NHS
Sheffield Clinical Commissioning Group

Primary Care Commissioning Committee
Unadopted minutes of the meeting held on 18 February 2016
Boardroom, 722 Prince of Wales Road

A

Present:	John Boyington CBE, Lay Member (Chair)
(Voting Members)	Kevin Clifford, Chief Nurse
	Professor Mark Gamsu, Lay Member
	Julia Newton, Director of Finance
(Non Voting Members)	Dr Amir Afzal, CCG Governing Body GP
	Paul Barringer, Primary Care Manager, NHS England (on behalf of the Contract Manager, NHS England)
	Dr Nikki Bates, CCG Governing Body GP,
	Dr Maggie Campbell, Chair, Healthwatch Sheffield
	Dr Mark Durling, Chair, Sheffield Local Medical Committee
	Amanda Forrest, Lay Member
	Dr Zak McMurray, Medical Director.
In Attendance:	Katrina Cleary, Programme Director Primary Care
	Chris Elliott, Management Trainee (observing)
	Carol Henderson, Committee Administrator

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**
01/16	**Welcomes** The Chair welcomed members of the Sheffield Clinical Commissioning Group (CCG) Primary Care Commissioning Committee and those in attendance to the meeting. The Chair explained that, as per the requirement of the Committee's Terms of Reference, only two of the CCG's three Lay Members could be voting members of the Committee. He clarified that Professor Gamsu had agreed to be the other voting Lay Member at today's meeting, along with himself.	
02/16	**Apologies for Absence** Apologies for absence from voting members had been received from Maddy Ruff. Apologies for absence from non voting members had been received from , Victoria Lindon, Contract Manager, NHS England, and Dr Stephen Horsley,	

Interim Director of Public Health, Sheffield City Council.

It was confirmed that the meeting was quorate.

03/16 **Declarations of Interest**

The Chair declared a conflict of interest in item 10: Update on Closure of Bent's Green practice in that a member of his family and their family were currently registered with the practice.

The Director of Finance declared a conflict of interest in item 10: Update on Closure of Bent's Green practice in that she and a family member had been previously registered with the practice.

Dr Bates also declared a conflict of interest in item 10: Update on Closure of Bent's Green practice in that she was a GP at Porter Brook Medical Centre, which was one of the surrounding practices on Bents Green practice patient dispersal list.

There were no further declarations of interest.

04/16 **Questions from the Public**

A member of the public had submitted questions before the meeting. The Chair advised the committee that, although it was hoped that these would be covered during discussions throughout the meeting, he would ask the member of the public at the end of the meeting if all their points had been addressed.

05/16 **Minutes of Previous Meeting**

The minutes of the meeting held on 18 November 2016 were agreed as a true and accurate record.

06/16 **Matters Arising**

a) Next Steps (minute 11/15 refers)

The Programme Director Primary Care confirmed that governance colleagues had reviewed the delegated authority the Commissioning Executive Team (CET) had in relation to signing off / determining the solutions for the applications from practices that the committee had deemed to be special cases and for those individual practice they had deemed had specific issues that needed to be addressed. She clarified that the Primary Care Commissioning Committee had the power to delegate these to either the CET or any other group within the organisation. However, these groups could only recommend to the committee proposed action to be taken as they did not have authority to make a decision on the committee's behalf.

b) Clover Group (minute 12/15 refers)

Ms Forrest advised the Committee that, at the time of the last meeting, they had not been advised that the tender for the commissioning of core and non core services currently provided by the Clover Group, and on the running of the services, had already been issued by NHS England a couple of days prior to that meeting, and had therefore raised concerns about the process with Governing Body a few days later. She commented that, if the committee had been aware of this at the meeting, her thoughts were that a slightly different conversation would have taken place.

07/16 Update on Equalisation of GP Finances - Special Cases

The Primary Director Primary Care presented this report which updated the committee on progress and next steps following the considerations at the last meeting of the 'special case' applications submitted by practices particularly facing significant financial loss, and discussions at the Commissioning Executive Team (CET) to which the committee had delegated authority to manage the process to completion.

She advised the committee that a considerable amount of work had been, and continued to be, undertaken in terms of meeting with the practices concerned to understand the non core services they provide to meet the needs of patients' needs not met by the Carr-Hill formula. Based on the findings of that, a recommendation had been made to the CET on 19 January that a Locally Commissioned Services (LCS) to cover the services that were over and above the existing contract to provide for the needs of patients where there was significant demand would be the best contracting method. She advised that a further update would be presented to the CET shortly, with a view that they would be able to get this progressing as soon as possible and to have a new LCS in place by the start of the new financial year, for two years initially, subject to review. The Chair of Sheffield Local Medical Committee (LMC) welcomed the opportunity to see the LCS specification, especially around the contracting mechanism and, to support the sustainability of these practices, would also welcome any additional funding for it to be extended beyond the proposed two years. The Chair commented that the problems in primary care and general practice were very well recognised, with the sustainability issue one that we needed to find an early solution on but to keep under review in the long term.

Professor Gamsu asked if the practices concerned would be able to cope with the timescales of this process. He also asked if the CCG should be doing anything at this stage with regard to engagement with members of the public served by those practices this affected. The Programme Director responded that patient and public engagement (PPE) dovetailed with some of the work the CCG was currently doing on the redesign of interpreting services and, once clear what that model would look like, would ensure that patients were informed as to what the changes might be. She also explained that some of the practices involved had

already lost funding as part of the Personal Medical Services (PMS) equalisation process and some through the special cases process, and still continued to raise issues with the CCG.

Professor Gamsu asked if the CCG's Membership understood, and had been given, updates on this process. The Programme Director explained that they probably were not aware in terms of the process but had been made aware of Governing Body's decision made at the meeting on 16 July 2015 on the proposals for the equalisation of finance.

She advised the committee that one of the practices that the committee had deemed not to have a special case had written to the CCG to formally challenge the process. It had initially been thought that any challenges would be taken through the NHS complaints process, however, the CCG had established that this was not an appropriate use of that process so colleagues were working to establish what this should be.

The Chair of Sheffield LMC commented that it was really important to recognise the level of anxiety caused by the process. The CCG needed to keep a running dialogue with the citizens of Sheffield to keep them informed them of the ongoing process, but in a way that would not prejudice any decisions.

The Chair of Healthwatch commented that, with regard to the special cases applications process and wider commissioning, there were specific practice issues that had been put forward to the CET that were not included in section 10 of the paper that described the non core services that the practices provided to meet the needs of patients not met by the Carr-Hill formula, that had a commonality across all those practices. For example, there was at least one practice whose special needs included having a large young people and student population, which sits outside Carr-Hill, but was not included. She advised the committee that Healthwatch was in the process of undertaking some Enter and View visits and had gathered some sort of idea about how that affected practices, and asked that this not be lost in the CCG's considerations. **KaC**

The Chair of Sheffield Local Medical Committee (LMC) explained that the formula used was actually called the Modified Carr-Hill Formula. He welcomed that the formula was being reviewed and hoped that it would make a difference in digesting primary care health needs going forward. .

The Chair of Healthwatch welcomed the CCG's emerging Primary Care Strategy, which had been very well received at Governing Body, and applauded the introduction of an Urgent Care Strategy, but questioned where the resources to enable primary care to provide the services would come from. The LMC Chair reported that the LMC was now becoming more aware of practice's intentions to manage their ability to maintain services safely, including how to deal with list issues, and would be having discussions with NHS England about how those practices could be supported. He commented that the downside risk was that there were a significant number of quite vulnerable practices that have great difficulty as they are subject to recurrent financial pressures that they could not **MD**

withstand, whilst trying to deliver quality care for patients.

The Committee received and noted the report.

08/16 **Update on Developing the Primary Care Strategy**

The Programme Director gave an oral update. She advised the committee that an early draft, which gave a flavour of the strategy, had been discussed at a recent Governing Body strategic session. She advised that the strategy was one pillar of the Care Outside of Hospital Strategy.

With regard to process, she advised the committee that there was still a lot of work to do, but it had been as inclusive as it could have been within the timescale, including discussions with all Locality Councils. She reported that a Local Delivery Group, including members of Governing Body and the LMC, had been established, so there would be challenges across the system. She also advised the committee that the CCG had been invited to discuss with the Our Healthier Communities and Adult Social Care Scrutiny Committee their concerns about GP access, which it was hoped to do before discussion at this committee on 1 April, and Governing Body in April when the final strategy would be presented for approval. She advised the committee that, because the CCG has been inclusive, some practices had already started to put things in place so that Active Support and Recovery services would start to wrap around them.

Professor Gamsu commented that it would be important to establish some milestones for outcomes in this process, and what would seem organisationally different was a climate that focused on delivery rather than iteration. The Chair of Sheffield LMC reported that the LMC supported the idea of a federation and practices working together and would do what they could to facilitate that, including conversations with GPs as to how it might work.

The Committee noted the update.

09/16 **Update on Co-Commissioning of Primary Care**

The Primary Director Primary Care presented an update on the progress that had been made in relation to primary care co-commissioning and what actions had been put in place to ensure a smooth transfer of delegation from NHS England to the CCG to take responsibility for commissioning of primary care services within Sheffield from 1 April 2016. She reminded members that a key function of this committee was to make sure that the co-commissioning was appropriate.

She drew members' attention to the key highlights which included the establishment of a sub group of this committee that spanned the CCG's directorates, including Mr Elliott, Management Trainee (who was in attendance at today's meeting) who had provided assistance with the project plan and NHS England. She also reported that the CCG had recently received a Scheme of Delegation from NHS England that had to be signed by the CCG's Accountable Officer and returned by the end of February. She agreed to circulate to members **KaC**

of the committee a summary of the delegated functions.

She advised the committee that the CCG continued to work with NHS England, especially in relation to what the workforce and capacity issues might be. One of the key things the CCG wanted to put in place was something that improved responses to practices from both organisations and, to assist with this, a junior administrator would be appointed. She also suggested that, as we move forward, a training and development plan be put together for practices. This could include, for example, practice managers' sessions on such issues as employment law, practice mergers etc. This and the above support post were the two key improvements that the CCG would want to see at an early stage. She also suggested that Mr Elliott contact individual members of the committee as to what other training and development needs they had in relation to co-commissioning. **KaC** **KaC(CE)**

The Chair agreed with this and suggested asking Primary Care Sheffield (PCS) to help with a session on supporting practices to become federations, etc. Dr Afzal also suggested that as one of the agenda items he would like including clarity between the national contract that GPs work under and what co-commissioning would mean in relation to that.

Ms Forrest advised the committee that, in addition to the webinars NHS England had put on for colleagues, Lay Member training had also been arranged. However, this was mainly focused around conflicts of interest. She commented that the CCG needed to know what it might be inheriting on 1 April and, as a Lay member on this committee, wanted to be aware of where the pressure points are, including which practices might be in danger of closing, etc. The Chair agreed that members of the committee needed to be absolutely sighted as to what the starting position would be and, in this regard, would discuss this in more detail in the private session.

The Chair of Sheffield LMC commented that co-commissioning was an expedient step which would allow the CCG to be more responsive to practices, as long as they had authority and close liaison with NHS England. The downside risk to this included how that would affect a Membership organisation in terms of contracting, and in management roles. He commented that, practically speaking, practices have struggled despite the best endeavours of NHS England's Area Team to maintain a responsiveness to practice problems, and he very much hoped that co-commissioning would improve the process, even though he had reservations about the culture of co-commissioning but felt the positives would outweigh those

The Committee received and noted the report.

10/16 **Primary Care Transformation Fund**

The Programme Director Primary Care gave an oral update on progress. She reported that CCGs had been asked to work with practices and NHS England to come up with proposals about what premises and digital technology they would want to receive in general practice. She clarified that practices could submit a bid for anything relating to premises or IT, ie updating of general premises, extending

current premises, current premises that were not fit for the future and required a new build, etc. She advised that an initial deadline for proposals to NHS England had been set for the end of February, which had now been extended to the end of April. She also explained that this was a three year process and was currently in discussion with NHS England as to whether the CCG has to submit a three year plan at the start or submit one for each year after that.

She explained that, just before Christmas 2015, the CCG had written out to all practices asking them for their thoughts / suggesting they speak to their Locality Manager, etc, also recognising that the resources, either from NHS England or the CCG, to support any revenue consequences that might be incurred was still to be determined . She advised that the deadline for bids from practices was 24 February and would work with practices when we were clear on the prioritisation process. The co-commissioning sub group, including finance and IT colleagues, would meet to prioritise the bids, and would recommend to this committee those they felt CCG should be looking to support. **KaC**

The Chair of Healthwatch commented that, in her experience, it might be that it was the patient and not the actual practice that would know what a practice might find would be improvement in terms of digital technologies and suggested that, in future, it might be helpful asking for contributions from patients / patient organisations / observations that were being gathered in other ways, and as a CCG, to say that we would have a particularly interest in taking our patient stories into account. An example of this related to outward-facing things, for example TV screens in practice waiting rooms that did not seem to be under the control of the practice in the contract they have and sometimes there were prohibitive costs, but there ought to be way to use these things for the benefit of all. She also commented that there might be some resistance in some practices to adopting some new technologies.

The Programme Director agreed to take this forward with the CCG's Head of Informatics. **KaC**

Professor Gamsu questioned whether, if a practice wanted to increase the size of its premises, the CCG would request that they look to host other services from there. The Director of Finance advised the committee that, as the CCG was already paying for void space in its LIFT buildings, we should be mindful not to agree to expand space that we did not need.

The Chair of Sheffield LMC seconded this. However, he commented that, sometimes general practices and GP partners were stuck with legacy costs that could strain them. This was a big priority area for development and hosting services and the CCG needed to find a way in helping practices overcome fears of sustainability, speaking to landlords, etc.

Dr Bates commented that this was another opportunity not to be missed for the CCG to communicate with its Membership, and in this respect suggested that a communication be sent out once all bids, etc, had been agreed and finalised, advising what the relevant practices would be doing.

The Chair of Sheffield LMC commented that this was another example of the devolvement of initiatives followed by rule sets, etc, where it was a pity that the rules did not allow GPs to decide on where and what the funding was spent on. However, he applauded the CCG's Head of Informatics, who had been working with practices for many years and had clear ideas about their requirements and the strategic way forward. He commented that the IT investment would be very welcome and very worthwhile, but needed to be made authentic, with shared knowledge rolled out to practices.

The Committee noted the update.

11/16 Update on Closure of Bents Green Practice

The Programme Director Primary Care presented this report which advised the committee with an update on what events and actions had already been undertaken, and described the current actions that were ongoing.

The Programme Director set the context and advised the committee that the practice was so small and financially unviable that it had not been considered sufficiently viable to warrant a replacement practice being procured She drew members' attention to Appendix 1 which presented the detail submitted to NHS England to support their decision. She also asked members to consider whether it included sufficient information for them to be able to have made a decision if the closure had happened after 1 April 2016, when the CCG would assume delegated co-commissioning responsibilities.

She advised the committee that although market testing had been undertaken to see if any other practice would be willing to take this on, NHS England, supported by the CCG, had agreed to the dispersal of the practice's patient list as opposed to putting the contract out to tender. The CCG had taken the view, although it was not usual practice, that the surrounding practices should provide a summary of their services which would also be included as supporting information in the letter sent out to the practice's registered list.

With regard to actions undertaken, the Programme Director advised the committee that, a well attended public meeting had taken place shortly before Christmas which had given people the opportunity to raise issues and / or voice their concerns, and letters had been sent out to patients, who were now starting to register with other practices, and on 1 April would check the list size to ascertain how many patients still needed to re-register. The Primary Care Manager advised the committee that, as the practice did not have a Patient Participation Group (PPG), NHS England had been approached by their local neighbourhood group, who had helped them to draft the letter, and had been happily surprised about the range of services that surrounding practices were offering.

Professor Gamsu's thoughts were that the voluntary sector had been left out in terms of communications about the closure of Bents Green. He commented that the CCG was seen as well intentioned and willing to go out and engage so his

thoughts were that we had a reputation we could maintain and build on.

The Director of Finance raised concerns about the number of very elderly and vulnerable people who had been registered with the practice a long time who would not be able to go through the processes of registering with another practice without support, and advised that the CCG could not register people on their behalf. The Programme Director responded that, by 1 April, it would hopefully only be a very small group of people still to register, and her view was that unless they chose to do something else then then we should allocate them to a practice, however, the CCG has been advised that this was not what allocation is for.

The Medical Director raised concerns about having unregistered, elderly, potentially vulnerable people, who would be more likely to end up in A&E, and asked if the CCG could ask NHS England to review the stance on allocating people to a practice. The Primary Care Manager responded that NHS England had requested further clarification on this and advised that something might happen, but had not been confirmed as yet.

Dr Afzal questioned as to whether those patients that had opposed the practice closing had received a response.

Ms Forrest commented that with regard to the process, her thoughts were that not enough work had been undertaken with local Councillors, MPs, etc, and did not think that there was a consistent message from the surrounding practices, some of which were being seen to 'lure' people to join them. She commented that there were things that could be learned from that which was more than just sending out a list of practices to patients.

Ms Forrest also suggested that an analysis of the media coverage be undertaken as part of a review of process for the committee to have an understanding of how some of the messages to patients had come about.

The member of public welcomed the CCG's and NHS England's input into resolving the concerns about the difficulties some patients might have in registering with another practice. He asked that both organisations not be afraid of the public process and commented that information had come out in the end that explained a lot of issues and had helped a lot of things to happen. He felt that the role of Patient Participation Groups was really important and we needed to find a way of involving them and building them up as patients always have things to say.

Ms Forrest commented that in the CCG's Patient Experience and Engagement Group (PEEG) they had talked about 'help and harness' PPGs and suggested possibly to hold twice yearly forums for them to all get together, as was working in other areas. She commented that there seemed to be a variation as to how PPGs work but the CCG could help them to have a focus.

The Chair suggesting setting some aside, either at a future meeting or workshop, to discuss this and future processes such as this, in more detail. It was not just

about doing things right but about doing the right thing.

The Committee received and noted the report.

12/16 Update on Alternative Provider Medical Services (APMS) Procurement

The Primary Care Programme Director gave an oral update on the outcome of the APMS procurement process, which she also agreed to provide in written form at some point.

She gave the committee some background context and advised that this related to two providers whose contract would come to an end on 31 March 2016, for which the rules stated that those services had to go out to re-procurement. She advised the committee that, once the tenders had been received, she had reviewed them with the CCG's Clinical Lead for Primary Care and NHS England colleagues, which had enabled the CCG to input some of the issues about which some third sector groups had raised concern.

She advised the Committee that the contracts for the Clover Group of practices and Broad Lane had been awarded to ta collaboration of Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) and Primary Care Sheffield (PCS). She advised the committee that the CCG was still in the process of working through with the Clover Group the non –core funding issues relating to their practices but in the meantime, it would be business as usual.

A member of public commented that the public were very uncertain about what primary care providers represented and asked if the CCG could find a way of explaining that in the future.

The Programme Director commented that the learning from this process is that any process for procurement which we devise locally needs to give due consideration to the role of active groups and interests. It was agreed that this should form part of the learning workshops as discussed earlier in the meeting.

The Chair of Healthwatch commented that part of that thinking needs to be around what information we should be asking the public for, ie were we asking them for something that was not going to be deliverable, as her thoughts were that the public's ability to take on new initiatives, etc, was consistently under estimated.

The Committee noted the award of the re-procurement contracts for the Clover Group of practices and Broad Lane to the collaboration between Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) and Primary Care Sheffield (PCS).

13/16	**Any Other Business**	
	a) Primary Care Commissioning Committee Workplan	
	The Chair suggested that an outline workplan to help the committee through the next six to nine months be developed for the near future.	**KaC**
	b) Conflicts of Interest	
	The Chair reported from a recent training session he had attended where they discussed as to whether voting members should declare as an interest which GP practice they were registered with. The feeling at the session had been, due to possible perception from members of the public, that it should be declared. He asked members for their views.	
	The Medical Director supported this but felt there should not be any pressure on individuals to do this.	
	Ms Forrest and Professor Gamsu supported this.	
	The Director of Finance and Chief Nurse had reservations about this and suggested that it should only be declared if there was an item specifically relating to their practice, to be discussed.	
	The member of the public commented that he supported declaring this interest only on a voluntary basis, as appropriate to the agenda.	
	The Chair agreed to take this forward outside of the meeting.	**JB**
	c) New Chair of Healthwatch Sheffield	
	The Chair of Healthwatch advised the committee that it was the last meeting she would be attending as she had stepped down as Healthwatch Chair. She reported that Judy Robinson would be taking over as Healthwatch Chair from Easter onwards, attending meetings of the Governing Body and its committees, where appropriate, and would ensure she was fully briefed.	
	The Chair thanked Dr Campbell, as Chair of Healthwatch Sheffield, for her contribution to the committee and wished her well for the future.	
14/16	**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.	

15/16	**Date and Time of Next Meeting** Friday 1 April 2016, 1.30 pm – 3.30 pm, Boardroom, 722 Prince of Wales Road