NHS
Vale of York
Clinical Commissioning Group

Minutes of the Primary Care Commissioning Committee held on 11 October 2018 at West Offices, York

Present

Keith Ramsay (KR) - Chair	Lay Member and Chair of the Quality and Patient Experience Committee and Remuneration Committee in addition to the Primary Care Commissioning Committee
Michael Ash-McMahon (MA-M)	Acting Chief Finance Officer
David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Phil Mettam (PM)	Accountable Officer
Dr Kevin Smith (KS)	Executive Director of Director of Primary Care and Population Health

In attendance (Non Voting)

Dr Paula Evans (PE)	North Locality GP Representative
Dr David Hartley (DH)	Selby and York Local Medical Committee Representative
Shaun Macey (SM)	Head of Transformation and Delivery
Lesley Pratt (LP)	Healthwatch York Representative
Michèle Saidman (MS)	Executive Assistant

Apologies

Heather Marsh (HM)	Head of Locality Programmes, NHS England (Yorkshire and the Humber)
Sharon Stoltz (SS)	Director of Public Health, City of York Council

Unless stated otherwise the above are from NHS Vale of York CCG

There were no members of the public in attendance.

Question from Bill McPate

It was reported at item 9 of the PCC Committee on 26th July that: "the CCG commissioned primary care services but had no role in regulation or inspection". What therefore is the role of the CCG in provide assurance to the public that GP practices are delivering a quality of service they can depend on. In particular, precisely how will the CCG respond to the Council of Representatives call reported at the same meeting that "monitoring should be proactive and specific enough to prevent further occurrences."

KS responded that the CCG's current position, like all CCGs, was one of risk of having an unidentified Practice struggling to meet the essential standards and therefore putting patient safety at risk. When this Practice was identified as a result of Care Quality Commission inspection findings there was not only the risk to patient

safety to urgently address what the CCG was not aware of but there would also be several other areas of concern to manage as a result of these findings, such as the regulatory sanctions that may be imposed, the potential legal ramifications, and the reputational risk and adverse publicity, as well as concerns of service users. By actively seeking assurance through a programme of quality assessment and identifying gaps in good quality service provision the CCG would be able to proactively identify patient safety concerns and better support Practices to address these areas of concern.

KS explained that CCG's plan would be discussed with the Council of Representatives on 18 October; this would be followed by a launch event:

1. Each Practice will be asked to complete a self-assessment questionnaire and return this to the CCG quality team within four weeks of it being sent out.

2. The questionnaire is based on the "Tips and Myths buster for GPs" information on the CQC website (https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-tips-mythbusters-gp-practices)

3. A 20% validation exercise will then be undertaken. Practices will be chosen at random and a Practice visit will be undertaken by a member of the quality team/NHS England support. This visit will involve reviewing the evidence the Practice proposes to use to demonstrate compliance with the Key Lines of Enquiry.

4. Publication of the findings will be done through the GP Practice bulletin with each Practice being given a unique identifier code to enable them to identify how they benchmark against their peers for each domain and/or criterion.

5. Individual feedback will be given to the Practices involved in the validation exercise. Should a Practice not chosen at random for the validation exercise wish to have a Practice visit this will be accommodated.

Further discussion ensued during which KS noted that, although the CCG received advance notice of the Care Quality Commission's schedule of visits in confidence, Practices were only notified two weeks in advance.

KS emphasised that there were many aspects to quality of which the Care Quality Commission process was one. He also noted the impact from Care Quality Commission reports on Practice staff, patients and the public highlighting this in the context of good patient care.

PE referred to discussion at previous meetings about the dashboard development in respect of a range of nationally published indicators and enquired whether such information would have highlighted emerging issues at Unity Health. In response KS advised that they had been outliers but whether in a positive or negative way was not known at the time. He emphasised the need to respond to 'soft intelligence' noting that the group established in this regard was meeting monthly. KS added that the

CCG had varying levels of concern about workforce and associated pressures at a number of Practices but not to the level of Unity Health.

DH joined the meeting

LP noted that the Care Quality Commission sought comments from Healthwatch in respect of care home visits and asked whether such an approach was adopted regarding Practice visits. SM would follow this up with them. *Post meeting note: The CCG's contact at the Care Quality Commission confirmed they ask Healthwatch and also look at other sources, including social media and NHS choices, as part of inspection planning.*

Agenda

1. Welcome and Introductions

KR welcomed everyone to the meeting. He particularly welcomed LP who was attending for the first time.

2. Apologies

As noted above.

3. Declarations of Interest in Relation to the Business of the Meeting

There we no declarations of interest in the business of the meeting. All declarations were as per the Register of Interests.

4. Minutes of the meeting held on 26 July 2018

The minutes of the meeting held on 26 July were agreed.

The Committee

Approved the minutes of the meeting held on 26 July 2018.

5. Matters Arising

KR noted that a number of matters arising were on the agenda and reported that SS had provided updates on her actions:

PCCC30 Proposal to be developed for Public Health commissioned services to be incorporated in the remit of the Quality and Patient Experience Committee: A proposal had been agreed at the Quality and Patient Experience Committee earlier in the day.

PCCC31 Update regarding liaison between Unity Health and the City of York Council's transport team on concerns relating to the transfer of services from the Hull Road Surgery to Kimberlow Hill Surgery: SS had been in touch with the Head of

Transport for City of York Council who was aware of the concerns which would be taken into consideration as part of the review of the local transport plan. No further action was planned.

Health and Social Care Network (HSCN) and Public Access Wifi: SM referred to the background to and potential benefits of the HSCN noting that procurement of connectivity was a national requirement. Funding from previous N3 services had been passed to CCGs to pay for these services which would connect health and social care sites.

SM highlighted that 60 of the CCG's 61 sites had completed the migration to HSCN; work was taking place to address the technical issue currently preventing the final migration, Kirbymoorside Surgery. SM commended both NYNET and the Practices in this achievement which was of note in the national context. He also advised that the CCG had been selected by NHS Digital as one of four 'benefits evaluation' sites noting that NHS Digital were hoping for many new health and care applications to be launched and supported by the new network infrastructure. However, new clinical and care applications would take time to establish but would start to enable more integrated working and wider use of applications such as video consultations and diagnostic image reporting.

In response to PE and DH noting that they were not aware of these developments SM advised that the CCG would be working with Practices and NHS Digital to explore the potential provided by the connectivity to develop new approaches for patient care. This would also require partnership working and creativity. SM noted the potential for investment by NHS Digital which was being coordinated at a Sustainability and Transformation Partnership level.

PM referred to the NHS England Local Health Care Record Exemplar programme. SM explained that this aimed to give GPs better access to such as A and E, hospital diagnostic and social care package information but noted it was complex to implement due to the technical architecture requirements and use of many different IT systems across health and care providers. KS added that he and Dr Nigel Wells, the CCG's Clinical Chair, had met with colleagues at York Teaching Hospital NHS Foundation Trust for similar discussions and explained a number of aspects of connectivity that required addressing in order for this to be progressed. SM reported that NHS Vale of York and NHS Scarborough and Ryedale CCGs had established a Digital Transformation Board which would progress this work but noted the need of additional clinical engagement to ensure that objectives remained clinically focused and to the benefit of patients.

With regard to General Practice public access wifi SM referred to previous reporting to the Committee advising that eMBED had still not completed the installation. SM and MA-M had met with eMBED when they had confirmed that a second contract extension would not be agreed also advising that contract penalties were now being considered by the CCG. A response from eMBED was now awaited. MA-M added that eMBED had provided additional assurance in terms of managing and monitoring of their sub-contractors.

KS commented that, whilst public access wifi had a number of advantages, it was not a requirement for effective patient care.

The Committee

1. Noted the updates.
2. With regard to the delayed Public Access Wifi programme confirmed that there should be no further extension to the CCG's contract with eMBED for the installation of public access wifi in Practices and that contractual penalties should be applied in the event of further delays.
3. Noted that regular updates would be provided with regard to the HSCN and General Practice public access wifi.

6. Primary Care Commissioning Financial Report

MA-M presented the report which detailed the financial outturn of the CCG's delegated primary care commissioning areas at Month 5 of 2018/19. He noted that updated information was also included since closure of the Month 5 position.

MA-M explained that the year to date position was in line with budget. The forecast outturn had moved from £43.3m to £43.1m, the only variance relating to Personal Medical Services monies which were forecast in full within Other Primary Care in the main CCG dashboard. There was an £80k overspend in the year to date position under Primary Care – Other GP Services as a result of the CCG's agreement to pay £100k relating to Unity Health's legal fees and stamp duty for their new premises due to lack of clarity in the associated paper work. MA-M confirmed that this in no way set a precedent and that this learning had been built into the approval of the latest Estates Technology and Transformation Fund bids. In response to DH referring to Premises Cost Directions stating that Practices should not be disadvantaged through legal fees, SM agreed to check this and report back.

MA-M advised that the CCG was working with NHS England in respect of the post Month 5 overall financial position and with the Primary Care Team in respect of the forecast. He highlighted that the recent 2% pay award was an additional £350k to £360k pressure from 1 April 2018 as CCGs had originally been asked to only account for an additional 1%. CCGs were in discussion with NHS England about whether they should be expected to absorb this additional pressure with no additional resource.

In response to PE seeking clarification KS confirmed that the Personal Medical Services Monies were not being moved. He noted that this information should be more explicit in future reports.

In respect of 'Other Primary Care', the areas that were not delegated, MA-M highlighted the £466k year to date underspend at the Other Primary Care line explaining that this related to slippage in the £3 per head expenditure. He also noted a number of aspects of the Primary Care Prescribing line which had a year to date deficit position of £117k and a forecast outturn of £397k deficit. MA-M referred to the CCG's introduction of Prescribing Indicative Budgets which had been affected by the national requirement for CCGs to improve their position with Category M

prescriptions benefit and the No Cheaper Stock Obtainable issue, the latter having cost the CCG c£2m over the year. Despite these adjustments Practices were commended for having achieved efficiencies in 2017/18.

MA-M advised that the CCG had informed the localities of their Prescribing Indicative Budget position and had requested discussion about potential proposals around the associated reinvestment in primary care. He confirmed the CCG's commitment to reinvest but was seeking support for this to be done within three to six months. KS added that the CCG was looking at prescribing from the longer term perspective.

MA-M also referred to the Other Prescribing budget line where there was a year to date £218k pressure and forecast outturn of £498k pressure. Whilst emphasising that the CCG wished to continue to incentivise Practices and recognising the national context of the CCG being the best in the country for a number of prescribing indicators, further savings were required.

DH referred to the fact that the Prescribing Indicative Budget scheme had not been available to all Practices as it had only been offered to federations and groups of Practices, also noting that his Practice had invested in clinical pharmacists from within their own existing resources. KS responded that any future scheme would be open to all Practices and that the CCG aimed to incentivise without negative impact on the financial position. He noted with regard to clinical pharmacists that a minimum population was required and also that there were issues with the current scheme; any future scheme would be considered on the basis of the CCG as a whole.

DB advised that the role of pharmacists as part of the CCG's wider strategy had been discussed as a concern at the Audit Committee and the Finance and Performance Committee. Whilst recognising the complexity due to pharmacies being businesses that were not co-ordinated or regulated, consideration should be given in the context of the strategic issue and the significant financial pressure. PE noted that her Practice employed a pharmacist who worked remotely and was therefore a shared resource. KS added that there were three key aspects in this regard: move to electronic prescribing, a pharmacist in General Practices and prescribers in Practice who could relieve pressure on GPs. The need for consideration of such as over ordering via electronic prescriptions was noted.

Members noted that the Finance Team was working to address the slippage in the CCG's financial position and that the prescribing concerns would be further discussed at the Finance and Performance Committee.

The Committee:

1. Received the Month 5 Primary Care Commissioning Financial Report.
2. Noted that SM would provide clarification regarding Premises Cost Directions in respect of legal fees.

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7. Update on General Practice Intelligence

KS referred to the discussion at the start of the meeting in response to the question and reiterated that the Primary Care Soft Intelligence Group continued to meet monthly, also noting the inclusion of the Care Quality Commission self-assessment.

KS reported increasing concerns were being noted regarding unfilled GP and nurse vacancies, lack of capacity and increased demand. A further concern was the unprecedented number of Practitioners absent from work due to occupational stress as a direct result of this and of the historic limited investment in primary care. KS noted that senior nurses were affected as well as Partners and GPs, adding that absence was at such a level that there was the potential for branch closure days. The CCG was working with Practices but discussions were also taking place with NHS England both locally and nationally in light of the present concerns.

PE noted that reduced working hours and similar issues with community staff were also having an impact on Practices.

In response to DH enquiring about the potential for the £3 per head and Improving Access to General Practice Services monies to be utilised to help with these pressures KS advised that the General Practice Forward View monies were subject to specific requirements. He also emphasised that short term funding was not the solution and agreed to DH's request to escalate Practice concerns as appropriate.

The Committee:

Noted the update.

8. Local Enhanced Services Review

SM referred to the report which provided an update on the review of Local Enhanced Services noting that clinical reviews at a CCG population level were underway, led by the Planned Care Team, for diabetes, PSA and bone protection services. The remaining enhanced services were being reviewed across the localities with Local Medical Committee and locality leads support. The ambition was for the localities to receive funding to provide the services ensuring availability for all patients.

In response to PE expressing concern about timescale and feasibility, including period of notice, SM referred to the earlier discussion about pressures on Practices and assured members that the CCG would work with the localities. A report would be presented at the January meeting of the Committee as there was no December meeting referred to in the report.

The Committee:

Agreed to receive a report on Local Enhanced Services for 2019/20 at the January 2019 meeting.

9. Personal Medical Services (PMS) Premium Monies Reconciliation

MA-M reported that, as agreed at the previous meeting of the Committee, Practices had been asked to submit any outstanding invoices in relation to the PMS premium monies by end of August 2018. As at the end of September 2018 £86k of 2017/18 PMS premium monies remained outstanding although a number of queries were being addressed. The remaining balance was expected to be between £80k and £86k.

With regard to 2018/19 PMS premium monies (£313k) and £3 per head transformation funding (£1.1m), which had been pooled, plans had been received from the North and Central Localities but not the South. To the end of September invoices totalling £185k had been received although there were again a number of queries to resolve. However, as all projects had slipped and were under-spending, it was not expected that the full value of PMS premium monies and £3 per head transformation funding would be utilised in year. Any year to date underspend against the £3 per head transformation funding would neither be made available over the remainder of the year nor carried over into 2019/20, although the intention was for the 2019/20 plan to include budget for £3 per head on an on-going basis. The Committee was asked to confirm that spend on projects in 2018/19 be funded in the following order:

1. Under spend in 2017/18 PMS premium monies in the first instance
2. Followed by 2018/19 PMS premium monies
3. Then £3 per head transformation funding.

KS advised that use of the monies had included support on developing proposals. He confirmed that the monies were being spent as originally intended and explained that unspent PMS monies could be rolled over into 2019/20 but £3 per head could not; however the CCG was proposing to continue the latter commitment into the next financial year. The proposed approach was to ensure and protect the investment in primary care. It was agreed that the detail be discussed outwith the meeting.

In response to DH referring to the complexity of the processes to access the monies KS explained the CCG's duty in the context of this being public money. MA-M added that each "pot of money" was required to recognise actual expenditure incurred.

PM noted that the CCG was continuing at risk to ensure the investment in primary care.

The Committee:

1. Noted the PMS premium monies reconciliation for 2017/18.
2. Confirmed the utilisation of all PMS premium monies before £3 per head transformation funding.

PE left the meeting

10. Improving Access to General Practice Services at Evenings and Weekends

KS presented the report which described the CCG's progress against the national 1 October 2018 target for CCGs to commission Improving Access to General Practice Services from 6.30pm to 8pm weekdays and at weekends. The procurement process had resulted in the successful award of contracts in the North and Central Localities which had been well received by the public. The CCG was actively working with providers in the South Locality to develop a service to meet the requirements.

KS reported that the contract in the North Locality, awarded to the Modality Partnership working with the Practices, had been successfully mobilised. He noted the additional sessions included practitioners other than GPs. The contract for the Central Locality had been awarded to Nimbuscare Limited and the service was being delivered by the Practices that had signed up. However, this was not all Practices and capacity was consequently proving a challenge. Additionally, IT issues were in the process of being resolved.

KS commended managers, GPs and all involved where the requirements had been met but noted it had been very challenging. He also expressed concern at impact on other services, notably GP out of hours.

SM referred to the Improving Access requirements in the context of the earlier discussion on concerns about capacity in Practices noting that this was an additional challenge. Nimbus was struggling to deliver the hours and the nature of the contract was such that it was difficult to recruit a pool of dedicated staff to work short evening shifts and weekends. The way to address this and to ensure sustainability was transformation to an 8am to 8pm service model.

DH noted that the cessation of the current Extended Hours Directed Enhanced Service, would be a considerable loss of income for Practices and this would not be replaced by the Improving Access income. He also noted that staff contracts were 8am to 6.30pm.

In respect of York Medical Group (the paper for this agenda item stated - It has also been noted that East Parade, Old School Medical Practice, and more recently York Medical Group have indicated that they will not be providing clinical staffing into the Central Improving Access service – and this places increasing pressure on Nimbuscare to fill rotas from the local pool of staff) DH highlighted that they were not declining to co-operate as described in the report but were not booking shifts as a Practice; information was being passed to Partners for individual decisions. SM responded that this was a change in the Practice's position since the time of the report being written.

The Committee:

Received the update and requested that this be kept on the agenda.

11. Unity Health Care Quality Commission Inspection Update

KS was pleased to report that the Care Quality Commission considered that Unity Health had made a level of progress in addressing the regulation breaches that enabled the lifting of suspension of new patient registrations. He wished to place on record appreciation of Jorvik Gillygate Practice's support to Unity Health student patients over the summer noting that the CCG was underwriting the associated costs and would fund gaps relating to movement of overseas students.

KS explained that, although Unity Health's rating would remain as 'Inadequate' and they would continue in Special Measures, the Care Quality Commission had been very impressed with the progress made across a range of improvements. They were continuing to address broader aspects of the Care Quality Commission report.

KS advised that NHS England had agreed to fund six additional GP appraiser sessions for Unity Health to hold development sessions with the partners to agree a new clinical model, He also noted that every CCG team had provided some support to the Practice since the CQC visit.

KS commended Unity Health for their approach and progress but added that they had been subject to a further issue, beyond their control, in the last week due to failure of the telephone line. The CCG had raised concerns from the NHS perspective with BT Openreach and had offered additional support and resources to Unity Health; the University of York was also providing support. KS emphasised that patients received good service from clinicians and administrative staff when they had gained access.

KS additionally noted that the Local Medical Committee and NHS England had provided support and were continuing to work with the CCG regarding a resolution to clinical leadership at Unity Health. He highlighted that Unity Health now received a level of scrutiny that no other Practice experienced advising that the CCG Communications Team was working with them in this regard.

The Committee:

1. Noted the update.
2. Expressed appreciation to Jorvik Gillygate Surgery for their support to Unity Health student patients over the summer months.

12. GP Patient Survey Results – Data collected between 2 January 2018 to 6 April 2018 from patients aged 16+ registered with a GP Practice in England

In presenting the results of the annual MORI GP Patient Survey SM noted that the questions had been changed from previous surveys therefore it was not possible to directly compare the information to previous years. He highlighted that aspects relating to quality of care were generally above the national average; where the CCG was below the national average related mainly to access to appointments as discussed at previous agenda items. The CCG would work with Practices to address

areas that required improvement. Much of this was driven by increasing patient demand on primary care services.

In response to LP reporting that York Older People's Assembly had been critical of the sample size, SM advised that MORI had sent out the survey and that the sample sizes were comparatively small every year.

The Committee:

Received the report on the key findings from the GP Patient Survey between 2 January 2018 to 6 April 2018 in respect of patients aged 16+ registered with a GP Practice in England.

13. Primary Care Commissioning Committee Annual Chair's Report

The Committee:

Received the Chair's Annual Report.

14. NHS England Primary Care Update including Rent Reimbursements

SM referred to the report which comprised assurance on contractual issues, provided an update on the General Practice Forward View, sought decisions on a number of rent reimbursements and reported on a review of dispensing patients included on GP Practice lists in line with Chapter 15 of the Pharmacy Manual. The latter related to people living within 1.6km of a community pharmacist.

SM provided clarification on a number of aspects of the rent reimbursements.

The Committee:

1. Received the updates from NHS England on items relating to the delegated commissioning agenda.
2. Approved the amendments to the notional rent payments, noting that this totalled c£5k, for:
    - Pickering Medical Practice, Southgate, Pickering YO18 8BL
    - Helmsley Surgery, Carlton Road, Helmsley, YO62 5HD
    - Elvington Medical Practice, Wheldrake Surgery, 54a Main Street, Wheldrake, YO19 6AB
    - East Parade Medical Practice, 89 East Parade, York, YO31 7YD
    - South Milford Surgery, Thorpe Willoughby Surgery, 12 Fox Lane, Selby, YO8 9NA
    - York Medical Group, Skelton Surgery, 32 Clifton, York, YO30 6AE
    - Sherburn Medical Practice, Old Hungate Hospital, Finkle Hill, Sherburn-in-Elmet, LS25 6BL
3. Approved the increase in actual rent for Pocklington Medical Practice, Beckside Centre, 1 Amos Drive, Pocklington, YO42 2BS.
4. Approved the actual rental figure of £6,995 per annum to allow a licence to occupy to be progressed for Priory Medical Group, Clementhorpe Health Centre, Cherry Street, York Y23 1AP.

15. Key Messages to the Governing Body

The Committee:

- Confirmed that contractual penalties should be applied in the event of further delays to installation of public access wi-fi in GP Practices.
- Noted the need for Prescribing Indicative Budgets to focus on achieving further savings and that the Other Prescribing budget line would be discussed at the Finance and Performance Committee.
- Noted concerns about capacity in primary care.
- Welcomed the development of a self-assessment tool to assist Practices in managing Care Quality Commission and other regulatory requirements in light of Unity Health's experience.
- Received an update on Unity Health.

In response to KR offering him the opportunity to add further to this, PM commended the work of KS and the CCG teams for their work and commitment beyond that which would be expected. He referred to the context of the Committee's commissioning role and emphasised within the context of the CCG's financial challenges the requirement for General Practice provider development. This, together with mental health services, is a priority for the CCG. DH noted that the Local Medical Committee had been asked to arrange a meeting with City of York Practices to progress breaking down of barriers and KS advised that the CCG was working to support primary care development but that Practices needed to have "one voice" in this regard.

Two further key messages were agreed:

- Commended the work of the Primary Care Team.
- Emphasised the need to strengthen primary care commissioning.

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

16. Next meeting

2pm, 22 November 2018 at West Offices

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE

SCHEDULE OF MATTERS ARISING FROM THE MEETING HELD ON 11 OCTOBER 2018 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCCC29	27 March 2018 26 July 2018 11 October 2018	Local Enhanced Services 2018/19	• Recommendations for future commissioning to be presented at the July meeting • Recommendations delayed • Report to be presented at the January Committee	KS/SM KS/SM	26 July 2018 11 October 2018 24 January 2019
PCCC33	11 October 2018	Primary Care Commissioning Financial Report	• Clarification to be sought regarding Premises Cost Directions relating to legal fees, SM agreed to check this and report back.	SM	22 November 2018