HEALTH SELECT COMMISSION
15th January, 2015

Present:- Councillor Watson (in the Chair); Councillors Havenhand, Kaye, Sansome, Swift, M. Vines and Whysall.

Apologies for absence were received from Councillors Dalton, Hunter, Jepson and Wootton.

67. DECLARATIONS OF INTEREST

There were no declarations of interest made at this meeting.

68. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public and press present at the meeting.

69. COMMUNICATIONS

There was nothing to report.

70. RESPONSE TO ACCESS TO GPS SCRUTINY REVIEW

The Chairman introduced the Cabinet's response to the Access to GPs Scrutiny Review and representatives present who would respond to issues raised by Select Commission members. The representatives included:-

Richard Armstrong	NHS England
Carys Murray Cook	South Yorkshire and Bassetlaw, Care Quality Commission
Chris Edwards	Rotherham Clinical Commissioning Group
Dawn Anderson	Rotherham Clinical Commissioning Group
Jacqui Tuffnell	Rotherham Clinical Commissioning Group

Recommendation 1. Patients' experiences of accessing GPs vary from practice to practice therefore NHS England needs to ensure that patients' views on access are reflected in the forthcoming Personal Medical Services contract re-negotiations and five year commissioning plan

Chairman – 1 of my concerns is the national GP survey. Whilst it gives the big picture I am concerned that in some of our practices we do not have that many responses. In some of the practices there are 30 responses which only have to have 1 or 2 patients who think differently on a certain day and it can switch a percentage. What are we doing to make sure we get big numbers in each practice?

Richard Armstrong – It is very complicated. The survey is run twice a year and Ipsos Mori, the company who conduct the survey do a detailed analysis of what has happened in the past. The survey has been taking place 6-7 years and they target those populations and practices to try and get a statistical and valid response i.e. where there were lower response rates they will survey more patients in that practice and will target in terms of trying to get a range of ages and sexes etc. They boost the survey every time for every practice to try and get that statistical validity. It was still dependent upon patients returning the surveys but there had been a fairly consistent response rate over the years fluctuating between 43-46%. It tended to be young minority ethnic communities for the lower response rate so there would be a big boost to try and improve that rate.

Councillor Sansome – Will the report come back here so we can see where the problems lay or where the best practice was that needed to be shared across other practices?

Carys Murray Cook – We are planning the Care Quality Commission inspection for Rotherham at the moment. There were 36 GP practices in the Rotherham area and we plan to inspect 18 of them in the first quarter of 2015/16. The inspections would be carried out from April onwards and we will be liaising with the Clinical Commissioning Group 2 weeks prior to the inspection starting regarding the practices we will be inspecting and notifying them. Following an inspection, a very detailed report was written which goes through our quality process and then made available to the public so will be available on our website.

Councillor Sansome – I think what is very key to this review, and the reason why it has been referred back, is that the people of the Borough need to see some clarification and conviction that this will be an exercise that people want. We need to see that it was something that all partners are taking as seriously as possible to make sure the care and treatment is there. The response we have given through our own individual input shows that we are serious and certain that we are going to improve access to GPs and the services they have got.

Councillor Kaye – Is the profile of the patients different within practices and is there a difference in an urban profile or a rural profile? When I visit my practice there are a lot of young people in there and lot of old people and I am looking for a % mix of that and whether that has an overall impression on what patients say and need from their GP

Richard Armstrong – There are different groups of patients who expect different things at different stages of their life. The biggest indicator of patient satisfaction of their experience of a GP is age. As the patient got older the way GPs offered services for that age range was quite convenient for them and, therefore, a much higher satisfaction levels than the younger population. The population that had the lowest satisfaction rate was 18-24 years from a minority ethnic background. They had the lowest satisfaction levels because they were expecting a different service.

They wanted something different from the practices other than what was usually provided. They wanted to be able to walk in, book in, have an appointment and leave and were less concerned with who they saw as long as they could be seen. We must try to get practices to provide a range of ways patients could be seen. As patients got older they normally wanted to see the same person but when younger and working they wanted appointments that were convenient.

Councillor Swift – We have done a similar survey at Treeton practice but not many people wanted to fill the survey in so it can skew the results.

Richard Armstrong – The GP survey is produced by Ipsos Mori. They design the surveys using GPs and academic professionals and have done a whole series of work with patient groups and individuals to ensure that the range of people can explain the questions they were seeking to get an answer to. They work on that throughout the year and keep refining and improving surveys so can normally see when a patient answered a question that is what they actually intended to say. Response rates were still an issue but we have tried to do everything we can – you can request the survey in different languages, by telephone etc. Most practices want to respond to their patients. Practices look at the results. We try to publish the results in a comparative way as well because GP practices do not want to be different from their colleagues.

Councillor Kaye – Can you explain the reinvestment of any funding released from one practice into primary medical care?

Richard Armstrong – Historically GP practices have been funded differently and the idea of bringing in new contracting arrangements in 2004 was to move to a more fair and equitable funding per capita. For a variety of reasons we got it wrong and as part of implementation there was a predominant variety in practices so there was an inequality in funding. There was some relationship between more underfunded practices in urban areas and more highly funded practices in more rural areas and the idea of moving to per capita and redistribution would mean some lost and some gained. We had been trying to do this since 2008 and still had a differential in funding between practices so the idea of successive Governments had been to say we would achieve fair funding between practices by this date. The commitment is we do not take funding out of GP practices but reinvest in the practice to buy in services and improvement in care. There was no relationship between how much money comes into the practice and how well that practice performed either in terms of service offer or satisfaction of patients.

Jacqui Tuffnell – We work with NHSE in terms of premia on services and what was happening across the wider community to ensure services are provided. We look to ensure better spend and medical services.

Chair – How will you look at cost in your inspection?

Carys Murray Cook –Our inspection was not just about arriving on the day; we do a lot of homework beforehand so we do send out comment cards to the practices and ask them to place them for patients to complete. We look at patient surveys, Clinical Commissioning Group data about the profile of patients and get a lot of other data as well. Patients/carers/relatives can also give us information about the practice. The practice should also be informing us of any Safeguarding incidents they have had within the practice and also any significant events so we should have some knowledge about those as well.

The inspection process went into a practice and left no stone unturned. We look at the practice and staff. We specifically look at patient themes of vulnerable, mental health illness, work age population, children, adults over 75 and those with long term conditions. The inspection itself would gather as much data as it could around those areas. The key to the inspection was to speak to all the staff in the practice and patients on the day. We like to speak to 8-10 patients on the visit about their experience and use of the practice. The process was very in depth. If inspectors did find anything within the Regulations that was not being met, then we can produce warnings and also take enforcement action.

Chair – When you do that do you then work with the Clinical Commissioning Group and NHS for future plans?

Carys Murray Cook - When we have completed the inspection of the GP practice we meet with the respective Clinical Commissioning Group to feed back the information on what we have found in that area.

Richard Armstrong – What would happen in most visits was there were some things to be addressed which could be improved and an action plan would be developed with the practice to work through to make the improvements/address the issues so by the time the Care Quality Commission went back some would have been addressed and improved and try and get continuous improvement in the practice. These would then be owned by the Clinical Commissioning Group in future work.

Chairman – What if there was a common theme amongst practices?

Carys Murray Cook – We would look at it on an individual basis and collaborative basis.

Councillor Kaye – What “teeth” did you have?

Carys Murray Cook – From our inspection we do not just take the practice’s word; we want to see it written down, to see policies, procedures and processes on how they captured feedback from patients, how they investigated their incidents, look at their outcomes, how they measured actions and implementation so it was a very robust process. Not just about them telling us but corroboration and evidence.

Richard Armstrong – Most GPs, Drs, nurses etc. have not trained for 10 years to deliver poor care to their patients and usually when you point something out to them they will address it themselves. As part of the developed action plan we will work with the practice to implement it. If the practice is working to try and implement it and were struggling there would be support to try and keep helping them.

If they did not recognise there was a problem, then we get into contract sanctions. If they did not co-operate we would serve a Breach Notice on them which is a warning which says they are in danger of losing their contract. Normally that is enough. If not, and we think it was sufficiently serious, we can withhold some element of the funding to them as a penalty. In terms of financial sanctions we can remove the contract saying to them in this case we do not think you are an appropriate provider and we will remove the contract. We have a duty to put a new contract in place. A practice must be registered with the Care Quality Commission for a Clinical Commissioning Group to hold a contract with them. If they did not listen the Care Quality Commission would deregister them and they could not hold a contract.

Janet Spurling – In relation to the minimum practice income guarantee (MPIG) was this generally in relation to GMS contracts?

Richard – PMS contracts before 2003 and into the GMS contract in 2003. Some practices took their historical income into their new contractual arrangements.

Across the country 50% of practices lost and 50% gained. The difference could be quite small in some places but in others very big and adjustments would be made for practices which have an atypical population. Where it was about the range of services they offered and services, if the Clinical Commissioning Group's wished to continue to buy these they would be explicitly commissioned and funded so practices may not see a change in funding but it would be commissioned by them. This enabled NHS England to see if the practice was funded fairly and all being treated fairly.

Councillor Kaye – Equality and the difference between different practices is that just within a geographic area or country wide in relation to funding?

Richard Armstrong – There was no divide across the country and it was nothing to do with how the funding formula worked. If you were trying to get a practice to improve you had to try and get a level playing field. When we talk about core funding this was the 55% of funding a practice got for baseline services. On top of that they received additional funding for enhanced services; funding through Quality Outcomes Framework; for premises costs; and for IT costs. If a practice said its funding had been reduced they were referring to the 55%. We are trying to get all the core funding equitable and anything released to invest in better services and care.

Chairman – Where are we with the 5 year area based commissioning plan?

Clinical Commissioning Group – The ability to have varying co-commissioning services has been incorporated into the 5 year strategy. NHS England was to discuss the strategy later that day.

Richard Armstrong – It is confirmed in the Clinical Commissioning Group's commissioning plan and an application for co-commissioning, access and improving access was highlighted.

Recommendation 2 – The continuation of the Patient Participation Directed Enhanced Service in 2014/15 should be used to ensure patients are well informed and empowered through the Patient Participation Groups to challenge poor access and suggest improvements. All practices should be encouraged either to participate in the PPDES or to establish other effective mechanisms for ensuring patient engagement

Councillor Kaye – I only found out this morning that my Doctor's practice had a website which contained all the information about the practice. I was unaware that that facility was available. I wonder whether there was a need for better publicity? It was a question of communication and how we meet nearly everybody's needs?

Richard Armstrong – Practices had been obliged to produce patient leaflets since 2004 and all the information should be within that leaflet. This was also checked by the Care Quality Commission on their inspection. We had been increasingly encouraging practices to use the internet to facilitate more access and make more information available. Having information available on the practice website was the best way for it – being able to book appointments, order repeat prescriptions and do more on electronic communication. Also had to recognise that not all patients wanted to do that and information was available through NHS Choices on the various helplines available. We could still do more to improve communications – NHS England to practices and practices to patients - and we will continue to work on that.

Carys Murray Cook – The Care Quality Commission looked at the information provided to patients and if it was not seen we give practices feedback.

Chairman – There was an original suggestion that NHS England look at developing an app. The demographic group that have said they were less satisfied were probably the group that would use it.

Richard Armstrong – It was part of the current Government's Policy to make more raw data available about the NHS but, rather than all do that, to allow commercial organisations to access that information and for them to develop apps, web tools etc. to put the data together. The 1 thing public surveys were not so good at was understanding the different sets

of data in order to tell you something additional to what the numbers said. There were already a number of apps that looked at GP improvement. They were available without the NHS spending any money. The data was made available for others to use.

Councillor Sansome – What died each practice offer when it put out the information online? Was it the same template which each practice had? Was there good practice issues and was there a local template?

Richard Armstrong – The contract specified what data had to be provided but not in what format. Some practices were better than others. The GPC provided a template for all practices that met the minimum standard. Those practices that were more pro active and probably looking for more patients and were better at explaining what they were and what they wanted and met the cost. There were organisations such as NHS IQ (Innovation and Quality), part of NHS England, whose job it was to support and innovate by supporting training to practices and how they could be better in responding to patients' needs and be more efficient in running their business. There was a whole programme of support which took best practice across the country. There was probably more that could be done to support those practices to access that but the tools were available.

Councillor Kaye – How many practices in Rotherham have availed themselves of that support?

Richard Armstrong – The relationship was between the practice and NHS IQ and not something NHS England would necessarily have information on.

Recommendation 3 – Although recognising the importance of clinical need, the expectations and preferences of patients are changing and practices should explore more hybrid and flexible approaches to appointments

Chairman – When this was discussed elsewhere 1 of the things mentioned quite strongly that there should be "sit and wait slots" at all practices. Having read your response the survey does not seem to support that.

Recommendation 4 – NHS England should maintain access to interpretation services for GPS with an emphasis on professional services, supported by training for GPs and practice staff to increase confidence in using telephone services where appropriate

Recommendation 5 – NHS England should review their current interpretation provision to see if economies could be achieved through signing up to Rotherham MBC's framework agreement which is open to partner agencies

Chairman – Having read the original response I would see this as 1 area that I felt disappointed in. Is anything actually going to happen? Have we a way to move forward?

Richard Armstrong – We inherited a whole range of different Interpretation Services and arrangements. One of the first things NHS England said was that we needed a master list and work commencing on defining a definitive list of Interpretation Services. 2 years later we are still waiting for that document. There was now a nationally agreed specification and the main players had been asked to procure a framework contract for the NHS people to use a group of providers who could meet that Service specification.

NHS England wanted a single Interpretation Service which covered your population and our population because they were the same patients. Richard needed to understand whether we could all use the same framework contract and have a Rotherham Interpretation Service that met all our requirements and gave access to our patients. Although the summary of details had only come out the previous week, NHS England were committed as a Clinical Commissioning Group and NHS England to get a better Interpretation Services due to the wasted money between the 2 in buying different services.

Councillor Sansome – What was behind the statement and what did it mean and what services did it provide? I appreciate the feeling of being hamstrung by the delay in policy but the population needed to be clear what this meant.

Recommendation 6 – GP practices should regularly showcase best practice and share successes on providing good access to patients through existing means such as the practice manager forum and Protected Learning Time events.
Chairman – Were the events held frequently?

Richard Armstrong – The NHS met infrequently. There were a number planned across the north of England during February and March to try and showcase what practices were doing and learn from each other. However, the events only ever can get to 100 GPs at a time so was much more reliant on what the Clinical Commissioning Group had been and were doing,

Dawn Anderson – The Clinical Commissioning Group had a regular programme of events for GPs – there was a Protected Learning Time event that day – that took place bi-monthly. In between practices were encouraged to hold their own in-house events with the Clinical Commissioning Group monitoring what topics were being discussed. There was also a Practice Managers' Forum held on a bi-monthly basis with best practice as a standing item on that agenda. There was a regular programme of events and although the Clinical Commissioning Group scheduled items space was left for topical issues.

Recommendation 7 – Patient information and education is important, both generic information about local services and specific information about how their surgery works

Chairman – I think we have covered most of that in the previous discussion.

Janet Spurling – 1 thing that we have not really touched upon was around the growing numbers of people not attending for appointments. I know a lot of practices had information on their screens about missed appointments and when speaking with the NHS England at the time of the Scrutiny Review they said they were going to talk to practices and get a flavour of how they were doing in terms of non-attendance. There was a recommendation about a campaign to raise public awareness of the importance of attending appointments. Again this linked in with "sit and wait" slots.

Richard Armstrong – Data was not collected on missed appointments in a consistent manner and where there had been such an exercise it showed that the rate had not increased or changed. It was a bugbear for GPs that patients did not attend but also for many it meant that the 10-15 minutes of no patient meant they could catch up. We had to make the best use of the capacity available and sometimes having that free slot allowed the practice to get back on time.

1 of the reasons patients were less satisfied was because of longer waiting times. Clearly there was pressure on practices with the number of people going attending having increased. This was 1 of the main reasons why it was thought that the solution was to improve the access and convenience, increase capacity and to get more people who walked into GP practices to make better use of the practice nurses, doctors from hospitals, physiotherapists and other health professionals. The Prime Minister's Challenge Fund was starting to demonstrate that with a whole new skill mix placed in and around the GP practice it could relieve some of the pressures and ensure patients still saw a clinician.

Carys Murray Cook – From a personal point of view it is around the sharing of what worked well across the board. From the inspections completed some quite innovative ways of working with other members of allied health professionals in health practices could be seen but what met the needs of the health population? Agencies needed to look at what the needs of patients were and how it was best met with the relevant development of staff within the practice. There were good examples of meeting patients' needs such as dementia screening appointments.

Councillor Kaye – Was there any comparison with what happened in GP practices to dentists for example? Were missed appointments right across the board?

Carys Murray Cook – The Care Quality Commission also regulated dentists but the missed appointment rate, compared to GPs, was significantly lower probably due to there being a cost involved with dental care and a patient making contact with the dentist when they had a problem and wanted the pain to be relieved so they would make sure they attended that appointment. There may be some best practice to share but the best practice seen was about informing patients of the impact that missing their appointment would have upon the practice.

Another good example was online booking appointments.

Richard Armstrong – That had been showed through GP surveys on how practices could improve satisfaction. Those practices that made more use of online booking had higher satisfaction levels.

Councillor M. Vines – Do you have a lot of missed appointments because you were so long waiting for 1?

Richard Armstrong – I think undoubtedly if a patient could get the convenience and access they wanted it inevitably impacted upon their immediacy or need to see a doctor. Practices were encouraged to try and meet that need. There was evidence from the survey that showed that nearly every patient wanted to see their doctor but that if they were offered an appointment earlier to see the nurse and they take it they were more satisfied rather than waiting longer to see the doctor. Practices needed to understand that quite often the customer wanted to be seen conveniently rather than waiting longer and that an offer to see another clinician would be better.

Chairman – Was there any evidence of lower satisfaction rates with single handed practice?

Chris Edwards – The advantage of a single handed practice was that the patient saw the same doctor every time so tended to be more satisfied.

Carys Murray Cook – From personal experience single handed practices had a smaller population size but still may have other health professionals working at the practice so I would see no difference.

Richard Armstrong – The data showed 2 interesting things; 1 that a smaller practice had higher satisfaction levels but also had greater variability. It came down to what the patient was looking for – if they wanted to see the same doctor but there may be a longer waiting time.

Janet Spurling on behalf of Councillor Hunter – Receptionist were very often performing the role of a triage nurse over the phone which affected who got what slot in the GP timetable with many then going to A&E or the Walk-in Centre

Richard Armstrong – Most practices had tried to create a slight barrier between the Reception to enable privacy for the customer. Receptionists did what their employers requested of them. If patients had concerns they should be expressing it to their GP not the receptionist and more feedback to the employer might affect that. The data suggested the biggest factors influencing a patient were (1) can I get an appointment (2) whether they were timely are not (3) can I get through on the telephone (4) what was my experience of the reception. These had an impact on how patients saw their GP.

Janet Spurling on behalf of Councillor Hunter – The District Nurse Team's role was changing in a way that meant they may not enjoy the very close working relationship with GPs they currently enjoyed which could increase pressure on GPs (more home visits etc.) which meant they could be less available for appointments. Ultimately District Nursing being GP based but not based in GP surgeries could have a massive impact on working relationships to the detriment of the patients.

Richard Armstrong – Personally I think we need better links across all health professionals and those working in the community whether it be the District Nurse, Social Workers, physiotherapist etc. There needed to be a key relationship knowing that you are working with the same patients for whatever reason. Those services were not stitched together for local patient needs and would bring more efficiency.

Chris Edwards – In Rotherham there had been great changes made – integration of the Hospital and Community Trust and everything the Clinical Commissioning Group was trying to do to integrate Primary and Community Care. It was such a big task that it would take a couple of years to achieve but it was a priority. In Rotherham the Clinical Commissioning Group was GPs led so the duplication would be found. There was a thread throughout the planned integration of Primary Care, Social Care and Community Care.

Recommendation 8 – In light of the future challenges for Rotherham outlined in the report the review recommends that a proactive approach is taken by the Health and Wellbeing Board to mitigate risk to the delivery of primary care
No comments.

Recommendation 9 – NHS England should consider incentives to attract GPs to start their career in Rotherham following training in the area to help address the demographic issues of our current GPs
Chris Edwards – For every 100,000 patients in Sheffield there were roughly 70 GPs. In Rotherham there were 58. In Yorkshire and the Humber the average was 58. Rotherham had some very challenging communities which were difficult to attract GPs to; Sheffield attracted more. There was 1 big advantage in Rotherham in that there was a training scheme which had 14 registrar GPs training. Rotherham was the only 1 to have it fully staffed and was perceived to be the best training

scheme in the Yorkshire and the Humber. The Clinical Commissioning Group had tried to get the 14 GPs to stay and embrace Rotherham and feel a sense of ownership. Financial incentives had been considered but extra funding could not be attracted for such payments. Hull only had 40 GPs for 100,000 and Rotherham had more than Doncaster and Barnsley. It was still tough and Primary Care staffing levels were not where we would want them to be.

Recommendation 10 – Rotherham CCG should collect and analyse monitoring information to ensure services are resourced to meet peaks in demand during protected learning time at the new Emergency Care Centre from 2015

Chris Edwards/Dawn Anderson – NHS 111 carried out the call handling and gave the Clinical Commissioning Group a summary of calls. Regular discussions were held with the Walk-in Centre to ascertain if demand had been catered for. There were not seen to be any issues with that.

Recommendation 11 – NHS England needs to be more proactive in managing increases in GP demand due to new housing developments rather than waiting for existing services to reach capacity

Councillor Swift – I was at a meeting last week at Treeton Health Centre. We have patients coming from the Waverley development but we are full and they are building more houses in Treeton and Catcliffe (which does not have a surgery). We cannot manage the appointments because there are so many people wanting to come. We have planning permission to build a new health centre but it has been suspended.

Chris Edwards – When the Primary Care Trust was dissolved in 2012 1 of the final acts was to prioritise 2 capital projects – Dalton and Treeton health centres, and funding was identified to put new builds in. Dalton had progressed and I believe starting construction. Treeton was still being discussed. This was the responsibility of NHS Property Services who the Clinical Commissioning Group consistently challenged and would continue to challenge. It was the understanding that funding was identified 2.5 years ago.

Councillor Kaye – As a member of the Planning Board I am aware of the number of houses to be built on the Waverley site in the next 25 years. When and where would be a tipping point? When was it big enough to have its own practice?

Richard Armstrong – There was no magic number but clearly as properties started to be built then work should be taking place to plan when the ideal time was to put a GP practice in place. However, it was an economic decision for a practice as they needed sufficient patients to register with them to generate income which allowed them to employ staff, therefore, there became a point when it was the right time to make such facility available. It took 9 months to carry out the procurement so there should be planning at least a year ahead. 1 of the difficulties had always

been the inertia of getting patients to move and change facilities and had to find a way of overcoming that and encourage patients to register.

Councillor Kaye – Waverley was quite near the boundary of Sheffield. Would Rotherham work closely with Sheffield or be separate?

Chris Edwards – It would be a question for NHS Property Services. Should they be invited to a future meeting as to how they approached capital build across the piste? It would be beneficial to see the strategy they had for South Yorkshire.

Richard Armstrong – Patients had the right to register with a GP practice where they wanted to. It was not just planning and the Rotherham/Sheffield boundary but understanding what the patients wanted as well as what NHS England wanted.

Recommendation 12 – Rotherham MBC when considering its response to the scrutiny review of supporting the local economy, should ensure health parents are invited by the Planning department to be part of the multi-disciplinary approach to proposed new developments
Chairman – A meeting was already in place.

Richard Armstrong then drew attention to Potential Actions of NHS England as follows:-

- Increasing the overall supply of clinicians in primary care including
  - Increase the number of training places for GPs
  - Increasing number of doctors qualifying that wish to enter general practice
  - Changes to the induction and returner scheme to enable GPs to return more swiftly to the GP perfomers list
  - New models of care which meet demand differently including through widening skill mix (e.g. minor ailments services, direct physio access and e-consultations)

- Looking to extend the availability of general practice
  - Expanding the Prime Minister Challenge Fund pilots – exploring models for 7-day access to general practice (year 1: £50M established 20 pilots nationally (7 in north) covering 7M patients. Year 2: additional £100M available to expand number of pilot areas)
  - 'Doctor First' – this is now being used by some practices. This enables same day telephone triage with around 2/3s of patients being dealt with by phone

- Ambition of 'Patient Online' – providing the ability to book appointments prescriptions and view medical records online

- Right Care: clearer to patients and the population how best to access the right care to meet their needs

- Using 111 can direct people to get the right care which can include self-care

- Encouraging use of pharmacy as an alternative to GP
  - Feeling Under the Weather is a national campaign focussing on the management of winter illnesses
  - Treat Yourself Better is a national campaign led by the industry focussing on the management of illness without expectation of antibiotics
  - Pharmacy First is a national 'brand' used by many CCGs which encourages patients with some minor ailments to use the pharmacy. Patients who are exempt from prescription charges receive free medicines from the pharmacist

Councillor Sansome – I have been doing a lot of research on the services of actual access to GPs and 1 issue was that of a confederation where GPs, the CCG and NHSE are 1 body. I would like the opportunity to discuss whether there was an opportunity going forward in Rotherham.

Chris Edwards - The current landscape was a bit confusing – it went from a Primary Care Trust to NHSE doing Primary Care, the Clinical Commissioning Group and then NHS Property Services. As from 1st April, 2015, the Clinical Commissioning Group would be taking delegated responsibility for NHS England which would join up the Clinical Commissioning Group and Primary Care. There would be Rotherham people making decisions about Rotherham services. There needed to be continued work with the Council. Property Services was not included in the delegated responsibility.

36 Rotherham GP practices had looked at forming a confederation. Currently a Limited Liability Partnership had been formed which was a local vehicle that allowed the GP practices to bid for business together. The Clinical Commissioning Group had assisted and had given 1 off funding for the legal costs. They expected to form the Limited Liability Partnership by the end of January.

The Chairman thanked everyone for their attendance.

Resolved:- (1) That a presentation be made to the June meeting on the Limited Liability Partnership.

(2) That the Rotherham Clinical Commissioning Group and NHS England contact NHS Property Services with regard to their plans for the development of Treeton Health Centre and supply the Select Commission with their response.

(3) That NHS Property Services be requested to attend the June meeting to inform the Select Commission of their strategy for Rotherham.

71. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 22nd January, 2015, commencing at 9.30 a.m.