NHS
Sheffield Clinical Commissioning Group

Primary Care Commissioning Committee
Unadopted minutes of the meeting held in public on 21 July 2016
Boardroom, 722 Prince of Wales Road

A

Present:	Mr John Boyington CBE, Lay Member (Chair)
(Voting Members)	Mr Kevin Clifford, Chief Nurse
	Professor Mark Gamsu, Lay Member (from item 61/16 onwards)
	Ms Julia Newton, Director of Finance
(Non Voting Members)	Dr Amir Afzal, CCG Governing Body GP
	Dr Nikki Bates, CCG Governing Body GP
	Dr Mark Durling, Chair, Sheffield Local Medical Committee
	Dr Trish Edney, Healthwatch Sheffield Representative
	Mr Greg Fell, Sheffield Director of Public Health
	Ms Victoria Lindon, Senior Primary Care Manager, NHS England
In Attendance:	Ms Sarah Baygot, Communications
	Mrs Katrina Cleary, Programme Director Primary Care
	Mrs Rachel Gillott, Deputy Director of Delivery and Performance (for item 64/16)
	Ms Carol Henderson, Committee Administrator

Members of the public:
There were five members 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
57/16	**Welcomes** The Chair welcomed members of the Sheffield Clinical Commissioning Group (CCG) Primary Care Commissioning Committee and those in attendance to the meeting. ***It was noted that the meeting was not quorate at this stage as Professor Gamsu had advised that he had been delayed returning from a meeting offsite. Therefore any decisions made until his arrival would need to be ratified by either himself or Mrs Maddy Ruff, Accountable Officer, after the meeting, and any such ratifications minuted accordingly. It was noted that the committee terms of reference were to be reviewed to try to prevent a recurrence of this situation.***	

58/16 **Apologies for Absence**

Apologies for absence from voting members had been received from Mrs Maddy Ruff, Accountable Officer.

Apologies for absence from non voting members had been received from Dr Devaka Fernando, Secondary Care Doctor, Mrs Amanda Forrest, Lay Member, and Dr Zak McMurray, Medical Director.

59/16 **Declarations of Interest**

There were no declarations of interest this month. The Chair advised members that in future not only would any conflicts of interested need to be noted but there would also need to be a note of action taken to manage this.

60/16 **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.

Professor Gamsu joined the meeting at this stage. This meant that the meeting was now quorate.

Post meeting note: No decisions had been made during this time.

61/16 **Minutes of Previous Meeting**

The minutes of the meeting held on 29 June 2016 were agreed as a true and accurate record, subject to the following amendments:

a) Proposed Temporary List Closure – Mosborough Health Centre (minute 50/16 refers)

An action for the eighth paragraph to be attributed to the Chief Nurse.

62/16 **Matters Arising**

a) The Sheffield Alliance of the Willing: Building a Truly Local Health and Care System (minutes 36/16 and 46/16(b) refer)

Professor Gamsu advised the committee that he would keep them advised of progress under any other business at future meetings.

The Committee agreed that this item could be removed from matters arising.

b) Review of Primary Care Commissioning Committee (PCCC) Meetings (minute 49/16 refers)

The Programme Director Primary Care advised the committee that she was in the process of arranging a confirm and challenge session / more qualitative review in private in October (following the September PCCC meeting) to test out the rationale / reasoning for papers presented in the private PCCC session, which would include representatives from NHS England, Sheffield Healthwatch, and Sheffield Save Our NHS (SSONHS). **KaC**

c) Overview of Care Quality Commission Ratings for General Practice (minute 52/16 refers)

The Chief Nurse advised the committee that the vast majority of practices in Sheffield that had been inspected at this stage had received overall ratings as Good. He suggested that he share the report that was received by the Quality Assurance Committee (QAC) at their quarterly meetings. **KeC**

63/16 Stocksbridge Medical Group Sale and Leaseback of Current Premises Proposal

The Programme Director Primary Care presented this report which updated the committee on the progress so far in relation to the ongoing discussions between Stocksbridge Medical Group (the former Valley Medical Centre) and a developer with regard to the proposed development of new premises in the commercial Fox Valley development in Stocksbridge.

She advised the committee that, from a practice perspective, they were looking to succession plan for the future and the best way forward as they have a number of GPs very close to retirement age. In the short term, therefore, the practice was looking at sale and lease back opportunities of its current premises, which would be an agreement between the current GPs and the new owners. She also advised the committee that the District Valuer (DV) had been involved for a while now, to work out what the core square meterage of a practice would be in any potential new premises within the Fox Valley development.

She advised the committee that the CCG and NHS England (NHSE) were looking at how they could support the practice in its sustainability. They were also asking the committee to support the DV's identified reimbursable area for the proposed new premises as being 833m2 for the purposes of General Medical Services (GMS) provision, and to request that the practice and developers of the Fox Valley development confirm to the CCG whether the practice relocation to a new site was likely to happen and within which timescale. With regard to the latter, she reported that the practice's practice manager had responded that the proposed timescale of end of October 2016 to confirm to the CCG that the practice relocation was likely to happen was quite tight and therefore would be looking to confirm either way by end of December 2016.

In response to a question from Professor Gamsu, the Programme Director confirmed that there would be no financial implications for the CCG relating to the proposed sale and lease back of the current premises.

The Director of Public Health asked about the role of the CCG and NHSE in the proposed arrangements, and questioned what would happen if the new owner of the current building decided to sell it and build something else. The Senior Primary Care Manager advised that the CCG, through its delegated co-commissioning role, reimbursed all its practices through notional rent, etc, and where it did this it was agreeing for them to provide services. With regard to the latter, this advised that it would be a 20 year lease with no break clauses, unless they jointly agreed to ruminate it before then.

Dr Afzal asked why the nearby Deepcar Local Improvement Finance Trust (LIFT) was mentioned within the paper. The Programme Director responded that, whilst the developer and the practice would like to see further expansion of services in the Stocksbridge area, it was important for the committee to recognise that the CCG was funding the Deepcar building which was not currently fully utilised so had to give due consideration to that. There was no suggestion that the practice should move into that building.

The Chair of Sheffield Local Medical Committee (LMC) suggested that the committee support the proposals as it should mitigate against future risks to the practice, provided it was all within the regulations. He also commented that sale and leaseback had become quite popular nationally, even though it did still require incoming GP partners to make a 20 year lease headline commitment.

Dr David Baron, GP at Stocksbridge Medical Group, who was in attendance for this item as a member of the public, thanked the Programme Director and Senior Primary Care Manager for the work they had undertaken to support the practice. He also advised the committee that the practice's Patient and Public Participation Group were overwhelmingly in favour of the proposals.

The Primary Care Commissioning Committee:

- Subject to any minor changes to the premises that might need doing, approved the proposed sale and leaseback arrangement of the Johnson Street surgery premises on the understanding that this lease would be surrendered by Landlord and Tenant if, and when, terms were agreed for the new premises and a new lease was put in place for those new premises.
- Accepted the District Valuer's identified reimbursable area for the proposed new premises as being 833m2 for the purposes of general medical services provision, and acknowledged that this would be what the CCG reimbursed the practice on.
- Requested that the practice and developers of the Fox Valley development confirm to the CCG by the end of December 2016 whether the practice relocation to a new site was likely to happen and within which timescale.

64/16 **Developing Primary Care Intelligence**

Mrs Rachel Gillott, Deputy Director of Delivery and Performance was in attendance for this item and presented this report which set out the proposed actions and timescales to take forward a piece of work the committee had requested in June regarding the development of a more robust business intelligence approach relating to practice specific issues as the availability of that information did not exist in a co-ordinated way as it had in the former Primary Care Trust (PCT). She drew the committee's attention to the key issues.

The paper reflected, at section 2, the CCG's current understanding of the position. She advised the committee that a task and finish group had been established to seek to identify the full suite of information that was available, and the different drivers and different pieces of information that would need to be pulled together to inform the decision making of the organisation and support neighbourhood working. She advised members that, although we were in a better position that we used to be, there may be gaps in what they were able to pull together, however, she hoped to be able to provide an update to the committee at the next meeting. **RG**

The Director of Public Health fully supported developing this intelligence and suggested that the Deputy Director of Delivery and Performance contact members of his team to discuss what public health information was available from the Public Health England (PHE) Fingertips tool, which is a data product with a range of indicators at GP practice level that is widely used and considered very useful. However, he advised the committee that he had heard that there were some uncertainties about the future production of Fingertips. **RG**

Professor Gamsu commented that paper F Alternative Provider Medical Services (APMS) Practices that would be discussed later in the meeting provided a good example of a proactive approach to gathering primary care intelligence, which was not just led by the data available nationally but also told a story of what was actually happening.

The Chief Nurse advised the committee that Quality did not hold, but absorbed, the information that primary care generated, and had to make the best use as possible of that information.

Dr Afzal commented that whilst he was under the impression that this type of data gathering would be used to understand problems in primary care, there was a fine line between delving into private areas relating to practice business and into something that would be good for the whole of Sheffield. The Programme Director commented that this would not be about delving into business decisions, etc, but into the range of data sources that were publicly available but not easily accessible by the CCG, and having that information available for the purposes of this committee, and for any number of potential users within certain parameters.

Dr Bates reported that at the City-Wide Locality Group meeting earlier in the week there had been a plea for some very good data, which was especially important it

was if the CCG was going to be developing neighbourhoods. She also reported that all practices in Sheffield had a requirement to make a presentation to the Care Quality Commission (CQC) as part of the series of CQC practice inspections, which was a bit like a story of what they have done and contained a lot of interesting information. She commented that it would be very helpful if this information could be shared with the CCG.

The Chair of Sheffield LMC commented that his observation was that there was a wealth of practice information relating to monitoring and activity availability so it was common sense to prevail and to make it meaningful and to use it as a tool to help patients and inform commissioning decisions. However, he asked the CCG to use caution in their interpretation of referral and consultation patterns, etc, from individual practices.

The Senior Primary Care Manager advised the committee that NHS England (NHSE) did not hold any information but accessed information from elsewhere, all of which was also accessible by the CCG. The Deputy Director of Delivery and Performance commented that the CCG needed to use NHSE knowledge as it was very difficult to get data and interpret what it was actually telling us and some would only give us an indication of what we needed to know. The Senior Primary Care Manager advised that she would be happy to work with the CCG with regard to turning the data into information and that information into intelligence.

Dr Edney advised the committee that Sheffield Healthwatch had established a new website that contained details of all Sheffield practices, on which anyone was invited to comment. It could also refer people to the practice's own website and to NHS Choices.

The Chair suggested that this could be a very comprehensive piece of work that needed to be developed. His thoughts were that as there was a lot of intelligence around, and we had four Locality Managers (LMs) in addition to the LMC working with our member practices, the PCCC, as a committee, should be trying to pull some of this subjective information together.

The Chair of Sheffield LMC asked for a commitment from the CCG to consult with them before any request for data gathering was sent out to practices. The Programme Director responded that the CCG was not at the stage as yet of being clear what questions needed to be asked of practices but it would not be about asking for new information but about gathering the information that was already there. Any proposal for new data gathering would need to be presented to the PCCC for discussion and approval.

Finally, the Chair asked the Programme Director if she would ask the Locality Managers to provide some general information that could form part of a discussion in a private PCCC session. **KaC**

The Primary Care Commissioning Committee:

- Noted the context and background to developing primary care intelligence.
- Agreed to the actions on developing primary care intelligence outlined in

section 3.

65/16 **Month 3 Financial Position**

The Director of Finance presented this report which provided members with an update on the financial position for primary care budgets at Month 3 together with a discussion on the key risks and challenges to deliver a balanced position at year end. She advised members that, although there was still limited information on actual or projected spend against some budget lines, she had been able to include some year to date information for the first time and there were a number of budgets where we had a bit more clarity, but the forecast year end financial position was currently to plan.

The Chair asked about section 2.3 and when it was expected that the CCG would be able to utilise the 1% non recurrent reserve it was required by NHSE England to hold back, and what it would be used for. The Director of Finance explained that the requirement for all CCGs to hold back 1% across their budgets including Primary Care co-commissioning budgets was part of the overall settlement arrangement between HM Treasury and NHSE. It reflects the considerable financial challenges faced by the NHS, particularly by provider trusts to achieve financial balance and permission for any spend against the 1% was linked to the overall financial position of the NHS. Thus the most likely scenario at this stage was the CCG would have to release the reserve and increase our year end surplus.

The Chair of Sheffield LMC commented that it was very frustrating in general practice to have this uncertainty. He suggested that ideally the CCG should develop a 'wish / to go list', with practices developing a variety of schemes for investment that could be ready for submission when the time was ready. The Director of Finance responded that she felt it would be inappropriate to give false expectations and so was cautious about putting a whole tranche of work in place at this stage.

The Programme Director reminded the committee that the CCG was trying to gather intelligence, which would help PCCC, as a committee, to shape where investment was most needed, eg to support the development of the neighbourhood model..

The Chair suggested that a future private session consider options for use of the funding non recurrently to make that biggest impact involving also the Locality Managers.

The Primary Care Commissioning Committee received and noted the report.

66/16 **Alternative Provider Medical Services (APMS) Practices – Locally Commissioned Services**

The Programme Director presented this report. She reminded members that due to the timescales and uncertainty regarding the new contract holders of The

Clover Group of practices, it had not allowed this group of practices to be included in the special cases process that had started in August 2016. To this end, on 1 April 2016, the committee had received and discussed a paper describing the challenges and issues around the Clover Group and Broad Lane Medical Centre under the remit of special cases. At that meeting they had agreed to the recommendations for more time to understand the complexities of their population's needs and to receive a final funding and contracting proposal for implementation no later than 1 October 2016. The paper presented today provided that proposal and a detailed description of the work of The Mulberry Practice that had been provided by The Clover Group.

She advised the committee that the CCG now felt that it understood the differences of the five practices that comprised The Clover Group in terms of a patient basis. She also advised the committee that they had gone through significant due process and it was clear that the Mulberry, Darnall and Highgate practices provided services over and above core contract services.

Mulberry Practice: The practice provides a service that meets the needs, and not just the primary care needs, of very vulnerable patients, and it had taken a considerable amount of time to understand what the demands of those services were. On an ongoing basis, it was evidenced that their patients did not use the hospitals due to the substantial services provided by the practice and relied on the practice for their main and sole services.

The practice did not have a district nursing service as their patients were spread across the city so part of the proposal was for the practice to have their own.

Darnall Primary Care Centre and Highgate Surgery

The Programme Director advised the committee that, based on the data submitted so far, both practices have very high use of interpreting services that goes beyond the 10% of the total list size threshold agreed by the committee in 2015. In this respect it was proposed to fund an amount, to be agreed within the overall contract offer to The Clover Group, for the cohort of non-English speaking patients within these two practices in line with the existing communities Locally Commissioned Service (LCS).

Dr Afzal asked how non-English speaking patients were defined. The Programme Director explained that this was defined by the degree to which practices use the interpreting services, if they have their own services, and if someone is required to come into the practice to provide that service.

Dr Afzal also commented that The Mulberry provided phenomenal services, including extensive health screening for Hepatitis B and C and latent TB, which should be recognised, and their health care professionals were super specialists, but, from a resourcing point of view, asked where their finances come from and why a practice care practice was dealing with something that was not primary care. The Programme Director explained that they provided a specialist medical service and basically the patients had nowhere else to go. The Director of

Finance also explained that the reality was that the money used to come to the practice from NHS England, which was transferred to the CCG for primary care.

The Chair of Sheffield LMC also commented that this practice required recognition for the services it provided.

Professor Gamsu commented that it was a really good piece of work and pleasing to see the full story included, but it was concerning to see that the practice's budget had been cut by almost one third since Primary Care Trust (PCT) days. The Senior Primary Care Manager explained that whilst there had been a reduction in the level of funding, there had also been changes in the way the contract was funded. . Professor Gamsu commented that this highlighted that members needed to develop further expertise on how it interpreted data.

At the invitation of the Chair Ms Rachel Pickering, Practice Manager for The Clover Group, who was in attendance at the meeting as a member of the public, thanked the committee for their positive comments about The Mulberry Practice, and advised that the services provided by the practice were recognised nationally, with Sheffield being a city of sanctuary. She advised members that, for The Clover Group, there had been a significant cut in funding as the CCG had had to move to Equalisation of funding, but wanted to be treated as any other practice. She thanked the Programme Director, in particular, for her support to the practice over the past year.

The Primary Care Commissioning Committee:

- Agreed additional funds for the existing specialist service at The Mulberry Practice, via a locally commissioned service which, for 2016/17 would be £230k pro-rata for six months.
- Agreed additional funding to extend the current communities LCS to support The Clover Group with its non-English speaking patients.

67/16 **Any Other Business**

There was no further business to discuss this month.

68/16 **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.

69/16 **Date and Time of Next Meeting**

Please note that the date and time of the next meeting has been rescheduled to take place on Thursday 8 September 2016, 2.00 pm – 4.00 pm, Boardroom, 722 Prince of Wales Road

Appendix A

Questions from Mr Mike Simpkin, Sheffield Save our NHS to the CCG Primary Care Commissioning Committee 21 July 2016

Question 1: **To what extent is GP list inflation adjudged to be a problematic issue in Sheffield?**

CCG response*: This has not been identified as a specific issue for Sheffield.*

Question 2: Has the CCG been involved in any discussions or made any representations regarding the reported NHS England instruction to purge GP lists of people who have not contacted their GP for 5 years by passing them to something resembling a debt collector agency run by Capita - whose performance after taking over primary care administration has already been subject to question.

CCG response*: NHS England has contracted Capita to provide the Primary Care Support England (PCSE) service. This service provides support and administrative services to primary care, including managing supplies, performer list and market entry applications and moving medical records.*

The 'Tackling List Inflation for Primary Medical Services' policy and procedure was published by NHS England in June 2013. Primary care professional bodies, representatives of patients and the public and other stakeholders were involved in the production of these documents.

Question 3: **Have NHS England subjected this policy to any kind of impact assessment and if so is this in the public domain?**

CCG response*: The Primary Care Commissioning Policies and Procedures underpin NHS England's commitment to a single operating model for primary care from 1 April 2013. All policies and procedures have been designed to support the principle of proportionality. The development process for the policy reflects the principles set out in "Securing Excellence in Commissioning Primary Care" and includes ensuring alignment with policy and compliance with legislation, including the Equality Act 2010.*