**		
4.	**Approval of minutes of previous meeting** The Primary Care Commissioning Committee is invited to approve the minutes of the previous meeting held on 18 November 2015	**A**	John Boyington, Chair
5.	**Matters Arising** The Primary Care Commission Committee is invited to note any matters arising	**B**	John Boyington, Chair
6.	**Update on Progress with Special Cases Applications** The Primary Care Commission Committee is invited to note the approach being taken	**C**	Katrina Cleary, CCG Programme Director
7.	**Update on Developing Primary Care Strategy** The Primary Care Commission Committee is invited to note an oral update on progress with development of the strategy	**Oral**	Katrina Cleary, CCG Programme Director
8.	**Update On Co-Commissioning of Primary Care** The Primary Care Commission Committee is invited to note the update	**D**	Katrina Cleary, CCG Programme Director
9.	**Primary Care Transformation Fund** The Primary Care Commission Committee is invited to note an oral update	**Oral**	Katrina Cleary, CCG Programme Director
10.	**Update on Closure of Bent's Green Practice** The Primary Care Commission Committee is invited to note the update	**E**	Katrina Cleary, CCG Programme Director

11.	**Update on Alternative Provider Medical Services (APMS) Procurement** The Primary Care Commission Committee is invited to note an oral update	**Oral**	Katrina Cleary, CCG Programme Director
12.	**Any Other Business**		John Boyington, Chair
13.	**Date and Time of Next Meeting** Friday 1 April 2016, 1.30 pm – 3.30 pm, Boardroom, 722 Prince of Wales Road		John Boyington, Chair
Representatives of the press, and other members of the public, will be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest			
P1.	**Specific Practice Issues**		Katrina Cleary, CCG Programme Director

NHS
Sheffield Clinical Commissioning Group

Primary Care Commissioning Committee
Unconfirmed minutes of the meeting held on 18 November 2015
Boardroom, 722 Prince of Wales Road

A

Present: **(Voting Members)**	John Boyington CBE, Lay Member (Chair) Amanda Forrest, Lay Member Diane Mason, Finance Manager (on behalf of the Director of Finance) Maddy Ruff, Accountable Officer
(Non Voting Members)	Dr Amir Afzal, CCG Governing Body GP Dr Maggie Campbell, Chair, Healthwatch Sheffield Victoria Lindon, Contract Manager, NHS England Dr Stephen Horsley, Interim Director of Public Health, Sheffield City Council Dr StJohn Livesey, Clinical Lead Primary Care (on behalf of the Medical Director)
In Attendance:	Tim Furness, Director of Delivery Carol Henderson, Committee Administrator, NHSSCCG

Members of the public:
There was one member of the public in attendance.
A list of members of the public who have attended CCG Primary Care Commissioning Committee meetings is held by the Director of Delivery

Minute		ACTION
01/15	**Welcomes** The Chair welcomed members of the Sheffield Clinical Commissioning Group (CCG) Primary Care Commissioning Committee and those in attendance to the meeting	
02/15	**Primary Care Commissioning Committee Terms of Reference** The Director of Delivery presented the Terms of Reference that were attached for members' information. He advised that the Committee had been set up in advance of our anticipated taking on delegated responsibility for commissioning primary care from 1 April 2016 because of issues that Governing Body needed to delegate before that time. He reported that NHS England had agreed to the establishment of the committee, as part of the CCG's recent proposed changes to the CCG Constitution. The Terms of Reference (ToR) had to be close to NHS England's model ToR to be acceptable and so it would be quite difficult to seek changes to them. The Contract Manager advised that probably about 95% of CCGs were using very	

similar models.

Dr Afzal asked if this committee was solely responsible for the decisions that it would take. The Director of Delivery explained that Governing Body had given delegated authority to the committee and would not be able to overturn any decisions the committee made. However, if it was thought that the committee had acted in a completely irrational way then the Governing Body would be able to take steps to change its membership, etc.

He advised that, if the CCG took on delegated responsibility for primary care, this would be the decision making committee.

Dr Afzal asked if the committee was solely responsible if a decision was disputed. The Chair commented that there may always be the potential for challenges to process, which the committee could be asked to review, however, there would ultimately be a judicial review if there was an appeal. The Director of Delivery advised that the Governing Body retained responsibility for issues it delegated and therefore any disputes or appeals should go to the CCG.

With regard to today's meeting, the minutes of the meeting, including a summary from the private session excluding confidential information, would be presented to the Governing Body for information in public on 3 December 2015, but he would be formally writing out to practices within the next couple of days to advise them of the committee's decision(s) following consideration of their individual special case submission. **TF**

The Committee received and noted the Terms of Reference.

03/15 **Apologies for Absence**

Apologies for absence from voting members had been received from Kevin Clifford, Chief Nurse, and Julia Newton, Director of Finance.

Apologies for absence from non voting members had been received from Dr Nikki Bates, CCG Governing Body GP, Dr Mark Durling, Sheffield Local Medical Committee, Dr Devaka Fernando, Secondary Care Doctor, and Dr Zak McMurray, Medical Director.

It was confirmed that the meeting was quorate.

04/15 **Declarations of Interest**

Dr Afzal advised the committee that he was a GP at Duke Medical Centre, which was a General Medical Services (GMS) practice, which would have no bearing on any of the special cases being discussed today.

Although she had sent apologies for today's meeting, the Director of Delivery advised the committee that Dr Bates was a GP at Porter Brook Medical Centre, which had submitted a special case application, and therefore had a conflict of

interest, which she had informed him she would have declared, if present. He confirmed that Dr Bates had not been sent a copy of the documentation that would be discussed in the private session.

Dr Livesey advised that he was a salaried GP at Jaunty Springs Health Centre, which was a low funded PMS practice, which would also gain from the redistribution of the Personal Medical Services (PMS) premium funding. He also advised that he had been a partner at The Avenue Medical Practice, an under funded PMS practice, which would also gain from the redistribution of the PMS premium funding, but was in the process of being bought out from the practice.

He advised that, whilst at the Avenue Medical Practice, they had grouped together as a number of practices to challenge NHS England to implement a policy of equalising core contractual funding for GP PMS practices.

The Committee recognised and noted Dr Livesey's interests and agreed they would not prejudice him from being part of the discussions or from presenting the recommendations from the Special Advisory Group to members.

All members of the committee confirmed that they were not registered with any of the practices that had submitted a special case application.

There were no further declarations of interest.

05/15 Questions from the Public

A member of the public had submitted questions before the meeting. The CCG's responses to these are attached at Appendix A.

06/15 Assessment Process for Agreeing Special Cases Applications

The Director of Delivery presented the decision making flow chart for special cases applications, which had been approved by the Special Cases Advisory Group on 17 September 2015 and used by them to assess the special business case applications from practices. Dr Livesey explained that the Carr-Hill formula was use to distribute the core funding (global sum) to general practices for essential and some additional services. Payments were made according to the needs of a practice's patients and the cost of providing primary care services. The formula takes into account issues such as age, deprivation and patient turnover. The purpose was to ensure an adequate GP income, ie so wherever a GP worked they would be assured of an income.

He advised the committee that the advisory group had assessed each application as to whether or not the formula recognised a workload associated with patient demographics that were not included in the formula. He explained that, if the group had thought there was a specific patient need identified in a case that was not already covered by the Carr-Hill formula, it would become part of the CCG's normal commissioning process and would be for the Commissioning Executive Team (CET) to agree a solution.

The group had also identified issues in the applications that did not meet the special cases criteria but would need to be addressed by the CCG. Such issues would be reported to the CET for action / to determine what the solution would be, as it was not within the group's remit to do that. Dr Afzal asked if it would be the CET that would decide the level of funding that practices would need and how that funding would be provided.

The Chair of Healthwatch asked if the process might also include issues arising from those practices not seen to be a special case but were providing services (non core) that may have to be withdrawn due to lack of funding, as it would be disappointing if the current experience of good practice were to change and asked for assurance that there would be a process beyond the financial support. The Director of Delivery advised that the CCG may wish to commission some services that were over and above core services provided by practices. There would also be advice and guidance available to practices on how best they could use the resources they have.

The Accountable Officer advised that there may also be opportunities for the CCG to look and see if there were other services that could be provided in different ways, for example practices working in partnership.

Dr Afzal welcomed the explanation of the process but queried as to whether the committee was in danger of setting a precedent with that process, especially as there could be areas of the city that changed, for example if there was a sudden influx of patients into a particular practice area. The Chair responded that he did not think that the process set a precedent any more than anything the CCG does for the first time, however, the committee was not reviewing the application of the formula in primary care but looking at the applications and other factors in the use of the formula.

The Director of Delivery commented that the process set a healthy precedent, and that it would be right and proper that it should be used if a practice advises the CCG that their population has changed and was creating an additional workload.

The Committee received, noted and agreed the assessment process.

07/15 **Role and Function of the Special Advisory Group**

The Director of Delivery gave an oral update. He advised that the Special Advisory Group had been set up, specifically as an advisory group, to review the special cases applications and make recommendations to the committee. The Clinical Lead Primary Care, who had attended the meeting of the group on 17 September to co-present the applications with the CCG's Programme Director Primary Care, would shortly be presenting the recommendations from the group to this committee.

The Committee noted the update.

09/15 **Confidential Section**

The Committee resolved that representatives of the press, and other members of the public, be excluded from the following item, having regard to the confidential information being presented as part of the business to be transacted, publicity on which would be prejudicial to the public interest.

10/15 **Recommendations from the Special Advisory Group Meeting held on 17 September 2015 and Consideration of each Special Case Submission**

The Chair advised the committee that the assessments had been made only on the information presented to them at that meeting, and not on any other passing information. He also advised members that all practices had been invited to submit an application.

The Clinical Lead Primary Care presented the minutes, including recommendations, from the Special Advisory Group meeting held on 17 September 2015, which the committee would be asked to base their decisions on. He advised the committee that the CCG had tried as far as possible to help those practices that had had difficulty submitting their bids, including requesting further information to support their bid.

Ms Forrest, who had attended the Special Advisory Group meeting, commented that it had been one of hardest pieces of work she had undertaken since joining the CCG. She was completely in support of the decisions the group had made and it was useful for members of the committee to have the summary of that meeting.

The Director of Public Health, who had also attended the Special Advisory Group meeting, commented that it had been very difficult to ascertain doctors' earnings from some of the information that had been presented so if a mistake had been made inadvertently this ought to be brought to the fore. The Chair responded that the CET, when determining the action / solution would have the right to go back and request further information, etc.

The Clinical Lead Primary Care presented the recommendations from the group in alphabetical order of practice. In each case, the Committee was asked to consider the applications and confirm or challenge the recommendations of the Special Cases Advisory Group.

Chapelgreen

The Special Advisory Group had agreed that, on the information provided, there was no special case to recommend to the Primary Care Commissioning Committee. The rationale for this was that the practice had not demonstrated that they have a significant workload associated with patient demographics that was not recognised by the Carr-Hill formula, and the declared pensionable earnings of four doctors were each above the agreed threshold.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was not a special case.

Devonshire Green and Hanover Medical Centres

The Special Advisory Group had agreed that, on the information provided, this was a special case to recommend to the Primary Care Commissioning Committee. The rationale for this was that the practice has a significant workload associated with patient demographics that is not recognised by the Carr-Hill formula, would lose a significant amount of funding, and no individual doctors had declared pensionable earnings above the agreed threshold.

The Clinical Lead Primary Care advised the committee that this was a unique practice in Sheffield with regard to their population, having a long history of dealing with homeless people in the city, and a high number of patients suffering from mental illness, alcohol dependency and drug dependency. This was a large function of their role and they had submitted a large amount of data to support that and demonstrated it very well.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was a special case

Dovercourt Surgery

The Special Advisory Group had agreed that, on the information provided, there was no special case to recommend to the Primary Care Commissioning Committee. The rationale for this was that the practice had not demonstrated that they have a significant workload associated with patient demographics that was not recognised by the Carr-Hill formula, and they had not provided sufficient financial information.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was not a special case

East Bank Medical Centre

The Special Advisory Group had agreed that, on the information provided, there was no special case to recommend to the Primary Care Commissioning Committee. The rationale for this was that the practice had not demonstrated that they have a significant workload associated with patient demographics that was not recognised by the Carr-Hill formula.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was not a special case

Foxhill Medical Centre

The Special Advisory Group had agreed that, on the information provided, there

was no special case to recommend to the Primary Care Commissioning Committee. The rationale for this was that the practice had not demonstrated that they have a significant workload associated with patient demographics that was not recognised by the Carr-Hill formula.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was not a special case

Harold Street Medical Centre

The Special Advisory Group had agreed that, on the information provided, there was no special case to recommend to the Primary Care Commissioning Committee. The rationale for this was that the practice had not demonstrated that they have a significant workload associated with patient demographics that was not recognised by the Carr-Hill formula.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was not a special case.

Page Hall Medical Centre

The Special Advisory Group had agreed that, on the information provided, there was a special case to recommend to the Primary Care Commissioning Committee. The rationale for this was that the practice had demonstrated that they have a significant workload associated with patient demographics that was not recognised in the Carr-Hill formula, and that although some of their pensionable earnings were high which gives them some ability to absorb the loss of income (c.12.5%), it did not appear the practice could continue to meet patients' needs without some additional support.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was a special case.

Park Health Centre

The Special Advisory Group had agreed that, on the information provided, there was no special case to recommend to the Primary Care Commissioning Committee. The rationale for this was that the practice had not demonstrated that they have a significant workload associated with patient demographics that was not recognised by the Carr-Hill formula

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was not a special case.

Porter Brook Medical Centre

The Special Advisory Group had agreed that, on the information provided, there was no special case to recommend to the Primary Care Commissioning Committee. The rationale for this was that the practice had not demonstrated that

they have a significant workload associated with patient demographics that was not recognised by the Carr-Hill formula, and their loss of income could be met by adjusting finances internally.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was not a special case.

Richmond Medical Centre

The Special Advisory Group had agreed that, on the information provided, there was no special case to recommend to the Primary Care Commissioning Committee. The rationale for this was that the practice had not demonstrated that they have a significant workload associated with patient demographics that was not recognised by the Carr-Hill formula.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was not a special case.

Sheffield Medical Centre

The Special Advisory Group had agreed that the practice had a special case for patient need on the information received. However, they felt that the information about the practice earnings and finances was unclear.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was a special case. However, they would ask the Commissioning Executive Team, when considering a solution, to take forward their concerns relating to the practice earnings and finances.

Sothall and Beighton

The Special Advisory Group had agreed that, on the information provided, there was no special case to recommend to the Primary Care Commissioning Committee. The rationale for this was that the practice had not demonstrated that they have a significant workload associated with patient demographics that was not recognised by the Carr-Hill formula.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was not a special case.

Tramways and Middlewood Medical Centres

The Special Advisory Group had agreed that, on the information provided, there was no special case to recommend to the Primary Care Commissioning Committee. This decision was made on the basis that, although they had identified a need, their population deprivation was reflected in the Carr-Hill formula. They had noted, however, that the practice has some financial challenges associated with the Middlewood site which they recommended that the Commissioning Executive Team should consider.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was not a special case.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that the Commissioning Executive Team should consider the financial challenges associated with the Middlewood site.

Upwell Street

The Special Advisory Group had agreed that, on the information provided, there was a special case to recommend to the Primary Care Commissioning Committee. The rationale for this was that the practice has a significant workload associated with patient demographics that is not recognised by the Carr-Hill formula, and the loss of income to the practice would be significant. However, they had been unable to determine clearly as to how much the practice could absorb and how much money they would need, as it had been unclear as to whether or not any individual doctors had pensionable earnings above the agreed threshold.

The Primary Care Commissioning Committee approved the recommendation from the Special Advisory Group that this was a special case. However, they would ask the Commissioning Executive Team to consider the extent to which the practice should be able to continue to meet these needs within the core funding.

11/15 **Next Steps**

The Committee agreed the following:

The applications the committee had agreed were special cases would be remitted to the CET for action. **TF**

The Director of Delivery was asked to review what delegated authority the CET had in relation to signing off / determining the solutions. **TF**

In addition, specific issues for individual practices that the committee had agreed required CCG action would be remitted to the CET for consideration. **TF**

The Director of Delivery was asked to draft letters to be sent to individual practices advising them of the committee's decision of the committee within the next few days. Members of the Committee were to be copied into all documentation that was sent out. **TF**

The minutes of this meeting would be published with the December Governing Body papers. **TF**

Ms Forrest and the Chair of Healthwatch asked how the decisions would be communicated to the public as it had been a long drawn out high profile process. It was agreed that the publication of the minutes of the meeting should be clear

as to what process had taken place and been followed, how far it had got and what still needed to happen, so that members of the public, and practices, could see that the process had been open and transparent. A press release should be published as well as the minutes of the meeting appearing in Governing Body papers.

Dr Afzal commented that it was also for the practices to be able to see that the funding was not going into the practices but was going for a specific need that was different to what everyone else was providing.

The Clinical Lead Primary Care advised the committee that he would be meeting with the Chair of the Local Medical Committee the following day and asked what information he could share with him at that stage. The Director of Delivery responded that there should be no reason why this information could not be shared with him if he would respect the confidentiality at this stage, and noted that he had been invited to be a member of this committee but unfortunately had not been able to attend this meeting.

With regard to commissioning responses to the special cases**,** the Director of Delivery advised that the Locality Manager, West, had agreed to take this forward. He reported that the CET had already seen and discussed a good piece of analysis on Devonshire Green. With regarding to the practices in the Page Hall area, he anticipated a population response rather than practice specific and in this regard he reported that Firth Park practice had submitted a proposal on behalf of them that would be considered. He also advised the committee that we would be seeking advice relating to the financial challenges associated with the Middlewood site.

<u>Timescales</u>

The Finance Manager advised the committee that the allocation of funding was from October and it would be challenging to work through the above three pieces of work by April 2016, so the CCG would need to consider the timetables and what resources it could put into them as practices could not destabilised while we get solutions. It was agreed that solutions should be agreed by Christmas, if possible.

128/15 **Any Other Business**

Clover Group

The Director of Delivery advised the committee that proposals on the tendering / procurement / commissioning of core and non core services currently provided by the Clover Group, and on the running of the practices, would be presented to the committee in due course.

Ms Forrest raised concerns about the Clover Group, in particular, Darnall Wellbeing, located at the Darnall Primary Care Centre which, she felt, might fall into the middle of two processes. She commented that Darnall Wellbeing was

	very intertwined as to how it works with the GPs in that practice and people needed to recognise the added value it had provided over the years, which we did not want to lose. The Director of Delivery advised that the core service specification includes a requirement about working with stakeholders, which the CCG representative in the process would focus on.	
13/15	**Date and Time of Next Meeting**	
	The Director of Delivery advised that a list of dates and times for future meetings would be issued, proposing that they take place monthly on a Wednesday afternoon from 1.00 pm – 3.00 pm, unless otherwise advised.	**TF(CRH)**

B

ACTION/MATTERS ARISING FROM THE MEETING OF THE NHS SHEFFIELD CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE HELD IN PUBLIC ON 18 NOVEMBER 2015

Minute	Item	Action to Take	Lead	Confirmation of action taken / still to take
02/15	Primary Care Commissioning Committee Terms of Reference	• Minutes of the meeting, including a summary from the private session excluding confidential information, to be presented to the Governing Body for information in public on 3 December 2015	**TF**	Complete
		• Formally write out to practices within the next couple of days to advise them of the committee's decision(s) following consideration of their individual special case submission	**TF**	Complete
11/15	Next Steps	• Those applications the committee agreed were special cases to be remitted to the CET for action	**TF**	Complete
		• Review what delegated authority the CET has in relation to signing off / determining the solutions	**TF**	KaC to give oral update at February meeting
		• Specific issues for individual practices that the committee agreed required CCG action to be remitted to the CET for consideration	**TF**	Complete
		• Draft letters to be sent to individual practices advising them of the committee's decision of the committee within the next few days.	**TF**	Complete
		• The minutes of this meeting to be published with the December Governing Body papers	**TF**	Complete

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NHS Sheffield Clinical Commissioning Group

Equalisation of GP Finances - Special Cases

C

Primary Care Commissioning Committee meeting

18 February 2016

Author(s)	Rachel Dillon, Locality Manager, West
Sponsor	Katrina Cleary, CCG Programme Director Primary Care

Is your report for Approval / Consideration / Noting

Noting

Are there any Resource Implications (including Financial, Staffing etc)?

Yes, via a Locally Commissioned Service

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?

2. To improve the quality and equality of healthcare in Sheffield

4. To ensure there is a sustainable, affordable healthcare system in Sheffield.

Equality Impact Assessment

Have you carried out an Equality Impact Assessment and is it attached? An equality impact assessment was carried out as part of the original Governing Body decision making process. The result of the EIA helped determine the need for a special cases process. I

PPE Activity

How does your paper support involving patients, carers and the public?
Currently it is the GPs within the practices identified as Special Cases that the CCG is predominantly working with

Recommendations

The Committee is asked to note this progress report.

NHS
Sheffield
Clinical Commissioning Group

Equalisation of GP Finances - Special Cases

Primary Care Commissioning Committee meeting

18 February 2016

Introduction

1. At the CCG governing body extraordinary meeting on the 16th July 2015 on equalisation of finances, the CCG agreed that in addition to a series of uplifts per patient to all practices, it would create a process for practices particularly facing significant financial loss to put in a 'special case' to the CCG for consideration to support and on what basis.

2. On the 18th November 2015 the Primary Care Commissioning Committee met to consider the applications from practices facing significant financial need. The main consideration was whether there was a level of patient need not fully recognised by the current Carr-Hill formula. Decisions were made, and the committee delegated authority to CET to manage the process to conclusion.

3. This paper provides an update on progress and next steps following a discussion at CET on the 19th January.

Background

4. The Primary Care Commissioning Committee agreed that four practices demonstrated a special case and were written to on the 20th November. These were Devonshire Green and Hanover Medical Centre, Upwell Street Surgery, Page Hall Medical Centre and Sheffield Medical Centre. Although Devonshire Green and Hanover Medical Centre is not a PMS practice, it faces a significant withdrawal of MPIG funding and therefore was included in the special cases process.

5. It was made clear in the letter to all practices that the financial value awarded would not necessarily be equivalent to what the practices were going to lose through the equalisation process.

6. In addition, a health needs overview was produced for people registered with Page Hall, Firth Park, Pitsmoor and Upwell Street surgeries identifying possible patient need not met by Carr-Hill to inform the decision making process. There were clear indications that there was a possible patient need and are now included in the process.

7. Also brought into this process is the Clover Group. Clover Group is being re-procured by NHS England. Although this is a different type of contract, the drivers and solutions are similar to this programme.

8. The committee needs to be mindful of the review of the interpreting services currently provided by the Sheffield Health and Social Care Trust because the highest using practices are also within this programme - Pitsmoor, Page Hall, Upwell St, Firth Park, Mulberry and Highgate, both part of the Clover Group.

9. Nationally, there is a review taking place of the Carr Hill formula of which the outcomes might affect our process.

Progress to date

10. Since the committee meeting in November, every practice has been visited to further understand the non-core services the practices provide to meet the needs of patients' needs not met by the Carr-Hill formula. There is commonality across all of them. The patients' specific needs are:

    a. High numbers of patients needing interpretation.
    b. High numbers of new arrivals needing interpretation and have multiple illnesses.
    c. High numbers of people including children with multiple complex physical and/or mental illness which are most commonly found in older people.
    d. Roma-Slovak specific needs.
    e. Significant oral health needs

11. The additional/different services which the practices provide to meet the needs of the above are:

    a. Longer and more frequent consultations which comprises of interpretation, opportunistic screening, public health education, larger families, complex illness, act as conduit between primary and secondary care.
    b. Increased and longer consultations for new registrations.
    c. Drop in/walk in sessions to ensure patients get access to primary healthcare.
    d. Undertake more multiple MDT meetings especially with schools, social services, police, secondary care, mental health services.
    e. More engagement and activity within the communities to help try and support the communities' health and care needs.
    f. Staff who are bi-lingual

12. It has also been recommended that we include Burngreave Surgery at this time to see whether they also have the same demands as its surrounding practices. To summarise we are now looking at eight practices.

CET discussion

13. CET at its meeting on the 19th January agreed to a proposal based on the above findings, to commission an LCS starting from the 1st April 2016 for two years, extending it, subject to review. The LCS will look to cover the services 'over and above' the existing contract which provide for the needs of patients not covered by Carr-Hill where there is significant demand. The committee should note that this is in addition to and complementary to the work we are doing on the redesign of the interpreting service. To be clear, this is a primary care service to meet the needs of this patient group and not an interpreting service.

14. In order to commission the LCS, we need a transparent and simple funding criteria and light touch specification and will develop this with the practices involved, LMC and colleagues within the CCG/Locality. It will reflect the common needs listed above and in addition reflect the patient needs specific to some practices, and not all, which were noted in the visits, e.g Roma Slovak community, Asylum seekers and city centre needs.

15. CET agreed that the work needs to be concluded quickly and will consider and approve an approach at CET on 1 March 2016.

16. CET recognised that some of the practices involved have already lost funding as part of the PMS equalisation arrangements and that a delay in formally offering the LCS until 1 April 2016 could have an adverse impact on the practice. As a result, CET agreed to explore an offer of a "one off" non recurrent payment in 2015/16 to practices who have already lost funding. It was agreed that we would be in a position to advise on this once we have a more detailed understanding on the LCS value and how this compares with the phasing of financial losses through transition.

17. Subject to the consultation, an LCS will be put in place for 1st April 2016.

Risks and Challenges

18. CET noted that there is not enough funding to compensate for the loss of funding practices are facing. Practices are aware of this but we will still need to manage the sensitivities and challenges around this. This is why it is important that our approach is consulted on and open and transparent.

19. It is imperative that the separate funding streams for the equalisation and interpreting services are used to maximise efficiency by both the CCG and practices.

Current Position

20. The above CET discussion and actions have been communicated to all practices involved and we are now starting to work with practices and LMC to consult and develop the funding approach to the LCS.

Summary

21. The Committee is asked to note this progress report.

Paper prepared by:

Rachel Dillon, Locality Manager West

Katrina Cleary, Programme Director Primary Care

February 2016

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Co-Commissioning of Primary Care Update

D

Primary Care Commissioning Committee meeting

18 February 2016

Author(s)	Christopher Elliot, Management Trainee
Sponsor	Katrina Cleary, Programme Director Primary Care

Is your report for Approval / Consideration / Noting

Noting

Are there any Resource Implications (including Financial, Staffing etc)?

Not specifically with regard to this paper, however staffing structures are being consider to ensure sufficient capacity within the CCG to take on this responsibility.

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?
4. To ensure there is a sustainable, affordable healthcare system in Sheffield.

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? No

If not, why not? Not relevant at this stage

PPE Activity

How does your paper support involving patients, carers and the public?
This is an update paper so does not specifically support this approach. However, as we move forward with co-commissioning engagement with key stakeholders will be crucial.

Recommendations

The Committee is asked to note the content of this paper

NHS
Sheffield
Clinical Commissioning Group

Co-Commissioning of Primary Care Update

Primary Care Commissioning Committee meeting

18 February 2016

1. INTRODUCTION

Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCG's to expand their role in Primary Care Commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded Primary Medical Care Commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

NHS Sheffield CCG applied to take on fully delegated responsibility for primary care commissioning for GP services within Sheffield and gained authorisation from NHS England in December 2015 that its application to gain full delegation had been successful. The scheme of delegation has been received from NHSE and is to be returned to NHSE by the end of this month, after which point NHS Sheffield CCG will be formally authorised to take responsibility for commissioning of primary care services within Sheffield from the 1st April 2016.

NHS Sheffield CCG formed the Primary Care Commissioning Committee which has delegated authority and decision making powers on behalf of the CCGs Governing Body. The purpose of this paper is to update the Committee on what progress has been made to date in relation to Primary Care Co-commissioning and what actions have been put in place to ensure a smooth transfer of delegation from 1st April 2016.

2. PROGRESS TO DATE

2.1 Creation of Primary Care Co-Commissioning Sub Group

Following NHS Sheffield CCGs application to move to Level 3 Co-Commissioning of Primary Medical Care services within Sheffield, a sub group was formed which has been meeting on a monthly basis and is chaired by the Programme Director for Primary Care at NHS Sheffield CCG. The purpose of the sub group is to address and overcome any operational issues which may occur in anticipation of gaining full delegation for Primary Care Co-Commissioning from NHS England on the 1st April 2016.

Membership of the sub group includes key stakeholders from within NHS Sheffield CCG including: Finance, Contracting, Governance, Quality, the Clinical Director for Primary Care and representatives of Executive Directors. Furthermore, Locality Managers attend on behalf of their respective areas so can bring any concerns / queries from Practice Managers, GPs and other clinical / non-clinical staff. Finally, representatives from the NHS England Regional Team (North – Yorkshire and Humber) attend to assist with the planning process for Co-Commissioning, to answer any questions (if possible) that arise during the sub group meeting about current processes at NHS England and to assist with

communication between NHS Sheffield CCG and their respective colleagues at NHS England.

2.2 NHS England Co-Commissioning webinars

NHS England is holding a series of webinars to support CCGs who have been approved to take forward delegated arrangements from 1 April 2016. These webinars are intended to support CCGs to implement the new arrangements and address any queries. Webinars on the following topics will/have taken place as follows:

- Governance: Tuesday 26th January 2016 at 2pm
- Delegation agreement: Tuesday 4th February 2016 at 2pm
- Finance: Tuesday 16th February 2016 at 2pm
- Workforce arrangements: Thursday 25th February 2016 at 2pm

Representatives from the respective departments at NHS Sheffield CCG are due to be involved in these events to help clarify any queries they may currently have, gain an insight into how other CCGs are preparing for the 1st April 2016 and address any issues which may occur due to the conversations which will be held on the above dates.

2.3 Delivery Plan

In anticipation of the transfer of responsibility for the commissioning of Primary Medical Services in Sheffield, a delivery plan is being produced which highlights key milestones and subsequent actions pre and post the 1st April 2016. Support is being provided by the Programme Management Office (PMO) on producing the delivery plan and will remain a live document which is constantly being amended and updated. Furthermore, the delivery plan will act as a tool to highlight possible risks that relate to Primary Care Co-Commissioning for example the impact of services transferring from NHS England and having an adverse impact on the workload of NHS Sheffield CCG staff. Once risks have been identified, actions can be put in place to minimise the risk they pose along with being added to the Operational Risk Log.

2.4 Communication with NHS England

Members of staff from NHS Sheffield CCG have been holding a number of discussions with their colleagues at NHS England about what functions will be transferred on the 1st April 2016 directly / indirectly relating to Primary Care Co-Commissioning. These conversations are enabling the CCG to become sighted on possible risks prior to the 1st April 2016 and put in preventative actions to minimise the impact and risks to CCG functions. However, continued communication with NHS England and NHS Sheffield CCG is crucial moving forward not just for the period prior to the 1st April 2016 but also for the foreseeable period post the transfer of full delegation from NHS England.

3. MOVING FORWARD

As previously mentioned above, conversations with NHS England colleagues will continue in anticipation of the 1st April 2016. Furthermore, the Primary Care Co-Commissioning Sub-Group will continue to meet on a monthly basis and address any operational issues should they arise prior / post the transfer of commissioning responsibility. The continued development of the delivery plan will allow NHS Sheffield CCG to mitigate against potential risks and put corrective actions in place if and when required. Furthermore, clear

communication is required with all stakeholders both internally and externally to NHS Sheffield CCG, including GP Practices and NHS England via a communication plan which is yet to be developed.

4. RECOMMENDATION

The Committee is asked to note the contents of this paper.

Paper prepared by Christopher Elliot, Management Trainee

On behalf of Katrina Cleary, Programme Director, Primary Care

February 2016

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Update on Bents Green Practice Closure

Primary Care Commissioning Committee meeting

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18 February 2016

Author(s)	Christopher Elliot, Management Trainee
Sponsor	Katrina Cleary, Programme Director Primary Care

Is your report for Approval / Consideration / Noting

Noting

Are there any Resource Implications (including Financial, Staffing etc)?

No

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?
4. To ensure there is a sustainable, affordable healthcare system in Sheffield.

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached?
This was not a CCG lead responsibility

PPE Activity

How does your paper support involving patients, carers and the public?
Considerable engagement was undertaken by NHSE and CCG as part of this process

Recommendations

The Committee is asked to note this progress report.

NHS
Sheffield
Clinical Commissioning Group

Update on Bents Green Practice Closure

Primary Care Commissioning Committee meeting

18 February 2016

1. Introduction

Bents Green Surgery is a two partner Primary Medical Services (PMS) practice with an actual registered list of 2,610 as at 1st October 2015. The partners from Bents Green Medical Practice wrote to NHS England to serve a termination notice for the Primary Medical Services (PMS) contract, with an end date of the 31st March 2016. NHS England had two possible options it could explore with the first being to put the contract of providing services out to tender and the second being to disperse the Bents Green list to other local GPs. The detailed paper presented to NHS England to support their decision is attached at Appendix 1.

This aim of this paper is to provide an update on what events and actions have already been undertaken, along with describing what current actions are ongoing.

2. Decision Regarding Practice Closure

Following a regional Senior Management meeting at NHS England, the decision was taken to disperse the Bents Green patient list as opposed to putting the contract out to tender. This decision was supported by NHS Sheffield CCG who acknowledged this was in line with their main Primary Care Strategy.

Once the dispersal had been confirmed, a meeting was held with the local practices with which patients could register to discuss how the list dispersal would be undertaken, to gain an insight into which practices would be prepared to accept Bents Green patients and decide on an action plan how to go about this. At the meeting, practices that were willing to accept new patients from Bents Green were asked to compile a brief document outlining their opening times, services offered and if they were planning to hold any open events for prospective new patients. This compilation of responses were included in the letter to patients from NHS England, which outlined what Bents Green patients should do next, the options available to them and providing a general update on the events which have unfolded in regards to the Bents Green Practice.

3. Recommendation

The Committee is asked to note the contents of this paper

Paper prepared by Christopher Elliot, Management Trainee

On behalf of Katrina Cleary, Programme Director Primary Care

February 2016