NHS
Vale of York
Clinical Commissioning Group

Minutes of the Primary Care Commissioning Committee held on 26 July 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
Heather Marsh (HM)	Head of Locality Programmes, NHS England (Yorkshire and the Humber)
Phil Mettam (PM)	Accountable Officer
Dr Kevin Smith (KS)	Executive Director of Director of Primary Care and Population Health

In attendance (Non Voting)

Dr David Hartley (DH)	Selby and York Local Medical Committee Representative
Shaun Macey (SM)	Head of Transformation and Delivery
Stephanie Porter (SP)	Deputy Director, Estates and Capital Programmes
Michèle Saidman (MS)	Executive Assistant
Sharon Stoltz (SS)	Director of Public Health, City of York Council

Apologies

Nigel Ayre (NA)	Healthwatch North Yorkshire Representative
Kathleen Briers (KB)	Healthwatch York Representative
Dr Paula Evans (PE)	North Locality GP Representative
Phil Goatley (PG)	Lay Member and Audit Committee Chair

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

Two members of the public were in attendance.

There were no questions from members of the public.

Agenda

1. Welcome and Introductions

KR welcomed everyone to the meeting. He particularly welcomed DH who was representing the Local Medical Committee.

KR commented on the number of items that were being presented as verbal updates and requested that written reports be provided for future meetings.

2. Apologies

As noted above.

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

DH had an interest in items 11 and 12 and SS had an interest in item 11. They did not take part in the discussion relating to these items. Other declarations were as per the Register of Interests.

4. Minutes of the meeting held on 22 May 2018

The minutes of the meeting held on 22 May were agreed.

The Committee

Approved the minutes of the meeting held on 22 May 2018.

5. Matters Arising

Health and Social Care Network (HSCN): SM explained that HSCN was the replacement network for N3 connection used by Practices to access clinical systems. Progress to date with the 61 sites on the schedule was: 51 had successfully migrated, five had scheduled dates; one was already on HSCN and there was currently no date for four due to technical issues that were being addressed with the supplier NYNET. SM expected that all Practices would have migrated to the HSCN platform by the end of 2018 and agreed to provide a further update at the next meeting.

MA-M clarified that two or three migrations had failed due to the allocation slot for the work being missed by Practices, but that these had safely been put back onto their existing systems with no downtime. He commended the Practices and NYNET where the migration had been achieved.

Public access wifi: SM reported there had been national technical issues and delays to the rollout of public access wifi. The CCG was working with eMBED on a completion date of mid September for all Practice sites. MA-M reported that the delay had been escalated with eMBED particularly as there had already been two extensions to the original contract timetable. He proposed, and members agreed, that there should be no further extension to the contract and that contractual penalties should be applied in the event of further delays.

The Committee

1. Noted the updates.
2. Agreed that there should be no further extension to the CCG's contract with eMBED for public access wifi in Practices and that contractual penalties should be applied in the event of further delays.

6. Primary Care Commissioning Financial Report

MA-M presented the report which detailed the financial outturn of the CCG's primary care commissioning areas at Month 3 of 2018/19 and provided an update on the remaining 2017/18 PMS (Personal Medical Services) premium monies.

MA-M explained that the £198k underspend in the delegated commissioning position was not expected to continue as it was due to the variances detailed in the report. The forecast outturn, i.e. in line with plan, had been agreed with the NHS England Primary Care Team.

In response to DH enquiring about release to Practices of the underspend against 2017/18 PMS premium monies MA-M advised that the £86k total carried forward to 2018/19 may be subject to change. He explained that this position was as at the end of June 2018 and referred to the fact that clarification was required, as detailed in the report. MA-M proposed, and members agreed that 1 September 2018 should be the cut off date for Practices to submit invoices against this budget. Any remaining monies would then be provided to primary care for other areas of investment.

DH noted that the criteria for accessing the defined monies contributed to the lack of activity by Practices and suggested release of the Part 3 – any remaining funding should be offered through localities to support constituent Practices in the management of demand – should include such as winter pressures. KS responded that criteria were required for monitoring purposes but that these should be proportional to the amount of funding. He proposed that any underspend be maintained separately for Practices to potentially pool bids. DH, in response, expressed the view that the locality structure was not at a stage of development where this would be feasible and HM advised that the South Locality had agreed a process for attendance at meetings.

The Committee:

1. Received the month 3 Primary Care Commissioning Financial Report.
2. Agreed the cut-off date of 1 September 2018 for Practices to submit invoices against the 2017/18 PMS premium monies.

7. Primary Care Assurance Report and General Practice Visits and Engagement Update

KS referred to the Primary Care Assurance report presented at the previous meeting of the Committee and advised that the group established to review this data and information from Practice visits now had a greater understanding of issues and support needs. He noted that, as Practices varied in levels of contact with the CCG, a proactive approach was now being adopted to ensure they were aware of any opportunities. This also enabled the CCG to identify underlying issues, the main one currently being capacity.

KS highlighted that the key issue of workforce in Practices related to nurses as well as GPs and commented that previous benefits of working in York had been eroded due to the pressures. He explained however that, although this was a major concern,

the CCG was not yet in a position of being regarded as “a hard to recruit” area which would attract funding and schemes to support recruitment.

KS explained in the context of Practice workforce pressures that the CCG needed to support Practices to develop resilience. He noted that data now enabled identification of referrals at clinician level and highlighted that locums were risk averse in this regard. Discussion was taking place with York Teaching Hospital NHS Foundation Trust to address the increase in referrals due to reduced capacity in the substantive workforce in primary care. KS advised that discussion was taking place with other CCGs regarding workforce strategy and noted that additional support was being sought from GPs and other professionals.

KS also referred to the fact that there was pressure on Practice finances highlighting that income may not be increasing sufficiently to meet the costs of running services. He noted that, although the CCG had little influence in this regard, support could be offered to reduce such as administrative requirements which may enable time to be released for clinical strategic development.

DH concurred that recruitment was becoming increasingly difficult and noted that this particularly applied to nursing teams in terms of both training and retaining nurses. He also referred to the fact that Practices were trying to diversify, such as employing Advanced Practitioners, but this was not supported nationally in terms of funding and GP Partners’ pay was reducing in order for Practices to remain solvent.

HM reported that NHS England had on behalf of the Sustainability and Transformation Partnership procured APEX, a Practice business intelligence tool that enabled a greater understanding of workforce and activity data. This would also inform work with Practices in respect of sustainability.

KS proposed, and members agreed, that this standing item should become Update on General Practice Intelligence.

The Committee:

1. Noted the update.
2. Agreed that this agenda item should become Update on General Practice Intelligence.

8. 2018/19 PMS Premium and £3/Head Transformation Funding: Update

KS referred to discussion at item 6 above which related to the 2017/18 PMS Premium monies. With regard to the 2018/19 PMS Premium monies and £3 per head transformation funding the Council of Representatives had supported a locality approach for the full year’s funding. Bids from the North and Central Localities had been approved by the Committee; a bid from the South Locality was still awaited.

SM reported that the North and Central Locality projects were starting to progress but, as discussed earlier, their recent focus had been on the Improving Access to GP

Services procurement. Neither locality had yet claimed against the monies; finance processes were being clarified for Practices in this regard.

SM provided an updated in respect of the North and Central Localities. The former was further developing the North Integrated Care Team and progress was being made in Central on supporting complex older patients in their homes, including care homes, and development of a Learning Disability Support Team projects. Discussion was taking place with York Medical Group regarding the falls prevention project, and the project for employment of up to eight primary care Mental Health Practitioners to work alongside the Central Locality Practices was being impacted by workforce availability.

SM highlighted that mobilisation at pace of these projects was affected by workforce and recruitment issues; discussions were taking place to support workforce planning in the longer term. However, the wider agenda of transfer of workforce from acute to primary care as part of system transformation work was complex due to different staffing terms and conditions between Providers.

In response to DH noting that Practices were unable to recruit staff due to the £3 per head being non recurrent, MA-M explained that the modelling of the CCG's Financial Recovery Plan, awaiting formal approval from NHS England, proposed to make this recurrent in line with the CCG's commissioning intentions. There were specific commitments to primary care and mental health in recognition of the respective pressures but these were partly premised on delivery in 2018/19. This information would be communicated to Practices on receipt of formal approval.

SS joined the meeting

KS emphasised that short term funding was not appropriate however the PMS Premium and £3 per head transformation funding were national monies for the current year. He highlighted that discussion would be required in September regarding any unutilised 2018/19 funding. The South Locality would then need to make a decision about their monies for the remaining six months of the year, there may be a potential for any underspend in Central Locality to be carried forward or invested, and new bids would be sought against any underspend in the North Locality.

MA-M explained that, although the funding was not of material amount in terms of audit, £1m had been set aside non recurrently for 2018/19 and from an accounting perspective the CCG would require invoices, or at least expenditure commitment, against this for the current financial year.

HM reported that the South Locality had developed a proposal but had had to start again. They had planned a pilot scheme in the context of sustainability of Practices with the aim of securing long term investment. However, Yorkshire Ambulance Service had not been able to support their request for Urgent Care Practitioners due to their own workforce pressures and the fact that the Urgent Care Practitioners were taking part in pilots in other areas.

KR requested that a solution be identified, working with other commissioners and including External Audit, to maximise any underspends from 2017/18 and 2018/19 for sustainability in primary care. KS agreed that once the balance was known a decision could be taken regarding investment through the winter. He would discuss this with the Council of Representatives at their September meeting and provide an update at the October Committee meeting.

The Committee:

1. Noted the update.
2. Requested that discussion take place at the October meeting regarding utilisation of any 2017/18 and 2018/19 PMS Premium and £3 per head Transformation Funding.

9. Care Quality Commission Inspection Report: Unity Health

KR referred to discussion at the previous meeting regarding concerns about Unity Health, the subsequent Care Quality Commission inspection, anonymous concerns raised by a member of the public and comments from PE, Chair of the Council of Representatives, following their recent meeting.

KS reported that the CCG had become aware of growing concerns relating to Unity Health towards the end of March/early April through a number of sources; this was followed by the issue relating to the telephone system. A letter had been sent to the Practice expressing the CCG's concerns and seeking assurance about their response in terms of improvement. At the same time the Care Quality Commission had undertaken a visit and Unity Health had voluntarily closed their list to new registrations, earlier than the Care Quality Commission's timescale of 28 days. The CCG, with the Care Quality Commission and the Local Medical Committee, were now working with the Practice to provide support. Discussion had also taken place at the City of York Council Health, Housing and Adult Social Care Policy and Scrutiny Committee.

KS explained that the Care Quality Commission report had been published on 20 July and the associated action plan, which included input from the CCG, was being reviewed and revised on a weekly basis. However, the underlying issues were, in addition to concerns previously raised, capacity within the Practice, the impact of the site move and the change of telephone system. KS noted that the Practice was fully engaged in addressing the issues.

KS advised that Jorvik Gillygate Practice had agreed to register the new student population; other new patients were being directed to NHS Choices to find alternative local Practices. The Care Quality Commission was due to return to Unity Health in September to review progress with the regulatory breaches. If satisfied that these had been address the Practice list suspension would be lifted but the CCG needed to be assured in terms of new patients being registered at the Practice.

KS reported that he had visited the Practice the previous day with NHS England's Assistant Medical Director. He confirmed that all the Partners were fully aware of the

seriousness of the Practice being in Special Measures and were engaged in the process to resolve this.

KS reflected that the CCG had offered the Practice support when a level of concern had been identified in December but they had not accepted, nor had they contacted the Local Medical Committee. He noted in this regard that consideration was required about Practice models overall but added that Unity Health was now receiving support from a number of sources to address the issues.

KR detailed the report back from the Council of Representatives who had been concerned and shocked on being informed about the position of Unity Health. The consensus had been that this highlighted the vulnerability of Practices. PE had also highlighted that Unity Health had promptly delivered the only significant new primary care facility in the CCG, stepped in at the last minute to manage the Long Acting Reversible Contraceptive contract for the CCG when City of York Council had proposed to cease the service, and taken part in the review of the excess suicide rate in the student population. PE had also referred to discussion at the Committee of assurance relating to primary care quality indicators and noted that the Council of Representatives was seeking assurance that lessons from the Unity Health situation would be learned and shared with Members and Practices, also that any monitoring should be proactive and specific enough to prevent further occurrences.

With regard to the telephone system KS explained that this was a specific issue and unrelated to the Care Quality Commission assessment. It had been due to the way Unity Health had set up their new telephone system and this had now been resolved.

KS reported that the NHS England Assistant Medical Director had offered additional capacity to support Practices regarding Care Quality Commission processes. He also advised that the CCG was reviewing further support for Practices but urged Practices to make early contact for support in the event of any concerns.

KR, on behalf of the Committee, expressed appreciation to Jorvik Gillygate Practice for their support with the new student population.

HM explained that there was a need to understand demand generated by students on services and noted that Unity Health's actual list size was 22,000 against a weighted population of 15,000. SS advised that the Health and Wellbeing Board, through the Joint Strategic Needs Assessment, had commissioned a student health needs assessment which illustrated mental health needs, long term health conditions, the fact that medical records did not always transfer and the significant number of overseas students. SS had been asked to provide a report on outstanding issues since the student health needs assessment; this could be utilised to inform a holistic system approach. She also noted that Unity Health would be invited to the September meeting of the City of York Council Health, Housing and Adult Social Care Policy and Scrutiny Committee.

In respect of Unity Health's Care Quality Commission action plan KS explained, under primary care delegated functions, the CCG role was to support the Practice noting that the CCG received the action plan and progress reports. He also reported that Unity Health had successfully applied for resilience funding for specialised

capacity and that further support, such as through the Royal College of General Practitioners, was being sought. The CCG's first duty was to be assured in terms of quality and safety about the clinical model from September.

DH, both from the Local Medical Committee perspective and that of his Practice, expressed appreciation for the CCG's support since agreeing to take on the new students. He also welcomed the support regarding preparation for Care Quality Commission visits but noted concern that Unity Health may experience impact in terms of future recruitment from the current situation.

DB commented that the CCG commissioned primary care services but had no role in regulation or inspection. He commended the proactive approach to providing support.

The Committee:

Noted the update.

10. Local Enhanced Services 2018/19: Update

HM reported that all but two Practices had responded to requests for data to inform the review of the current Local Enhanced Services which were at varying stages of progress. Recommendations for the 2018/19 Local Enhanced Services would be presented at the next meeting.

In response to DH requesting that the current bureaucracy required for Practices to claim for Local Enhanced Services, which were c7% of their income, be reduced, KS agreed that the aim was to make improvements in this regard. SS added that she was committed to working with the CCG in terms of joint commissioning and any flexibilities to ease the burden on Practices. PM advised that a Joint Commissioning Steering Group with City of York Council was being established which would provide structure and governance in this regard.

The Committee:

Noted the update.

11. Primary Care Estates Capital Bids

In the context of the earlier discussion SP highlighted that this item was the culmination of a further workstream that Practices had been progressing. She explained that over the last 24 months a significant number of bids had been reviewed and prioritised through an approach similar to that for business cases in order to understand revenue impact and seek assurance in terms of appropriateness for CCG support and their affordability. The governance structure and criteria for assessing the bids were detailed in the report.

SP reported that City of York was currently undertaking a strategic review on the impact of planned growth in the city and the CCG was considering bids in this context. SP noted aspects of historic legacy and highlighted that, as schemes would

take time to deliver, consideration was required to match capital investment in premises with particular reference to system recruitment and workforce strategies.

KR highlighted that the bids had already been considered by the Finance and Performance Committee and the Governing Body and were unchanged with the exception of Priory Medical Group Burnholme new build scheme. KS explained the additional work that had taken place in response to the CCG's request that consideration be given to the floor space requested for General Medical Services and advised that this was now proportionate. KR sought assurance in terms of City of York Council's potential to deliver community services alongside services provided by health and, whether in the event, it would be appropriate for the Practice to seek a financial contribution. He also referred to the strategic context regarding potential over supply in the city in view of discussion about development of the Bootham Park Hospital site. SP responded that the Burnholme proposal had not yet been subject to NHS England due diligence and that depending on the outcome of this process, they should be party to these discussions.

Following clarification by SP on aspects of the other schemes the Committee approved the recommendations.

The Committee:

1. Approved submission to NHS England of the Project Initiation Document for consideration of an Estates, Technology and Transformation Fund grant for the Easingwold Integrated Care Centre new build proposal.
2. Approved submission to NHS England of the Project Initiation Document for consideration of an Estates, Technology and Transformation Fund grant for the Sherburn and South Milford single site new build proposal.
3. Approved submission to NHS England of the Project Initiation Document for consideration of a Estates, Technology and Transformation Fund grant for the Priory Medical Group Burnholme new build scheme.
4. Approved submission to NHS England of the Project Initiation Document for Carlton Branch Site for consideration of an Estates, Technology and Transformation Fund grant for the new build.
5. Approved submission to NHS England of the Project Initiation Document for consideration of an Estates, Technology and Transformation Fund capital grant for Pickering Medical Practice.
6. Approved non Estates, Technology and Transformation Fund primary care estates investment for Unity Health's payment of the one-off fees incurred by the Practice, in line with the Premises Costs Directions, in respect of their new premises.
7. Approved non Estates, Technology and Transformation Fund primary care estates investment proposals for Tollerton Surgery to increase costs for non-recurrent fees to a capped figure of £40k.

12. NHS England Primary Care Update including Rent Reimbursements

HM presented the report which comprised assurance on contractual issues, provided an update on the General Practice Forward View, sought decisions on a number of rent reimbursement and reported that the National Audit Office had published its

report on NHS England's management of the primary care support services contract with Capita.

With regard to the General Practice Forward View HM highlighted that only a small number of the Practice applications submitted to the NHS England Resilience Programme had been successful; Practices were being informed of the outcomes. She also noted in respect of Patient Online that there was a robust process to ensure lessons were learnt from the recent issues with Unity Health and that there was engagement with Healthwatch.

HM provided clarification on the rent reimbursement information. In this regard DH reported that, in the context of the earlier discussion on pressures in primary care and the fact that notional rents were out of the control of Practices, he had been asked by Local Medical Committee officers to raise concerns about clawback proposals. MA-M responded that notional rent was considered to be business as usual with amounts generally being marginal. He also noted the CCG's commitment to invest in primary care and expressed the view that the principle of consistency should apply whether for loss or gain with regard to rent reviews. In response to DH requesting that the timescale be reviewed HM noted that it would be helpful if the Local Medical Committee encouraged Practices to return rent review forms within the specified timescales. It was noted that PM may consider responding to the Local Medical Committee outside the meeting.

The Committee:

1. Received the updates from NHS England on items relating to the delegated commissioning agenda.
2. Agreed the increase in notional rent in respect of Tadcaster Medical Centre, Crab Garth, Tadcaster, LS24 8HD.
3. Agreed in respect of York Medical Group, York St John University, Lord Mayors Walk, York, YO31 7EX the actual rental reimbursement of £16,600 as advised by the District Valuer and agreed to the recovery of £1,200.
4. Agreed the increase in notional rent in respect of Drs Jones and McPherson, The Surgery, North Back Lane, Stillington, York, YO61 1LL.
5. Agreed that overpayments should be recovered from York Medical Group, Woodthorpe Surgery, 40 Moorcroft Road, York, YO24 2RQ; Haxby Group Practice, Gale Farm Surgery, 109-119 Front Street, Acomb, York, YO24 3BU; and The Old School, Bishopthorpe.
6. Approved the outstanding notional rent payments, and noted the ongoing notional rent payments from 1 April 2018 and the retrospective payment to the Practice of £9,405.45 to offset the historic credits and debits in respect of Priory Medical Group.

13. North Yorkshire and York Screening and Improvement Plan

KS explained that, although the CCG was not legally responsible for these services, the North Yorkshire and York Screening and Improvement Plan was presented to provide assurance.

In response to DH referring to the complexity of the associated payment to Practices, KS advised that the CCG had raised similar concerns. He explained that the service was commissioned on behalf of the Secretary of State through NHS England but the CCG held the contract.

The Committee:

Received the North Yorkshire and York Screening and Improvement Plan.

14. Key Messages to the Governing Body

The Committee:

- Received an update on the Care Quality Commission assessment of Unity Health and associated action plan.
- Sought clarification on a number of the primary care estates capital bids prior to approving the recommendations of the technical team.
- Requested a solution be developed working with other commissioners to maximise any underspends from 2017/18 and 2018/19 PMS Premium and £3 per head Transformation Funding for sustainability in primary care.

The Committee:

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

15. Next meeting

1.30pm, 11 October 2018 at West Offices

Exclusion of Press and Public

In accordance with Paragraph 8 of Schedule 2 of the Health and Social Care Act 2012 it was considered that it would not be in the public interest to permit press and public to attend this part of the meeting due to the nature of the business to be transacted as it contained commercially sensitive information which, if disclosed, may prejudice the commercial sustainability of a body.