NHS
Vale of York
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

21 November 2019, 9.30am to 11.30am

George Hudson Boardroom, West Offices, Station Rise, York YO1 6GA

AGENDA

Prior to the commencement of the meeting a period of up to 10 minutes, starting at 9.30am, will be set aside for questions or comments from members of the public who have registered in advance their wish to participate in respect of the business of the meeting.

1. 9.40am	Verbal	Welcome and Introductions		
2.	Verbal	Apologies		
3.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
9.45am 4.	Presentation	Update from the Primary Care Workforce and Training Hub, Hosted by Haxby Training	To Receive	Dr Andrew Lee Executive Director of Director of Primary Care and Population Health
10.05am 5.	Pages 3 to14	Minutes of the meeting held on 19 September 2019	To Approve	Julie Hastings Committee Chair
6.	Verbal	Matters Arising		All
10.15am 7.	Pages 15 to 20	Primary Care Commissioning Financial Report Month 7	To Receive	Simon Bell Chief Finance Officer
10.25am 8.	Pages 21 to 30	Primary Care Networks Update	To Receive	Dr Andrew Lee Executive Director of Director of Primary Care and Population Health
10.35am 9.	Verbal	Care Quality Commission Ready Programme	To Note	Dr Andrew Lee Executive Director of Director of Primary Care and Population Health

10.45am 10.	Pages 31 to 34	Update on Local Enhanced Services	To Receive	Shaun Macey Head of Transformation and Delivery
11.00am 11.	Pages 35 to 50	Statin Optimisation Pilot Evaluation	For Decision	Dr Andrew Lee Executive Director of Director of Primary Care and Population Health
11.10am 12.	Pages 51 to 62	NHS England Primary Care Update	To Receive	David Iley Primary Care Assistant Contracts Manager NHS England and NHS Improvement (North East and Yorkshire)
11.20am 13.	Pages 63 to 67	Risk Update Report	To Receive	Dr Andrew Lee Executive Director of Primary Care and Population Health
11.25pm 14.	Verbal	Key Messages to the Governing Body	To Agree	All
15.	Verbal	Next meeting: 9.30am, 30 January 2019 at West Offices	To Note	All

EXCLUSION OF PRESS AND PUBLIC

In accordance with Paragraph 8 of Schedule 2 of the Health and Social Care Act 2012 it is 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. This item will not be heard in public as the content of the discussion will contain commercially sensitive information which if disclosed may prejudice the commercial sustainability of a body.

A glossary of commonly used primary care terms is available at:

http://www.valeofyorkccg.nhs.uk/data/uploads/about-us/pccc/primary-care-acronyms.pdf

Item 5

Minutes of the Primary Care Commissioning Committee held on 19 September 2019 at West Offices, York

Present

Julie Hastings (JH)(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)	Deputy Chief Finance Officer
David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Dr Andrew Lee (AL)	Executive Director of Director of Primary Care and Population Health
Phil Mettam (PM)	Accountable Officer

In attendance (Non Voting)

Dr Aaron Brown (AB)	Liaison Officer, YOR Local Medical Committee Vale of York Locality
Caroline Goldsmith (CG) – item 6	Deputy Head of Finance
Lesley Pratt (LP)	Healthwatch York Representative
David Iley (DI)	Primary Care Assistant Contracts Manager, NHS England and NHS Improvement North Region (Yorkshire and the Humber)
Stephanie Porter (SP)	Assistant Director of Primary Care
Michèle Saidman (MS)	Executive Assistant
Gary Young (GY) – items 9 and 10	Lead Officer for Primary Care York

Apologies

Simon Bell (SB)	Chief Finance Officer
Chris Clarke (CC)	Senior Commissioning Manager, NHS England and NHS Improvement (North East and Yorkshire)
Dr Paula Evans (PE)	North Locality GP Representative
Phil Goatley (PG)	Lay Member and Audit Committee Chair
Sharon Stoltz (SS)	Director of Public Health, City of York Council

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

There was one member of the public in attendance and no public questions had been received.

Agenda

1. Welcome and Introductions

JH welcomed everyone to the meeting.

2. Apologies

As noted above.

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

There were 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 11 July 2019

The minutes of the meeting held on 11 July were agreed.

The Committee:

Approved the minutes of the meeting held on 11 July 2019.

5. Matters Arising

PCCC35 Local Enhanced Services Review 2019/20: AL reported that Local Enhanced Services were continuing to be reviewed across the CCG for the report to the next meeting, also noting SP, not SS, should be listed as Responsible Officer.

PCCC37 Care Quality Commission Ready Programme Update: AL reported that all the CCG's practices had completed the self assessment and no major issues had been identified. He commended Unity Health on their outcome of 'Good' following the Care Quality Commission's recent re-assessment visit; LP added that Healthwatch had received positive feedback from Unity Health patients. AL had additionally met with members of City of York Health Overview and Scrutiny Committee earlier in the week to discuss General Practice issues, particularly recruitment. In this regard he referred to agenda item 9.

Other matters were agenda items, had not yet reached their scheduled date or were carried forward.

The Committee:

Noted the updates.

6. Primary Care Commissioning Committee Terms of Reference

SP highlighted that the proposed amendments were in the Membership section of the terms of reference to reflect the establishment of Primary Care Networks. She agreed to obtain the views of the six Primary Care Networks on how they would wish to be represented at the Committee.

Discussion ensued with regard to facilitating wider engagement, for example through the Lead Officers for Primary Care, a pre-meet or pre-discussion. AB additionally noted that Dr John Crompton, former Chair of North Yorkshire Branch of YOR Local Medical Committee, was now their Primary Care Network and System Integration Lead, and as such could potentially represent the six Primary Care Networks.

PM referred to the Committee's statutory responsibility of resource allocation and contracts with primary care as providers which would continue through the development of Integrated Care Partnerships. He also emphasised the CCG's commitment to support the development of Primary Care Networks, including in terms of innovation and resilience noting in this regard the appointment of the two Lead Officers for Primary Care.

The Committee:

1. Approved the changes to the Primary Care Commissioning Committee Terms of Reference.
2. Requested that SP progress with the Primary Care Networks their representation on the Committee.

CG joined the meeting

7. Primary Care Commissioning Financial Report Month 5

CG referred to the report that forecast an £8k over spend against the delegated primary care budget of £45.3m, reduced from the original plan of £45.8m due to the transfer of £313k Personal Medical Services monies to the CCG core budget as detailed. She explained the forecast variance of £120k in General Medical Services would be largely offset by the over spend in 'Other GP services' and described the negative adjustment relating to the £230k shortfall included in reserves during the planning stage.

CG emphasised the expectation that the £48k year to date underspend for additional roles in the Primary Care Networks, namely Clinical Pharmacists and Social Prescribing Link Workers, would be fully spent by the end of the year. AL noted in this regard that Tadcaster and Selby Primary Care Network had appointed a Clinical Pharmacist and a Social Prescribing Link Worker but they had not yet taken up post.

CG highlighted slippage in primary care prescribing as the main variance in 'Other Primary Care' explaining that there was no QIPP (Quality, Innovation, Productivity and Prevention) included in the reported position. She noted the imminent implementation of the second Prescribing Indicative Budgets scheme, a gain share incentive and confirmed that the forecast was premised on the full achievement of primary care prescribing QIPP. CG additionally noted that the Medicines Management Team had already identified savings programmes for the new Prescribing Indicative Budgets scheme, unlike the first occasion when practices had been required to identify opportunities in advance. AL additionally emphasised the risk associated with the £2m efficiency savings noting that it was contingent on achievement by GPs.

Discussion and clarification included: emphasis that the Prescribing Indicative Budgets schemes were good practice in terms of medicine as well as achieving cost savings; the recently implemented changes to repeat prescribing; the need for patients to be informed in advance of changes; and recognition of the risk associated with the financial value of the savings requirement but noting that mitigations had been identified.

The Committee:

Received the Primary Care Commissioning Financial Report as at Month 5.

CG left the meeting

8. Primary Care Estates Strategy

SP gave a presentation *Vale of York CCG's Primary and Community Estates Strategy* which provided analysis to 21 August 2019 by consultants *Shared*Agenda who had been appointed in April to support development of the strategy. She noted that this position statement had also been presented at a Practice Managers meeting. The information included: estates and clinical data; key service development opportunities; and various aspects of capacity analysis to inform assessment of estate capability to manage known growth and changes such as skill mix developments. SP advised that the Local Authorities were involved in the work, particularly in terms of housing growth, and noted the context of Integrated Care Systems including co-location of service delivery and new ways of working. She also highlighted the pressures on clinical rooms across the Primary Care Networks, referred to an initial assessment of proposed property disposals and explained potential project requirements, pressure points and opportunity areas. SP provided clarification on aspects of the latter, including the fact that practices would experience the impact of increased patient registration before funding became available, the context of working with the Local Authorities to build homes for the future and support keeping people at home for longer, and noting City of York Council's proposal for an additional 200 nursing home beds in Acomb with the associated impact on General Practice. SP emphasised estates as an enabler for transformation but highlighted timescales of up to five years, affordability and availability of land. She also noted that engagement was already taking place with practices and Primary Care Networks.

AB referred to the fact that his practice, York Medical Group, currently had eight sites across York, four within 2.5 miles of each other. He emphasised that this was not sustainable and rationalisation was required but noted that practices were required to follow process for site closure. In response SP explained that full consultation and consolidation was required across the system but in particular in the City of York and as part of transformation. She noted that the CCG's 26 practices currently had 62 buildings of various quality and highlighted indicators of estates, digital developments and workforce as indicators for service change. AL emphasised the need for public consultation and noted the role of Healthwatch in this regard.

In response to DB seeking clarification about this strategy in the context of local investment and the wider developments, including across Humber, Coast and Vale, SP explained that the wider system strategy was being built up from a 'place based' approach and that discussions were taking place with partner organisations to develop short, medium and long term plans by December 2019. Work was taking place in terms of co-locating primary and community services.

PM commended the scoping work described in the presentation but highlighted the need for engagement with partner organisations, particularly City of York Council and North Yorkshire County Council. He emphasised that, in the absence of available capital, innovation was required. AB additionally noted the potential for efficiencies to be identified through engagement with NHS Property Services and LP reminded members about the patient perspective of service change, including transport, but also noting the role of the voluntary sector, such as through car sharing, in this regard. PM in response noted opportunities to learn from other areas referring to work in the North Locality to address rurality issues through developing new ways of providing care.

The Committee:

1. Noted the ongoing work to develop the CCG's Primary and Community Estates Strategy.
2. Requested that PM give consideration to engagement with City of York Council and North Yorkshire County Council.

GY joined the meeting

9. Primary Care Resilience

GY apologised for the late circulation of his report which emanated from a Rapid Review of General Practice across the City of York to understand the risks and issues affecting General Practice resilience. He explained that a series of structured interviews and meetings with GPs, Practice Managers, and GP Rota Managers had been undertaken during August and September. Ten of the twelve central practices had responded to offer a deeper insight into the health of General Practice across the Central locality and all practices reported they were operating at, or near, maximum capacity with some reflecting a feeling on some days of possibly operating beyond maximum capacity.

In addition to a detailed overview of the pressures and challenges, the report specified risks and drivers, namely: GP workforce; changes in services, specifications and waiting times; IT and estate, and individual practice support. It also described proposals for improvement and offered recommendations.

GY highlighted GP workforce as the major concern noting that GP recruitment was a national problem but also expressing concern in the context of capacity being a risk to the whole health and social care system. He also noted differential rates of pay compared with Leeds and Hull; recognition of potential from the new roles but noting the timescale for recruitment, training and supervision; concern about impact from risk aversion; and room space in practices. Additionally, implementation of Improving Access to General Practice, whilst helping some, was not equitable and also had impact on continuity of care. GY expressed concern that the various challenges detailed in his report made for a potential "perfect storm". He did note that his appointment as Lead Officer for Primary Care in Central Locality and that of Fiona Bell in the North and South Localities appeared to be appreciated by GPs and enabled the CCG to gain a greater understanding.

GY referred to the key proposals for improvement detailing those emerging in response to this rapid review. He emphasised the importance of listening to GPs locally. DB additionally noted potential learning opportunities from his role as a Non Executive Director at Rochdale Health Alliance Limited and agreed to discuss this with AL and GY outside the meeting.

AB welcomed the report but commented that the Local Medical Committee had been raising concerns, particularly about the impact on General Practice from the out of hospital agenda, for a long time.

AL requested that AB feedback to local GPs that the CCG is cognizant of the stresses and pressures they are experiencing. AL also noted that whilst capacity and resilience was a national problem, the local system was one where patient expectations were beyond what could be provided from the available resources. He also referred to the context of hospitals not being permitted to fail but emphasised the knock on effect if a practice failed. JH noted the CCG wished to be proactive in terms of support.

Further discussion included: recognition that despite the challenges and issues patient survey results were of good services in the Vale of York; the context of staff retention, other than GPs, in light of varying rates of pay between practices; pressures from work associated with registering and de-registering patients from neighbouring practices; the need to educate patients in terms of expectations, including costs of medical interventions such as scans.

PM commended GY's work and requested that he work up some of the proposals described for consideration by the Committee. PM also referred to the context of opportunities of support, other than financial, being identified by the Primary Care Networks and presented to the Committee, such as through the Protected Learning Time or training; notably a holistic approach that could be mobilised quickly.

In response to AB referring to the risk register, including at Governing Body meetings, and the context of decisions relating to the hospital impacting on General Practice, PM emphasised that the CCG fully recognised the significant risk to continuity of primary care. He noted that relevant governance processes were in place to manage such as quality issues.

The Committee:

1. Received and commended the report on Primary Care Resilience and Capacity in the Central Locality.
2. Noted that DB would discuss with AL and GY opportunities to learn from Rochdale Health Alliance Limited.
3. Requested that GY develop some of the improvement proposals and work with the Primary Care Networks on opportunities for consideration at a future meeting.

10. Primary Care Networks Update

Central York

GY reported that, as referred to above, feedback indicated appreciation on the part of the Primary Care Networks for the CCG's appointment of the two Lead Officers for Primary Care. The Clinical Directors were meeting on a monthly basis, communication now reflected the Primary Care Home model which included the Local Authority and the voluntary sector, and there was a coherence in terms of addressing the different health needs. GY also reported that two Clinical Directors from different Primary Care Networks were now co-chairing the meeting.

GY referred to geographical boundaries between Primary Care Networks and highlighted positive relationships across these with local as well as system conversations. He noted the Clinical Directors had completed their Maturity Matrix. There were three contract

holders plus the City and the Local Medical Committee was providing support, including from a wider perspective.

GY reported on a positive meeting between the CCG and the Clinical Directors from across the Vale of York earlier in the week as a first step to setting up a common framework. He noted that his role was to continue to foster relationships between the Practices, the Primary Care Networks and Nimbuscare Limited. GY also noted the many demands and expectations placed on the Primary Care Networks, particularly the Clinical Directors, from across the health and care system including the context of attendance at meetings. AB echoed the latter highlighting that the Clinical Directors were only funded for one day a week.

AL emphasised the crucial role of the two Primary Care Lead Officers in supporting the development of the Primary Care Networks, particularly in terms of quickly becoming system players. He proposed that the Committee receive regular progress updates.

AB left the meeting during the following discussion

Vale

SP reported that the North Locality had more of a history of collaborative working noting a number of pilot projects. She highlighted the many faceted demands on the Primary Care Networks from the CCG, the system and NHS England, the latter including the Maturity Matrix, and some having short timescales. AL added that South Hambleton and Ryedale had been nominated as Primary Care Network of the Year for their work focusing on the frail elderly and cancer care.

With regard to the South Locality SP reported that progress was being made and noted, as referred to at item 7 above, Tadcaster and Selby Primary Care Network had appointed a Clinical Pharmacist and a Social Prescribing Link Worker who were due to take up post in November.

The Committee:

1. Noted the updates.
2. Agreed that this would be a standing agenda item at each meeting.

GY left the meeting

11. £3 per head Locality Updates

MA-M noted that the Council of Representatives later in the day was also being briefed on the £3 per head position. He advised that a document was being developed that was aimed at providing clarity to all practices about access to and invoicing for the primary care funding streams available in 2019/20 whose components were Personal Medical Services monies, Prescribing Incentive Budgets (PIB) and additional resources to support the Primary Care Networks.

MA-M referred to the historic issues and differing perspectives associated with General Practice's ability and capacity to access the 2017-19 £3 per head funding emphasising

the CCG's focus now was to move forward in a way that maximised the available resource and minimised the complexity of access within the context of this being public money. He confirmed that information to this effect would be circulated to General Practice but also emphasised the need for trust from all parties.

PM explained that the CCG, while under legal Directions, had made the £3 per head available in full to General Practice without the support of the Regulators in 2018/19, noting too that any part of this resource not deployed in year could not be carried forward. He highlighted the lack of financial flexibility due to the deficit position of both the CCG and the system as a whole which meant decisions and autonomy of those decisions created an unhelpful timeline which he hoped would be better and more transparent going forward. PM advised that discussion at the Council of Representatives would be reported back to the next meeting of the Committee.

AB returned to the meeting

AB advised that the Local Medical Committee appreciated the CCG's transparency and now wished to move forward on this matter in the way the CCG had described. He noted however that, whilst welcoming the block contract with York Teaching Hospital NHS Foundation Trust, GPs continued to have major concerns about impact on the primary care workload. MA-M commented that secondary care had similar concerns about referral rates. He re-emphasised that the CCG was working to, within the rules, maximise the primary care funding streams availability as far as possible and reduce processes for accessing these.

The Committee:

1. Noted the update.
2. Noted that feedback from the discussion at the Council of Representatives later in the day would be provided at the next meeting.

12. Primary Care Neonatal Local Enhanced Service

SP referred to discussion at previous meetings regarding neonatal checks. She presented the report which described the position whereby the CCG had recently become aware of changes in the commissioning arrangements for maternity services, and specifically the newborn checks that had been undertaken by some practices through the CCG's Neonatal Local Enhanced Service. She advised that hospital maternity services were now commissioned to undertake these newborn checks, and in order to ensure compliance with national commissioning arrangements and avoid duplication, approval was sought for withdrawal of this Local Enhanced Service from General Practice at a date to be notified. SP noted that the CCG had engaged informally with the four practices who currently carried out these checks and confirmed that assurance had been sought from the perspective of the hospital carrying out the checks.

In response to AB enquiring about the position if a practice wished to continue the Local Enhanced Service, AL advised that the CCG would seek to understand the reasons. SP highlighted that this was as a result of a nationally commissioned service but agreed to write to the practices, for purposes of an audit trail, detailing the rationale and giving a period of notice before the cessation date.

The Committee

Approved the contract termination notice for the Neonatal Local Enhanced Service.

13. NHS England Primary Care Update

DI presented the report which provided updates under the headings of: Contractual relating to Personal Medical Services contract variations to support alignment of General Medical Services and Personal Medical Services payments and primary care provision across multiple site practices. With regard to the former MA-M referred to discussion at item 7 above noting that the £117k was in addition to the £320k Personal Medical Services monies.

PM sought an update on the commissioning decision to move the anti coagulation service from hospital in to primary care. SP reported that this allowed an accessible service to patients; consultation with patients' own GP gave a more integrated service; and a single visit for patients. Therefore the quality of the service to the patient had improved.

The report also provided updates on: Estates relating to business as usual capital estate schemes, for which six had been approved, and notional rent approvals; General Practice Forward View/Transformation in respect of Primary Care Networks Additional Roles Reimbursement Scheme: Establishing the workforce baseline and assessing additionality and Primary Care Network Development Support Prospectus and Maturity Matrix, National review of access to General Practice and the regular General Practice Forward View transformation programme update. DI also reported the Humber, Coast and Vale Health and Care Partnership Long Term Plan workforce planning requirement noting that the CCG had met the requisite timescale for submission in this regard.

SP expressed appreciation for the support provided by DI and his team embedded in the CCG which enabled access to regional funds such as the schemes for Business as Usual Capital Estates

The Committee:

Received the NHS England Primary Care Update.

14. Risk Update Report

SP described risks and associated mitigations for risk references PRC11 Estates and Technology Transformation Fund Strategy, PRC 12 Commissioning of evening and weekend access to General Practice for 100% of population and PRC13 Primary Care Team resource to deliver statutory CCG functions. Members requested two further risks be added to the risk register: Development of a system estates strategy and Primary care resilience.

The Committee:

1. Agreed that references PRC11 Estates and Technology Transformation Fund Strategy, PRC 12 Commissioning of evening and weekend access to General Practice for 100% of population and PRC13 Primary Care Team resource to deliver statutory CCG functions be accepted on the risk register.

2. Requested the addition of two further risks: Development of a system estates strategy and Primary care resilience to the risk register.

15. Key Messages to the Governing Body

The Committee:

- Emphasised the need to be mindful of the pressures in primary care noting that the CCG would give this consideration in the context of risk mitigation and resilience
- Acknowledged and supported discussion of financial resources between the Primary Care Commissioning Committee and the Finance and Performance Committee.

The Committee:

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

16. Next meeting

9.30am, 21 November 2019 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 the following part of the meeting due to the nature of the business to be transacted. This item would not be heard in public as the content of the discussion would contain commercially sensitive information which if disclosed may prejudice the commercial sustainability of a body.

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE

SCHEDULE OF MATTERS ARISING FROM THE MEETING HELD ON 19 SEPTEMBER 2019 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCCC35	24 January 2019 9 May 2019	Local Enhanced Services Review 2019/20	• Report on PSA review as part of the LES report to the November meeting	SP	9 May 2019 11 July 2019 21 November 2019
PCCC37	11 July 2019	Care Quality Commission Ready Programme	• Full review report to November meeting	AL	21 November 2019
PCCC38	11 July 2019 19 September 2019	Estates Capital Investment Proposals – Progress Report	• SS to facilitate engagement with City of York councillors through Members Briefings	SS	19 September 2019 21 November 2019
PCCC39	19 September 2019	Committee's Terms of Reference	• SP to progress with the Primary Care Networks their representation on the Committee	SP	
PCCC40	19 September 2019	Primary Care Estates Strategy	• Consideration to be given to engagement with City of York Council and North Yorkshire County Council.	PM	

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCCC41	19 September 2019	Primary Care Resilience	• DB to discuss with AL and GY opportunities to learn from Rochdale Health Alliance Limited. • GY develop some of the improvement proposals and work with the Primary Care Networks on opportunities for consideration at a future meeting.	DB, AL, GY GY	
PCCC42	19 September 2019	£3 per head Locality Updates	• Feedback from the discussion at the Council of Representatives to be provided at the next meeting	PM	21 November 2019
PCCC43	19 September 2019	Risk Update Report	• Development of a system estates strategy and Primary care resilience to be added to the risk register	SP	

Item Number: 7

Name of Presenter: Simon Bell

Meeting of the Primary Care Commissioning Committee

Date of meeting: 21 November 2019

NHS
Vale of York
Clinical Commissioning Group

Primary Care Commissioning Financial Report Month 7

Purpose of Report
To Receive

Reason for Report

To update the Committee on the financial performance of Primary Care Commissioning as at the end of October 2019.

Strategic Priority Links

- ☒Strengthening Primary Care
- ☐Reducing Demand on System
- ☐Fully Integrated OOH Care
- ☐Sustainable acute hospital/ single acute contract
- ☐Transformed MH/LD/ Complex Care
- ☐System transformations
- ☒Financial Sustainability

Local Authority Area

- ☒CCG Footprint
- ☐City of York Council
- ☐East Riding of Yorkshire Council
- ☐North Yorkshire County Council

Impacts/ Key Risks

- ☒Financial
- ☐Legal
- ☒Primary Care
- ☐Equalities

Risk Rating

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

☐ Quality Impact Assessment
☐ Equality Impact Assessment
☐ Data Protection Impact Assessment
☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

Recommendations

The Primary Care Commissioning Committee is asked to note the financial position of Primary Care Commissioning as at Month 7.

Decision Requested (for Decision Log)

(For example, Decision to implement new system/ Decision to choose one of options a/b/c for new system)

Responsible Executive Director and Title	**Report Author and Title**
Simon Bell, Chief Finance Officer	Amanda Ward, Primary Care Accountant Caroline Goldsmith, Deputy Head of Finance

NHS Vale of York Clinical Commissioning Group Primary Care Commissioning Financial Report

Report produced: November 2019

Financial Period: April 2019 to October 2019

Introduction

This report details the year to date financial position as at Month 7 and the forecast outturn position of the CCG's Primary Care Commissioning areas for 2019/20.

Delegated Commissioning Financial Position – Month 7

The table below sets out the year to date and forecast outturn position for 2019/20.

Delegated Primary Care	Month 7 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Primary Care - GMS	12,835	12,714	121	22,003	21,837	166
Primary Care - PMS	5,230	5,187	43	8,966	8,916	50
Primary Care - Enhanced Services	658	674	(16)	1,106	1,130	(24)
Primary Care - Other GP services	2,445	2,289	156	4,387	4,250	137
Primary Care - Premises Costs	2,587	2,552	35	4,436	4,388	48
Primary Care - QOF	2,547	2,602	(55)	4,367	4,442	(75)
Sub Total	**26,302**	**26,019**	**283**	**45,265**	**44,963**	**302**

- The draft plan included total expenditure for delegated primary care of £45.8m including contingency of £229k (0.5%) as per the planning requirements which is recorded within the CCG core budget. PMS premium monies of £313k were transferred into CCG core budget in Month 4, reducing the total delegated primary care budget to £45.3m.

- The **forecast outturn** is £45.0m with an underspend of £302k against budget. The main reason for the movement compared to previous reports is the proposed reduction in the dispensing drugs tariff of 19.5% from October as per guidance published by NHS Digital.

- **GMS** is based upon the current contract and list sizes to date and is showing a year to date underspend of £121k due to smaller list size movements than expected. MPIG is as per current contract, which has reduced by 50% compared to 2018/19.

- **PMS** contracts has a year to date underspend which is due primarily to list size adjustments of £37k.

- A more detailed breakdown of **Enhanced Services** is shown in the table overleaf.

Enhanced Services	Month 7 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Extended Access	338	337	1	559	557	1
Learning Disability	48	60	(12)	83	99	(16)
Minor Surgery	258	263	(5)	443	451	(8)
Violent Patients	13	14	(1)	22	23	(1)
Sub Total	**658**	**674**	**(16)**	**1,106**	**1,130**	**(24)**

- A more detailed breakdown of **Other GP services** is shown in the table below.

Other GP Services	Month 7 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Dispensing/Prescribing Doctors	1,265	1,165	100	2,201	1,885	316
PCO Administrator	618	641	(23)	1,060	1,107	(48)
GP Framework:						
Network Participation	359	359	(0)	616	616	-
Clinical Director	82	82	0	184	184	-
Additional Roles	192	27	165	432	432	-
Needle, Syringes & Occupational Health	11	16	(5)	19	27	(8)
Reserves	(81)	-	(81)	(124)	-	(124)
Sub Total	**2,445**	**2,289**	**156**	**4,387**	**4,250**	**137**

Dispensing Doctors are paid two months in arrears and has a year to date underspend of £100k due to the proposed tariff reduction from October of 19.5%. This has been reflected in the year to date and forecast position.

Additional Roles has a year to date underspend of £165k. This is due to slippage in PCNs recruiting to the clinical pharmacist and social prescriber roles. This has been forecast to be spent in full by the end of the year.

PCO Administrator has a year to date overspend of £120k in relation to maternity; this is largely due to two material claims received in October from Haxby Group. Practices have been reminded of the requirement to submit claims promptly. The maternity overspend is largely offset against an underspend on seniority which is being phased out and an underspend on retainers.

The draft plan included an adjustment of £230k in **reserves** to balance expenditure and allocation as required by NHS England. This was offset with £77k in relation to PMS list size adjustment duplication and £30k balance from the GP Framework which reduced the required adjustment to £124k. However, due to improvements in other areas of expenditure, no forecast against reserves is now required.

- **Premises** are based on current costs including any revaluations due this financial year. Business rates accruals are as per actual rate bills submitted by practices and verified

by GL Hearn. Premises water costs have been accrued based on claims submitted pro rata or to budget.

- **QOF** has a year to date overspend of 55k which includes a prior year overspend of £27k. The accrual for 2019/20 is based on 2018/19 points and prevalence at 2019/20 price with a 1.2% demographic growth assumption. A 0.46% growth adjustment has been applied to the points, which reflects the increase in points between 2017/18 and 2018/19.

Other Primary Care

The table below sets out the core primary care financial position as at Month 7.

Primary Care	Month 7 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Primary Care Prescribing	28,257	29,216	(959)	47,319	49,309	(1,990)
Other Prescribing	1,154	1,140	14	1,978	2,121	(143)
Local Enhanced Services	1,378	1,289	90	2,242	2,124	118
Oxygen	217	225	(8)	371	385	(14)
Primary Care IT	535	518	17	917	861	57
Out of Hours	1,894	1,904	(10)	3,247	3,380	(133)
Other Primary Care	1,439	1,487	(48)	2,466	2,431	35
Sub Total	**34,873**	**35,777**	**(904)**	**58,540**	**60,610**	**(2,070)**

The year to date **prescribing** position is overspent by £959k as at Month 7. This position is based upon 5 months of prescribing data and includes two months of estimated QIPP (totalling £108k). This reflects the fact that PIB 2 started in September, however data is not yet available for September onwards. The forecast position of an overspend of £2.0m assumes achievement of £1.0m of the total QIPP target of £2.0m and includes a £665k pressure in relation to Category M price increases from August onwards.

Other prescribing is forecast overspent due to spend on dressings purchased through North West Ostomy Supplies. This should be offset by a reduction in expenditure on dressings in the main prescribing budget.

Local Enhanced Services have been accrued and forecast based upon Q1 and Q2 claims. The biggest underspend within this category is anti-coagulation which is forecast to underspend by £121k.

The **Out of Hours** contract with Northern Doctors is currently overtrading and based upon activity to Month 6 is forecast to overspend by £133k.

Allocations

The CCG received the following allocations for Primary Care in Months 6 and 7.

Description	Month	Recurrent / Non-recurrent	Category	Value £000
GPFV – Practice Resilience – STP Funding	7	Non-recurrent	Core	30
GPFV – GP Retention – STP Funding	7	Non-recurrent	Core	10
Enhanced GP IT infrastructure and resilience arrangements	7	Non-recurrent	Core	91
Additional Primary Care allocation in Months 6 and 7				**131**

QIPP

The 2019/20 financial plan includes two QIPP targets in relation to primary care.

The prescribing QIPP is forecast to achieve £1.0m from a target of £2.0m. This is due to slippage in starting the PIB 2 schemes. Contracts have been agreed from 1st September 2019 and work on agreed schemes is underway.

The primary care underspend target of £600k has been increased to £700k in line with Executive approval. To date, £311k has been achieved and plans for the remaining £389k are on-going.

Description	Value £000
Primary Care QIPP target	**700**
Limited Improving Access service in the South locality	(200)
18/19 PIB underspend compared to year-end forecast and budget	(64)
Underspend on £3/head schemes	(47)
Remaining QIPP target	**389**

Recommendation

The Primary Care Commissioning Committee is asked note the financial position of the Primary Care Commissioning budgets as at Month 7.

Item Number: 8

Name of Presenter: Dr Andrew Lee

Meeting of the Primary Care Commissioning Committee **Date of meeting: 21 November 2019**	NHS Vale of York Clinical Commissioning Group

Report Title - Primary Care Network Update

Purpose of Report
For Information

Reason for Report

To update the Committee on current progress with the Central York Primary Care Network and Vale Primary Care Networks.

Strategic Priority Links

☒Strengthening Primary Care	☐Transformed MH/LD/ Complex Care
☒Reducing Demand on System	☐System transformations
☐Fully Integrated OOH Care	☐Financial Sustainability
☐Sustainable acute hospital/ single acute contract	

Local Authority Area

☐CCG Footprint	☐East Riding of Yorkshire Council
☐City of York Council	☐North Yorkshire County Council

Impacts/ Key Risks	**Risk Rating**
☐Financial ☐Legal ☐Primary Care ☐Equalities	

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

☐ Quality Impact Assessment
☐ Equality Impact Assessment
☐ Data Protection Impact Assessment
☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

Recommendations

Decision Requested (for Decision Log)

Responsible Executive Director and Title	**Report Author and Title**
Dr Andrew Lee Executive Director of Primary Care and Population Health	Fiona Bell, Lead Officer Primary Care (Vale) Gary Young, Lead Officer Primary Care (Central)

Primary Care Network (PCN) Update (Central York)

In Central York, the 5 Clinical Directors (CDs) and Nimbus Medical Director formally meet monthly and continue to work well together, taking a collaborative view on the shared needs of all Central York practices, and their patient populations.

Primary Care Home

The Clinical Directors all take an active role in Primary Care Home (PCH) Steering Group, with one CD (Dr Rebecca Field) and Nimbus Medical Director (Dr Emma Broughton) continuing to act as co-chairs for the group. The PCH Steering Group is a body representing commissioners and key health and care providers at a senior clinical and/or operational level including CVS, represented by Ways to Wellbeing.

The establishment of PCNs on a different, less geographic, basis than PCH has interrupted the flow and progress of PCH. Anticipating this risk, the group embarked on an early piece of organisational development redefining its role, value and brand going forward. Midway through the process, PCH is fundamentally a 'provider alliance' that is well placed to be the forum for PCNs to develop their clinical and professional relationships at a city-wide level, using data and evidence of gaps and inequalities to define future collaborative projects. A CD (Dr David Hartley) and Lead Officer for Primary Care (Gary Young) also attend Better Care Fund (BCF) Steering Group which has a track record of delivering innovative, collaborative projects and services in the city.

Maturity/Development

Central PCNs completed the NHS England Development Needs/Maturity Matrix. Feedback from the Sustainability and Transformation Partnership via NHS England local team (Dave Iley) is that VOYCCG PCNs delivered robust and credible plans. At a recent meeting with NHS England, initial funding allocations have been set and a follow up meeting to discuss matching funds to development needs identified on the maturity matrix is due later this month. Additionally, discussions with NHS England national team for Time for Care (Charlie Keenan) indicate that much of the development could be funded from a national budget so offering opportunity to make greater use of the local development budget to fund clinical (GP, Nurse, etc) and non-clinical backfill (typically Managing Partners and Practice Managers) to speed PCN development backed by robust management at a practice level.

Additional Roles

All central PCNs expect to fully utilise Clinical Prescriber and Social Prescriber roles. Due to the border of Pocklington, MyHealth, and Elvington practices with East Riding. 0.5wte of the Social Prescriber role will be with East Riding; the remaining 4.5wte will be delivered collaboratively across city PCNs through Ways to Wellbeing.

Navigating the rules for additional roles, especially the risk of practices paying a 20% vat levy on Social Prescribers (SPs) has led to delays in recruiting. Working with BCF and CCG Finance team, York PCNs came up with a novel solution of PCNs

recruiting SPs directly and then seconding to Ways to Wellbeing. This has been tested by CCG with NHSE national team who have approved the approach.

RISK: Due to delays, there is likely to be a sizable element of unclaimed additional roles entitlement for and it is not yet fully clear how this will be managed. PCNs are expressing concern and, together PCNs, LMC, and CCG are leading discussions on establishing a clear position going forward.

Primary Care Resilience

At the September meeting, Gary Young presented a paper 'Primary Care Resilience' highlighting some of the challenges and risks faced by General Practice in the city.

Two key proposals (Urgent Care Practitioners for home visits and a different model for managing same/next day urgent care) have been progressed:

- Discussions have started with Yorkshire Ambulance Service regarding Urgent Care Practitioners. The spread of hours has been condensed into highest need times and a discussion to explore greater access to UCPs by General Practice is ongoing.

- Progress has also been made on urgent care with York Hospital (Urgent Treatment Centre), and Vocare (GP Out of Hours and GP Front Door at ED) together with Nimbuscare (Improving Access) to develop an innovative model presenting a bid to deliver extra urgent care capacity for 10-weeks (end of November to early February) to ease winter pressures. This collaborative model may pave the way for managing urgent primary care in the city going forward.

Central PCN representation at PCCC

The central PCNs have agreed Dr Tim Maycock will represent central York PCNs at PCCC going forward.

Summary

Individually, Central York PCNs are progressing well with developing PCNs and, collectively, they are starting to speak with 'one voice' for central York practices.

There have been challenges, especially ambiguity of additional roles funding, but central PCNs are overcoming these obstacles in collaboration with partners.

Practice resilience remains a risk and progress has been made to provide support for practices, especially over the winter period.

Primary Care Network (PCN) Update (Vale)

1. PCN Development

Across the Vale, the 3 PCNs meet monthly within their localities, supported by the Lead Officer. At present, these meetings remain separate to reflect the different health needs and geography of the Vale practices although recent discussions have been held about exploring areas of commonality where the Vale PCNs might want to work together to address shared challenges and needs across their rural areas . Wider system opportunities are also emerging: eg: In South Hambleton and Ryedale PCN, future work will explore wider links with the PCNs in Scarborough and Ryedale and across North Yorkshire. The Lead Officer meets regularly with the Medical Director from the Leeds CCGs/Clinical Director from Whitby PCN to explore wider opportunities for sharing good practice and future collaboration. Similar discussions need to be developed for Tadcaster and Rural PCN with West Yorkshire and with Selby Town PCN with their neighbouring PCNs.

A workshop has been planned with North Yorkshire County Council (NYCC) colleagues on 5th December to start conversations about linking the Clinical Directors into the wider system and developing priorities for population health management as an early step towards an Integrated Care System working.

2. Maturity Matrices and Organisational Development Plans

All Vale PCNs completed the NHS England Development Needs/Maturity Matrix in time for the September deadline. Feedback from STP via NHS England local team is that VOYCCG PCNs delivered robust and credible plans. A recent meeting with NHS England colleagues indicated that initial funding allocations to support the organisational development needs of the PCN have now been set at PCN level based on a per capita formula and linked to the needs identified through the maturity matrices. It is expected that these allocations will be signed off at the STP Primary Care Board meeting on 14th November with communications on the allocations and framework for utilisation to CCG and PCNs to follow.

Both Lead Officers have met with the NHS England national team for Time for Care. This nationally funded improvement support programme) has been used by some of the Vale of York practices in the past as part of the predecessor programme ‘Productive General Practice’. There is now an opportunity through this national funding to provide both practice and PCN level improvement support around set up and service development across Vale of York. This will enable PCNs to focus spend of their development monies on other areas.

3. Additional Roles

All 3 Vale PCNs have developed outline workforce plans for the next 3 years to optimize the recruitment of additional roles based on their locality priorities. See PCN update below for detail. Time taken to recruit to these posts means that all PCNs in Vale of York will have uncommitted funds against the additional roles Directed Enhanced Service (DES) allocations for 2019/20, and discussions are urgently

needed with NHS England and the CCG to agree how and if these can be made available to primary care to deliver the DES and support development of the wider primary care team.

Navigating the rules for additional roles in relation to the payment of VAT and management costs remains a complex area and NHS England have been asked to support the PCNs with understanding these issues as part of the shared OD support offer.

4. South Hambleton and Ryedale PCN (SHaR)

The PCN continues to move at pace with their approach to working with wider partners. A large number of external stakeholders including representatives from mental health, North Yorkshire County Council, the voluntary sector, Yorkshire Ambulance Service, pharmacy and acute trust and community attend the monthly partnership and engagement meetings. This is being reflected in a significant number of service improvement initiatives now in development including anticipatory care models, multi disciplinary teams for frailty, cancer and Parkinson's Disease, and work to improve dementia diagnosis rates.

The focus for additional Roles in South Hambleton and Ryedale is on recruiting Clinical Pharmacists and optimising the current Living Well offer before recruiting additional Social Prescribing Link Workers. A trial of a First Contact Practitioner Physiotherapist is underway at Pickering Surgery in advance of these roles being funded next year. Links have been made with the Urgent Care Practitioners and the practices are starting to work more closely with this service to think about how best to develop the model of care.

The PCN was recently a finalist for PCN of the Year in the National Association of Primary Care Awards in Birmingham and the Clinical Director has presented at both the NAPC conference and at an STP event with Professor Don Berwick to raise the profile of progress in their small rural PCN.

5. Selby Town PCN

The PCN is making significant progress in developing its three year strategic workplan and making links to wider partners and several planning days have been held with the Clinical Director and lead clinicians. Current priorities center around obesity, reducing inequalities, care homes and improving dementia diagnosis rates. The PCN is working with NYCC Living Well service to recruit 2 social prescribing link workers, and has recruited a clinical pharmacist. They are also working closely with colleagues at York Trust to develop a sustainable model for a first contact practitioner physiotherapy service and are keen to bring these roles forward if possible.

In terms of wider partnership working, the PCN and Lead Officer now regularly attend the multiagency group Selby Health Matters chaired by Selby District Council with a focus on reducing inequality and improving wider health and wellbeing around housing, environment, physical activity and safety.

6. Tadcaster and Rural PCN

The main challenge for this PCN remains its relatively small size (28,000 population) and the pressure that this puts on the 3 practices to share joint working and clinical and management resource. The PCN has appointed both a Social Prescribing Link Worker and a Clinical Pharmacist and is looking to extend pharmacy support through use of this years additional roles underspend. The wide geography of this small PCN means that a proportion of its population receive social care services from West Yorkshire, and a proportion from NYCC with resultant differences in the offer to its population. Initial priorities are on reducing inequalities and improving access to services in an area with poor transport links to other main hubs. Significant housing developments are underway and planned in the area and this will create pressure for already stretched primary care. Future focus of PCN development needs to include greater links to some of the key system partners.

Summary

The 3 Vale PCNs are developing well and working collaboratively to share resources and roles. The planned discussions with NYCC colleagues will be a key next step to developing their focus on the wider system and how they can influence service delivery.

See attached spreadsheet for more detail on individual PCN plans.

Vale Primary Care Networks - progress review 2019/20

	July	August	September	October
Network development	Networks formally established and submissions sent to NHSE. CD's appointed and in post.	regular meetings established - full PCN board meetings bimonthly, practice managers meeting bimonthly. Lead officer meeting with CD's.	PCN board meeting agreed to widen membership to other partners - initial focus on community and integrated care offer linked to DN workforce review.	Board meetings continue with wider partners starting to be invited.
Additional Roles			First VoY PCN to recruit to both additional roles. Social prescribing link worker starting 16/09/2019. Clinical Pharmacist starting 26/11/2019 Care home pharmacist role now recruited from STP funding in partnership with Selby Town PCN - post now commenced and undertaking training.	Practice continues to explore use of underspent additional roles funding to optimise impact in the locality. Priority remains additional clinical pharmacist post if more can be recruited.
Maturity Matrix			Meetings with each of the Vale CD's and lead practice managers held throughout September with Version 1 stocktake of maturity matrix underway for submission by 30/9.	Submitted as per NHSE guidelines. Feedback given that Vale of York submissions were one of the best received in the STP.

Service Improvement plan			PCN has identified a gap in provision leading to health inequality for a substantial number of their patient cohort. Core service improvement focus for 2019/20 is on developing the social prescribing link worker role. Roll out of health navigator planned throughout October 2019	Decision made by PCN not to fund the roll out of health navigator care coaching in Tadcaster or South Milford practices. Focus remains on social prescribing link worker particularly for the population which does not receive services from Living Well, NYCC. Tadcaster practice is part of the York offer for the IAGP service leaving 2 practices collaborating to try to deliver the required contract for the remainder of the patch. Plans in place to offer a partial service from early December but this will leave resilience challenges.
System Role				More work required to develop close working relationship with wider partners.
Miscellaneous			First workshop of all Clinical Directors planned for 17th September 2019.	contact made with NYCC senior leadership team to start discussions re place based integrated care across the NY footprint. Meeting planned fgor 5th December.

issues and support needed			CCG providing support to help locality implement Improving Access LES - PCN keen to develop an offer with the resources they have available. Have requested additional support to understand their population health needs using both NYCC and West Yorkshire data for their population.	The main challenge for T&RS PCN remains scale - with only 3 practices to collaborate across, there is pressure on resources to take pieces of work forward. Significant housing development in the area is causing concern - +750 houses in development in Sherburn, and +3,000 in Church Fenton in planning. some of the practice population receive social care services from West yorkshire, Some from North Yorkshire and this causes inequity of access for some things, eg social prescribing.

Item Number: 10

Name of Presenter: Shaun Macey

Meeting of the Primary Care Commissioning Committee

Date of meeting: 21 November 2019

NHS
Vale of York
Clinical Commissioning Group

Report Title – Update on Local Enhanced Services

Purpose of Report *(Select from list)*
For Information

Reason for Report

This report is a periodic update to the Committee on the review of our Local Enhanced Services with General Practices.

Strategic Priority Links

- ☒Strengthening Primary Care
- ☐Reducing Demand on System
- ☐Fully Integrated OOH Care
- ☐Sustainable acute hospital/ single acute contract
- ☐Transformed MH/LD/ Complex Care
- ☐System transformations
- ☒Financial Sustainability

Local Authority Area

- ☒CCG Footprint
- ☐City of York Council
- ☐East Riding of Yorkshire Council
- ☐North Yorkshire County Council

Impacts/ Key Risks

- ☒Financial
- ☐Legal
- ☒Primary Care
- ☒Equalities

Risk Rating

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

☐ Quality Impact Assessment
☐ Equality Impact Assessment
☐ Data Protection Impact Assessment
☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

Not applicable

Recommendations

The Committee is asked to note the updates presented in this paper.

Decision Requested (for Decision Log)

Updates noted.

Responsible Executive Director and Title	**Report Author and Title**
Dr Andrew Lee Executive Director of Primary Care and Population Health	Stephanie Porter Assistant Director Primary Care

Local Enhanced Service Contracts – current position

The Committee has been updated periodically of the Local Enhanced Service Contracts (LES) the CCG has with our GP practices. The last full report was prepared for the January 2019 meeting which highlighted a number of proposed changes to some of the services based on changes in the specification following the review.

The main process change which was introduced was a simplification of the data collection process and payment mechanism and this has now been introduced.

One LES was not reviewed at that time, and that was the PSA blood test –for prostate cancer as part of a yearly exam. Dan Cottingham, Macmillan GP Cancer and End of Life Lead for the Vale of York CCG, has reviewed the current specification and has updated the reference to NICE guidance to bring the guidance up to date. Currently the description of the service refers to prostate disease while the rest of the specification seems to focus on prostate cancer with the caveat the patient is on the Prostate Cancer Register to receive payments linked to monitoring PSA levels. The CCG is checking with contacts at the LMC to clarify that this is accurate.

The current specification also seems to be aimed at testing patients that have been discharged post cancer treatment. The new NICE Quality standard recommends that PSA testing or active surveillance is seen as an equal choice alongside surgery and radiotherapy. The CCG believes that this will be carried out in secondary care and we need to be clear about this as if testing is expected to happen in Primary Care we will also need to pay for these tests and update the specification. Once we are clear on this point, the specification will be amended.

More recently we have also highlighted and implemented the withdrawal of the Neonatal check LES, which the committee approved at the last meeting.

Local Enhanced Services – future proposals

The CCG will set up a project group in December to review the overall approach to LES contracts. Neighboring CCGs have significantly fewer LES contacts and have moved to an approach where these extra services are ‘absorbed’ with remuneration into a GMS core plus, type agreement with practices, where the LES is the plus element. For example Leeds CCG has 2 LES contracts to our 16.

The project group will be supported by a GP lead (funded) and will seek a collaborative approach to achieving contracting arrangements with all providers, and LMCs determining where services best sit to ensure a consistent service offer to patients. PCCC members may recall, that not all practices sign up to every LES, so

the CCG then has to fill that gap via alternative commissioning arrangements. The approach will be to ensure a level of devolved responsibility, with light touch monitoring – probably transitioned into via a 12 month pilot and review period.

Ideally the aim will be to complete the assessment and recommendation for change, prior to the new contracts being awarded 1 April 2020. This may be overly ambitious, if this is the case, we will work with providers and contracting colleagues to enter into steady state contracts which will allow a variation when the project has concluded and proposals approved.

PCC should expect a full update in March 2020.

Item Number: 11

Name of Presenter: Dr Andrew Lee

Meeting of the Primary Care Commissioning Committee

Date of meeting: 21 November 2019

NHS
Vale of York
Clinical Commissioning Group

Report Title – Statin Optimisation Pilot Evaluation

Purpose of Report *(Select from list)*
For Decision

Reason for Report

The 2016 NICE guideline for cardiovascular disease prevention (CG181) recommends that patients with existing coronary disease, and those at high risk, should be treated to a cholesterol target of <=4 mmol/l. It also recommends the use of Atorvastatin for both primary prevention of cardiovascular disease and for those with existing disease. 2016/17 ePACT2 data on statin prescribing amongst Vale of York GP practices showed an almost equal split in the use of Atorvastatin (46%) and simvastatin (45%), suggesting that targeted work was required to ensure that the NICE guidelines are being implemented and that all patients are on optimised treatment.

The Vale of York Executive Committee approved commencement of a pilot in Haxby Group Practice. A dedicated pharmacist would work with the practice to identify patients at high risk of a cardiovascular event, and with a cholesterol of >4mmol/l, and ensure that they were being treated on the most appropriate statin therapy (Atorvastatin). Evidence suggests that optimising the statins of patients with established CVD (secondary prevention) and those with CV risks Qrisk > 20% (primary prevention) is likely to improve cardiovascular outcomes while reducing cardiovascular mortality.

The pilot commenced in February 2019 and an evaluation has been completed to capture the mobilisation process, uptake of optimisation, improved clinical outcomes, financial impact and lesson learnt.

The overarching assumptions based on pilot findings are:

- People who take atorvastatin are likely to achieve target cholesterol of ≤4 mmol/l (2/3rds of pilot cohort achieved target cholesterol, whilst vast majority of people's cholesterol improved post switch).
- Taking atorvastatin means people will further reduce their risk of developing a heart attack or stroke by 2% over ten years.
- Additional prescribing costs are marginal
- Results are consistent with NICE guidance and we would recommend atorvastatin as first line treatment.

It is therefore recommended that the pilot is scaled up and a targeted approach to statin optimisation is carried out across the whole of the Vale of York CCG. This would require pharmacist and CCG support.

Strategic Priority Links

☒Strengthening Primary Care
☒Reducing Demand on System
☐Fully Integrated OOH Care
☐Sustainable acute hospital/ single acute contract
☐Transformed MH/LD/ Complex Care
☐System transformations
☐Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks	**Risk Rating**
☒Financial ☐Legal ☒Primary Care ☐Equalities	

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

☐ Quality Impact Assessment
☐ Data Protection Impact Assessment
☐ Equality Impact Assessment
☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

Impact assessments to be completed if wider roll out agreed

Recommendations

It is recommended that the pilot is scaled up and a targeted approach to statin optimisation is carried out across the whole of the Vale of York CCG. This would require pharmacist and CCG support.

Decision Requested (for Decision Log)
Decision to allocate resource to mobilise statin optimisation across the wider Vale of York CCG footprint.

Responsible Executive Director and Title	**Report Author and Title**
Andrew Lee Executive Director of Primary Care and Population Health	Alex Kilbride Commissioning and Transformation Manager

Statin Optimisation Pilot Evaluation

Introduction and Background

The 2016 NICE guideline for cardiovascular disease prevention (CG181) recommends that patients with existing coronary disease, and those at high risk, should be treated to a cholesterol target of ≤4mmol/l. It also recommends the use of Atorvastatin for both primary prevention of cardiovascular disease and for those with existing disease. 2016/17 ePACT2 data on statin prescribing amongst Vale of York GP practices shows an almost equal split in the use of Atorvastatin (46%) and simvastatin (45%), suggesting that targeted work is required to ensure that the NICE guidelines are being implemented and that all patients are on optimised treatment.

The Vale of York Executive Committee approved commencement of a pilot in Haxby Group Practice. A dedicated pharmacist would work with the practice to identify patients at high risk of a cardiovascular event, and with a cholesterol of >4mmol/l, and ensure that they were being treated on the most appropriate statin therapy (Atorvastatin). Evidence suggests that optimising the statins of patients with established CVD (secondary prevention) and those with CV risks Qrisk > 20% (primary prevention) is likely to improve cardiovascular outcomes while reducing cardiovascular mortality.

The pilot commenced in February 2019 and this evaluation has been completed to capture the mobilisation process, uptake of optimisation, improved clinical outcomes, financial impact and lesson learnt.

Implementation

Haxby Group Practice were asked to take part in the pilot and to allow pharmacists and pharmacy technicians from Prescribing Support Services (PSS) and the CCG to conduct the work.

The Haxby Group pilot aimed to take a practice level approach to identify patients not optimised on a statin, with no contraindication or previous intolerance to being prescribed a statin or a higher dose statin.

The choice of statins for this project was Atorvastatin (primary prevention Atorvastatin 40mg OD and for secondary prevention Atorvastatin 80mg OD as per NICE guidelines).

Atorvastatin is generic and cost effective and more potent than simvastatin dose for dose. Atorvastatin 40mg is classed as high intensity compared to Simvastatin 40mg which is classed as medium intensity.

For the Haxby Group pilot two groups of patients were agreed to be optimised (see table 1).

Table 1: Groups of patients identified as needing dose optimisation

Priority group	Reasons for ease or difficulty in implementing change
1. Established CVD and prescribed a low potency statin and cholesterol >4/ LDL>2	High number of patients. High risk group. Already on a statin so perhaps more receptive to potency increase. Can be done by letter
2. CV risk > 20% and prescribed a low potency statin and cholesterol>4/ LDL>2	Higher risk group in primary prevention population. Already on a statin so perhaps more receptive to potency increase. Can be done by letter. High number of patients.

Full details of the methods are included in the Standard Operating Procedure (SOP). SOPs were checked and signed, and the data processing contract was signed by the practice prior to commencing. The pilot commenced in February 2019.

Individual patient records were searched manually to check if a higher dose statin (optimisation) had been tried before or if there were any other reason the patient had declined a statin/higher dose statin. The final list was sent to the practice for the GP lead to identify patients they would consider not appropriate to change by letter.

Patients were offered a more potent statin by letter with an option to contact a pharmacist staff helpline if they wanted to discuss the reasons for recommending a more potent statin or to decline the change. All patients not declining the change had their statin dose optimised 28 days after being sent the letter.

Clinical codes indicating cognitive impairment, or a palliative diagnosis were built into the search to identify patients whom it would not be appropriate to inform them of the change by letter.

If there were any patients unsuitable picked up in the searches such as palliative care, renal care, coding error of CVD, patients on warfarin, other specific drug interactions and those already on maximum dose and patients who cannot tolerate higher intensity Atorvastatin these were flagged up the lead GP at the practice to review.

Following discussions with the lead GP at Haxby Group practice it was decided to include patients who were not ordering their current statin and patients who required lipids checking post starting their current statin. This was due to the large number of patients in this category and for patients not ordering in the hope that the switch would trigger them to restart.

Patients who required lipids post their current statin were switched based on recent LFTs being done and aiming to get patients onto the recommended guideline dose. All patients switched were issued with blood forms to check their LFTs and total lipids/LDL 3 months after the switch. In the Airdale, Wharfdale and Craven CCG

project, advice from a hepatologist consultant was that the risk of raised ALT (transaminitis) is <1% and the risk of acute liver failure is negligible. So, from that point of view it is argued that a baseline ALT is not necessary. BHH guidance suggests that there is no need to measure LFTs in statin use unless there is a clinical concern. This is in line with the American FDA guidance. NICE suggest baseline LFTs be measured before starting a statin, repeated 3 months of starting treatment, again at 12 months, but not again unless clinically indicated. Other countries advise no checking of LFTs.

There is evidence even if cholesterol <4, switching from Simvastatin to a more effective dose of Atorvastatin will reduce CV risk, but it is more resource-efficient to target those with higher lipids first, so it was decided that those with cholesterol >4 were targeted first for this project.

Patients up to 84 years for both primary and secondary prevention were included. This was due to the practice reviewing the prescribing of statins for over 84s. Patients over 84 were picked up in the search, however excluded from the switch. The list of over patients over 84 was forwarded to the practice for review.

Switch Outcomes

Table 2: Primary and secondary prevention switch figures

Primary Prevention Optimisation		**Secondary Prevention Optimisation**	
Number of patients reviewed	**413**	**Number of patients reviewed**	**354**
Number of patients >84 excluded	31	Number of patients >84 excluded	74
Number of patients not suitable to optimise	68	Number of patients not suitable to optimise	96
Number of patients sent letters to optimise statin	**272**	**Number of patients sent letters to optimise statin**	**192**
Total amount of patients declined offer	31	Total amount of patients declined offer	12
Total Number of patients optimised after 28days of receipt of letter	**241**	**Total Number of patients optimised after 28days of receipt of letter**	**180**

A total of 767 patients were reviewed, however some patients were interchangeable i.e. no longer coded for secondary prevention or a secondary prevention patient included in the primary prevention list due to a previous Qrisk score recorded in their record. There were 269 patients unsuitable in total as explained in the reasons above. This list was forwarded to the practice for review. There were also a small number of patients no longer at the practice since the initial review.

Following letters being sent there was a good response from patients. The practice staff and PSS helpline were there to support patients with the switch and were able

to explain the guidelines and added health benefits. Advice about healthy living and dietary changes were also provided as this can be as effective as taking a standard medication (more so if done well). Smoking is the single biggest modifiable risk in CV disease. In high risk patients, stopping smoking can reduce risk by up to 50%.

For **primary prevention 89%** of patients were optimised and for **secondary prevention 94%** of patient's doses were optimised after the 28 day opt-out period.

Familial Hypercholesterolemia (FH) - total cholesterol >7.5 or LDL>4.9 prior to statin therapy or currently. Also consider patients with triglyceride level consistently >10.

Patients with cholesterol levels suggestive of familiar hypercholesterolemia (FH) were flagged to the practice to allow them to refer into the local FH service. At the end of the project a reminder letter was sent to Haxby practice listing all the possible FH patients that had been identified.

For primary prevention 96 patients were identified as eligible for FH referral and 54 for secondary prevention. A further 43 patients were identified in the over 84s group for both primary and secondary prevention. **In total 193 were identified as eligible for FH referral.** This list was forwarded to the practice for review.

Clinical Outcomes Three Months Post Switch

Primary Prevention Overview

For Primary Prevention out of the 173 people reviewed 88% of patients remained on the statin they had been switched to during the pilot. Out of the 173 patients reviewed, 99 of them had returned to have their bloods re-checked after 3 months in line with the pilot guidance. This showed that 89% of these have had an improvement in their cholesterol levels and 65% now had a cholesterol level of ≤4 recorded. Across the cohort of those re-tested (99 people), the average reduction in cholesterol level was 0.9mmol/l.

In addition, out of the 173 people reviewed 6 who were not previously ordering their Statin seemed to now be engaged and ordering post switch. However 2 patients who were previously ordering regularly now seemed to be disengaged and the new Statin has never been issued. These individuals have been flagged to the lead GP at the practice.

Primary Prevention Analysis

Table 3: Primary prevention switch figures

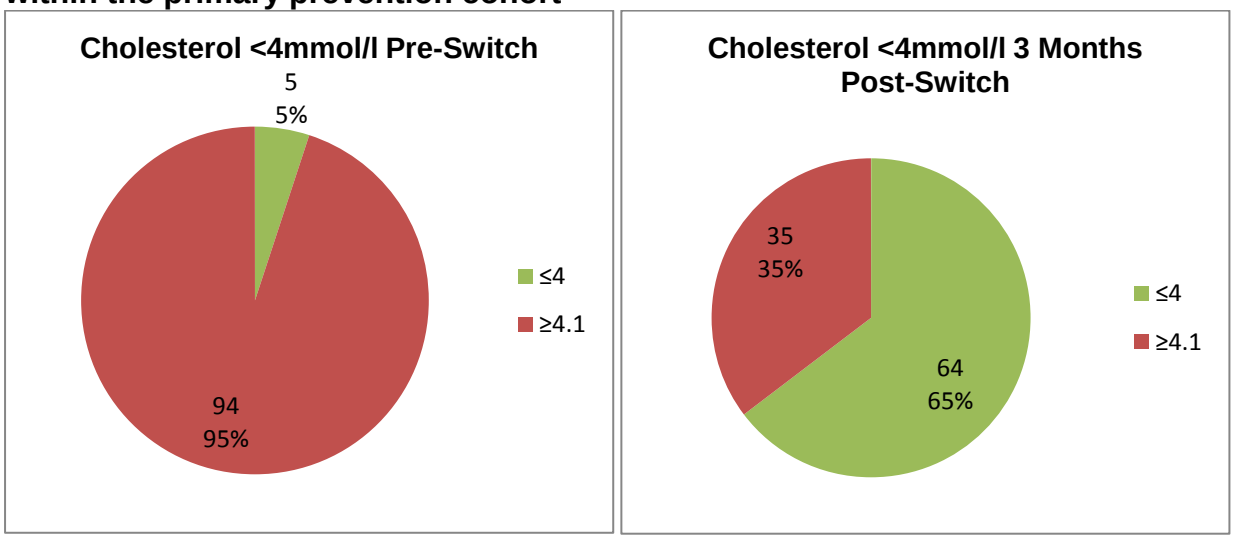
	Primary Prevention Optimisation	
Switch	**Number of patients reviewed**	**413**
	Number of patients >84 excluded	31
	Number of patients not suitable to optimise	68

	Number of patients sent letters to optimise statin	**272**
	Total amount of patients declined offer	31
	Total Number of patients optimised after 28days of receipt of letter	**241**

Table 4: Primary prevention outcomes 3 months post switch

Findings 3 months post Switch	**Remained on statin**		
	Sample of patients reviewed	173	N/A
	Total remained on switched statin	152	88%
	Total who did not remain on switched statin	21	12%
	Cholesterol improved		
	From sample of those who remained on statin total number who had bloods retested 3 months post switch Cholesterol results were:	99	N/A
	Improved	88	89%
	Stayed the same	2	2%
	got worse	9	9%
	Cholesterol now in target range ≤4		
	Of bloods received (99) - total previous cholesterol ≥4.1	94	N/A
	Now in target post switch:		
	≤4	64	65%
	≥4.1	35	35%
	Average cholesterol improvement		
	Of the ones that improved the average level of cholesterol improvement was:	0.9	mmol/l

Figure 1: Cholesterol Target Achievement of ≤4mmol/l pre and post switch within the primary prevention cohort



*Data from 99 people whose bloods were re-tested within the primary prevention cohort

Secondary Prevention Overview

For Secondary Prevention out of the 178 people reviewed 85% of patients remained on the Statin they had been switched to during the pilot. Out of the 178 patients reviewed, 83 of them had returned to have their bloods re-checked after 3 months in line with the pilot guidance. This showed that 88% of these have had an improvement in their cholesterol levels and 69% now had a cholesterol level of ≤4 recorded. Across the cohort of those re-tested (83 people), the average reduction in cholesterol level was 1.0mmol/l

In addition, out of the 178 people reviewed 1 who was not previously ordering their Statin seemed to now be engaged and ordering post switch. However 2 patients who were previously ordering regularly now seemed to be disengaged and the new Statin had never been issued. These individuals have been flagged to the lead GP at the practice.

Secondary Prevention Analysis

Table 5: Secondary prevention switch figures

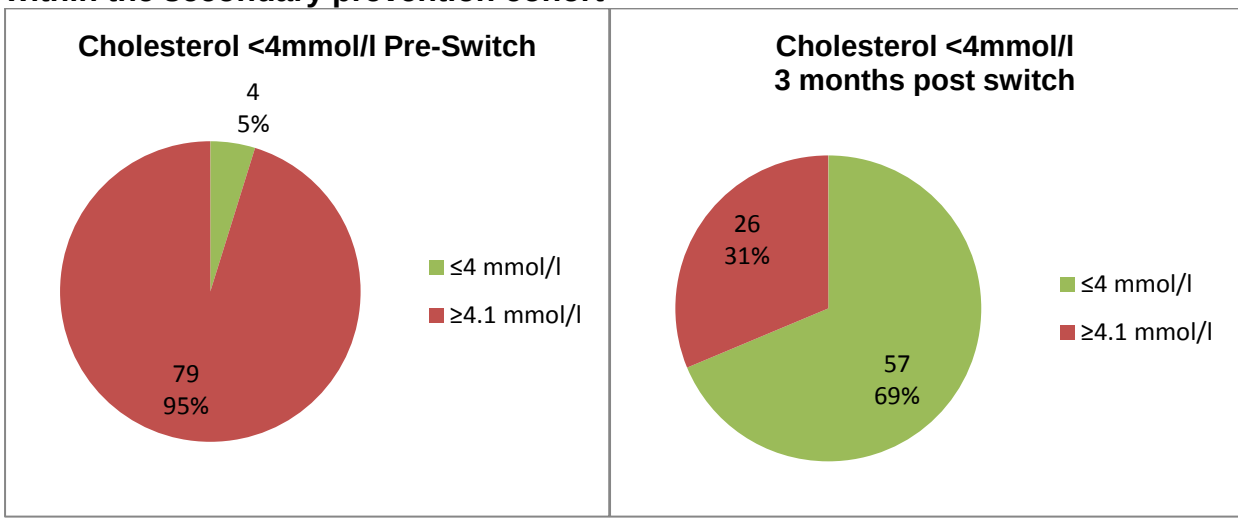
	Secondary Prevention Optimisation	
Switch	**Number of patients reviewed**	**354**
	Number of patients >84 excluded	74
	Number of patients not suitable to optimise	96
	Number of patients sent letters to optimise statin	192
	Total amount of patients declined offer	12
	Total Number of patients optimised after 28days of receipt of letter	**180**

Table 6: Secondary prevention outcomes 3 months post switch

Findings 3 months post Switch	Remained on statin		
	Sample of patients reviewed	178	
	Total remained on switched statin	152	85%
	Total who did not remain on switched statin	26	15%
	Cholesterol improved		
	From sample of those who remained on statin total number who had bloods retested 3 months post switch Cholesterol results were:	83	N/A
	Improved	73	88%
	Stayed the same	4	5%
	got worse	6	7%
	Cholesterol now in target range ≤4		
	Of bloods received (83) - total previous cholesterol ≥4.1	79	N/A
	Now in target post switch:		

	≤4 mmol/l	57	69%
	≥4.1 mmol/l	26	31%
	Average cholesterol improvement		
	Of the ones that improved the average level of cholesterol improvement was:	1.0	mmol /l

Figure 2: Cholesterol Target Achievement of ≤4mmol/l pre and post switch within the secondary prevention cohort



*Data from 83 people whose bloods were re-tested within the secondary prevention cohort

Assumptions from analysis

QRisk example: a 64 year old man, with no other risk factors, normal BP, weight and personal medical history has approximately a 15% chance of developing a stroke or having a heart attack over a 10 year period, if his cholesterol is 5.

If his cholesterol is 4 his risk drops to 12.7%, therefore we would assume that 2 lives are saved over a ten year period.

Therefore the overarching assumptions based on the clinical findings are:

- People who take atorvastatin and are optimised are likely to achieve target cholesterol of ≤4 mmol/l (2/3rds of cohort did, whilst majority of people's cholesterol improved).
- Taking atorvastatin means people will further reduce their risk of developing a heart attack or stroke by 2% over ten years.
- Additional prescribing costs are marginal
- It would be recommended that no patients are started on simvastatin now – any doctors initiating patients on simvastatin should be contacted to find out why. The number of patients this affects should diminish over time

Caveat: The cohorts of patients in the pilot were already on a statin and therefore some of their risk had already been reduced, it had just not been optimised.

Reflection on Pilot Mobilisation

Preparation required by practice:

- A clinical member of the practice who could make decisions about large-scale medication switches needed to review the proposal and protocols from the CCG, in Haxby's case this was the GP prescribing lead. Suggestions were made to the protocols/SOPs to fit the practice's requirements and letters to patients were changed (estimated total 3 hours of GP leads time).
- Practice staff are involved in setting up IT rights, data protection etc. for overseeing staff (1 hour max)
- Additional background checks into PSS were already completed by practice so not repeated. Some practices may want to do this to ensure 3rd parties are not benefitting financially from switches or will not encounter negative publicity/accusations from NHS campaign groups.

What went well:

- It was easy to communicate by email with PSS pharmacist, pharmacist technician and CCG staff to progress pilot
- SOPs and letter templates were already produced and easy to understand.
- There was flexibility for the practice to tailor the letters/SOPs so it fits with the practice requirements.

Improvements suggested:

Better foresight of what problems are likely to be encountered. These were all worked through during the pilot mobilisation; however it would have been easier if answers to these were clarified before roll out. All of this could be done in one mobilisation meeting with the practice

Things to clarify would be:

- which patients will need consideration of exclusion (warfarin, renal disease, ages for primary and secondary prevention etc)
- when letters are sent (several batches)
- how blood forms are created and when to send them
- how to follow up and who is responsible for following up
- Issue and complaints route for patients
- anticipation of results blood results coming back and how to deal with these
- people who go too early for bloods and need new forms sending
- Anticipated impact on blood taking services in the practice and local area.

Haxby Group practice chose to put a note on prescription item to check LFTs and cholesterol in 3 months to help to identify patients with a prescription reauthorisation. The fact the switched prescription was not linked to a problem was helpful to the practice staff as it stood out as odd against the other items. This was done by the PSS and CCG support team.

When looking to implement wider it needs to be clear in the roll out plan which organisation is responsible for sending the letters and blood forms to patients, how this is done practically and how this is funded.

The original pilot proposal asked the practice to complete this task, however due to practice pressures there was limited capacity to complete this so the CCG pharmacist technician went into the practice to support this element of mobilisation. This was a timely task for the technician as Haxby Group practice opted to send the 3 month blood forms with the switch letter. The letters could have been sent to patients using mail merge software; however the blood forms require an individual request which meant that the pharmacist technician had to go into every patient record on ICE to create the blood form. This took 40 hours to complete for 464 patients.

This element of the pilot required additional resource which was not originally accounted for in the pilot proposal. The resource required was intensive and therefore it is recommended that this part of the mobilisation process is reviewed if wider roll out is supported.

Launch

All practice staff need briefing on when the pilot is commencing and the likely impact of this on the day to day running of the practice. Preparatory statements for front desk staff and processes clarified for patients to ask questions e.g. direct to pharmacist helpline, directing them to the information in the letter, escalation procedures if a patient wants to complain and how best to avoid duty systems for questions. GPs need warning of likely impact and resources to help. Estimated 2 hours to write and disseminate briefs and answer questions etc.

There was little impact on Haxby Group practice in terms of letters and switches as this was done by PSS and the CCG support team.

Further elements to consider for wider roll out would be briefing local pharmacies about the change.

Early impact on the practice

Despite having the PSS dedicated helpline a number of complaints and resistance from a minority of patients were received by the practice. Specific data was not captured on this. Offspring of some patients were quite animated, and the usual paradoxical resistance to improving care was encountered. Patients contacted the practice by phone, email, requested same day phone calls with GPs, refused to call the helpline, wanted duty GP or own GP. Some difficulty was experienced at the practice front desk. It was difficult to quantify time involved but this had to be dealt with as a specific problem for a few weeks and unfortunately coincided with the practice going live with EPS.

Despite difficulties experienced at the practice from a minority of patients there were no formal complaints and the practice thought the dedicated helpline was very helpful as it took the bulk of queries from patients and reduced the impact this could of had on the practice.

The dedicated pharmacist helpline received 72 calls in total from patients. The key themes from the calls were people ringing up for clarification on the details of the proposed switch and then either declined the offer or were happy to change.

Improvements:

A shorter and clearer letter may make it easier for patients to understand the medication switch and reduce the number of queries the practice and pharmacist helpline receive. It is suggested the helpline number is highlighted at the top off the letter so it is immediately noticed by patients. Better wording may be required to explain that the helpline is supported by a dedicated pharmacist who is specialising in this switch and advising GPs' and/or similar.

Late impact on the practice

Very few patients requested to switch back.

All 3 month blood tests were coming back to the lead GP. This was a problem for the lead GP initially but the practice implemented changes which mitigated this. 2 hours were spent by the lead GP reviewing results overall and the vast majority were filed and did not require follow-up actions.

There is time required to follow-up/chase those patients who have not had a blood test. There is no process for this identified at the practice and this is happening ad hoc at the moment. It is taking up the time of the practice medicines management team and is often being overlooked by GPs. In future roll out plans these needs to be considered and a plan put in place for this process at the practice.

FH cohort still requires follow-up by the practice. This part of the project has been deemed a relatively low clinical priority by the practice so has been postponed as the practice is focussing on other CCG initiatives.

Summary

The principle to change to evidence-based guidance to improve patient care is unquestionable.

It is a large, time consuming switch which practices would find difficult to do without support from PSS and the CCG.

The support provided by the CCG via PSS was good, though the preparatory process could have been more efficient. The pilot process has identified problems that would be common to all practices and where individual practices may differ. Some of this could be centrally decided by the CCG such as age cut-offs, what to do

with renal disease patients etc. Individual practices have little time or knowledge to assess the risks of this.

Early impact was minor but significant and there needs to be robust briefing for all staff with clear strategies for dealing with complaints. The helpline was very good support.

A defined process for the FH cohort is needed. It is recommended that the CCG work to develop this process. Although it is a worthwhile/important part of the project, the low priority for practices means that with current resources it is difficult to allocate staff time to do this as well as other major prescribing system changes.

Pilot Mobilisation Timeline

Table 7: Mobilisation timeline

DATE	RESPONSIBILITY	MILESTONE
February 2019	PSS Pharmacist	Develop searches for identified practice system
March 2019	PSS Pharmacist Practice CCG	SOPs signed off Helpline confirmed Patient letters drafted and uploaded to clinical system Initial searches ran to identify patients eligible for primary and secondary prevention.
March and April 2019	PSS Pharmacist CCG Pharmacist Technician	Batches of letters and blood forms are sent to eligible patients. Patients are given a 28day period to contact the helpline and/or opt out.
April and May 2019	PSS	Eligible patients are switched to optimised statin
October 2019	CCG Pharmacist Technician	Data collected for analysis 3 months post switch
November 2019	PSS Pharmacist Practice CCG	Evaluation and recommendations completed

Financial Assessment

In 2019/20 the average NHS cost of a heart attack based on tariff for Vale of York CCG is £4k and the average cost of a stroke is £10k.

The average NHS and social care cost for each person that has a stroke is about £22,000 a year, and around £45,000 over five years.

Based on the pilot:

- Payment for PSS pharmacist to run searches and perform switches :

If approximately 500 patients eligible for switching, allowing for 15 minutes per switch per patient, at a pharmacist cost of £30ph this would represent an approximate cost of £3,750
- Cost of letters £500
- Marginal additional prescribing costs of Atorvastatin based on the most common switches from the pilot

Primary Prevention Cost Analysis

The three main switches in the primary prevention pilot were:

- Atorvastatin 20mg → Atorvastatin 40mg
- Simvastatin 20mg → Atorvastatin 40mg
- Simvastatin 40mg → Atorvastatin 40mg

See table below for cost implications:

Table 8: primary prevention cost analysis

Atorvastatin 20mg → Atorvastatin 40mg	
Amount of Patients Switched - 61	
Atorvastatin 20mg Tablets	Atorvastatin 40mg Tablets
£0.99 per pack	£1.22 per pack
Cost difference per pack - £0.23	
Overall cost difference for the 61 patients switched:+£14.03 per month	

Simvastatin 20mg → Atorvastatin 40mg	
Amount of Patients Switched - 37	
Simvastatin 20mg Tablets	Atorvastatin 40mg Tablets
£0.91 per pack	£1.22 per pack
Cost difference per pack - £0.31	
Overall cost difference for the 37 patients switched:+£11.47 per month	

Simvastatin 40mg → Atorvastatin 40mg	
Amount of Patients Switched - 43	
Simvastatin 40mg Tablets	Atorvastatin 40mg Tablets
£1.03 per pack	£1.22 per pack
Cost difference per pack - £0.19	
Overall cost difference for the 43 patients switched:+£8.17 per month	

Secondary Prevention Cost Analysis

The four main switches in the secondary prevention pilot were:

- Atorvastatin 10mg → Atorvastatin 80mg
- Atorvastatin 20mg → Atorvastatin 80mg
- Simvastatin 20mg → Atorvastatin 80mg
- Simvastatin 40mg → Atorvastatin 80mg

See table below for cost implications:

Table 9: secondary prevention cost analysis

Atorvastatin 10mg → Atorvastatin 80mg	
Amount of Patients Switched - 15	
Atorvastatin 10mg Tablets	Atorvastatin 80mg Tablets
£0.86	£1.82
Cost difference per pack - £0.96	
Overall cost difference for the 15 patients switched:+£14.40 per month	

Atorvastatin 20mg → Atorvastatin 80mg	
Amount of Patients Switched - 41	
Atorvastatin 20mg Tablets	Atorvastatin 80mg Tablets
£0.99	£1.82
Cost difference per pack - £0.83	
Overall cost difference for the 41 patients switched:+£34.03 per month	

Simvastatin 20mg → Atorvastatin 80mg	
Amount of Patients Switched - 17	
Simvastatin 20mg Tablets	Atorvastatin 80mg Tablets
£0.91	£1.82
Cost difference per pack - £0.91	
Overall cost difference for the 17 patients switched:+£15.47 per month	

Simvastatin 40mg → Atorvastatin 80mg	
Amount of Patients Switched - 34	
Simvastatin 40mg Tablets	Atorvastatin 80mg Tablets
£1.03	£1.82
Cost difference per pack - £0.79	
Overall cost difference for the 34 patients switched:+£26.86 per month	

Conclusion

The principle to change to evidence-based guidance to improve patient care is unquestionable. It is a large, time consuming switch which practices would find difficult to do without support from PSS and the CCG.

It is therefore recommended that the pilot is scaled up and a targeted approach to statin optimisation is carried out across the whole of the Vale of York CCG. This would require pharmacist and CCG support.

Item Number: 12

Name of Presenter: David Iley

Meeting of the Primary Care Commissioning Committee **Date of meeting: 21 November 2019**	NHS Vale of York Clinical Commissioning Group

Report Title – Primary Care Update

Purpose of Report *(Select from list)*
To Receive

Reason for Report

Summary from NHS England North of standard items (including contracts, planning, finance and transformation) that fall under the delegated commissioning agenda.

Strategic Priority Links

☒Strengthening Primary Care	☐Transformed MH/LD/ Complex Care
☐Reducing Demand on System	☐System transformations
☐Fully Integrated OOH Care	☐Financial Sustainability
☐Sustainable acute hospital/ single acute contract	

Local Authority Area

☒CCG Footprint	☐East Riding of Yorkshire Council
☐City of York Council	☐North Yorkshire County Council

Impacts/ Key Risks	**Risk Rating**
☐Financial ☐Legal ☒Primary Care ☐Equalities	

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

☐ Quality Impact Assessment
☐ Equality Impact Assessment
☐ Data Protection Impact Assessment
☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

N/A

Recommendations

For the Committee to receive the report

Decision Requested (for Decision Log)

Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam Accountable officer	David Iley Primary Care Assistant Contracts Manager

Annexes (please list)

- Appendix 1 - Vale of York CCG Delegated Commissioning Primary Care Commissioning Committee Annual Chair's Report
- Appendix 2 – GP Forward View Update

Vale of York
Delegated Commissioning
Primary Care Update
November 2019

Prepared by David Iley

Primary Care Assistant Contracts Manager

NHS England and NHS Improvement – (NE and Yorkshire)

12th November 2019

1. Items for Approval

1.1 Vale of York CCG Delegated Commissioning Primary Care Commissioning Committee Annual Chair's Report

The purpose of this report is to update Board members with the progress of the work of the Primary Care Commissioning Committee for the period April 2018 - March 2019. Please see appendix 1

The Committee is asked to receive the Annual Chair's Report

2. Items for Noting

2.1 Contractual

No items for noting

2.2 Estates

No items for noting

2.3 GP Forward View / Transformation

2.3.1 General Practice Forward View

The CCG continues to be actively involved with the NHSE/I GPFV transformation programme. As previously agreed with the committee we will provide regular updates against all the elements of the programme.
The details of the programme are contained in appendix 2.

2.4 Other

2.4.1 Community Pharmacist Consultation Service

The NHS Community Pharmacist Consultation Service (CPCS) will launch on 29th October 2019 as an Advanced Service. The service, which will replace the NUMSAS and DMIRS pilots, will connect patients who have a minor illness or need an urgent supply of a medicine with a community pharmacy. The CPCS will take referrals to community pharmacy from NHS 111 initially, with a rise in scale with referrals from other parts of the NHS to follow. The CPCS will relieve pressure on the wider NHS by connecting patients with community pharmacy, which should be their first port of call and can deliver a swift, convenient and effective service to meet their needs.

The CPCS provides the opportunity for community pharmacy to play a bigger role than ever this winter as an integral part of the NHS urgent care system. This will continue to be supported by the NHS Help Us Help You Pharmacy Advice campaign.

The Committee is asked to note the update

Appendix 1

Primary Care Commissioning Committee
Chair's Annual Report
1 April 2018 to 31 March 2019

1. Introduction

1.1 The purpose of this report is to update Board members with the progress of the work of the Primary Care Commissioning Committee for the period April 2018 - March 2019. For the purposes of this report the term 'the Committee' will be used.

1.2 Since April 2015 the CCG has operated at Level 3, fully delegated commissioning, of primary medical care services. The new Terms of Reference of the Primary Care Commissioning Committee reflecting this change came into effect from April 2015.

1.3 The Committee has continued to manage conflicts of interest robustly and in line with the CCG Conflicts of Interest policy.

2. Role and Membership of the Primary Care Commissioning Committee

2.1 The role of the Committee includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers;
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).
- Currently commissioned extended primary care medical services;
- Newly designed services to be commissioned from primary care.

2.2 The CCG Lay Member, who was also Chair of the Quality and Patient Experience Committee and the Remuneration Committee, acted as Chair with the Vice Chair as the CCG Lay Member and Chair of the Finance and Performance Committee. The full membership, which

changed following review of the terms of reference at the May 2018 meeting, is attached as Appendix 1.

2.3 6 out of 6 meetings were quorate and, in the main, core members consistently attended or sent a deputy. Voting member attendance was as follows.

Committee Member	Job Role	No of meetings attended	% of meetings attended
Keith Ramsay (Chair)	Lay Member and Chair of Quality and Patient Experience Committee and Remuneration Committee in addition to Primary Care Commissioning Committee	6/6	100%
Michael Ash-McMahon *30 April 2018 to 31 July 2018*	Acting Chief Finance Officer	2/2	
Simon Bell *from 30 July 2018*	Chief Finance Officer	3/4	
David Booker	Lay Member and Chair of Finance and Performance Committee	6/6	100%
Michelle Carrington	Chief Nurse / Executive Director of Quality and Nursing	1/1	
Phil Goatley *from 3 July 2018*	Lay Member and Audit Committee Chair	1/5	
Heather Marsh to 24 January 2019	Head of Locality Programmes, NHS England (Yorkshire and the Humber)	3/5	
Phil Mettam	Accountable Officer	5/6	
Dr Kevin Smith	Executive Director of Primary Care and Population Health	6/6	100%

2.4 The agendas of the meeting are developed dependent on the work schemes and projects being undertaken that require an update or decision from the Committee as well as matters arising from previous

Committee meetings. Generally discussions would revolve around one of the following areas:

- Quality
- Workforce
- Transformation
- Service Development
- Finance and Contracting

3.0 During 2018/19 the key areas of work and achievements of the Primary Care Co-Commissioning Committee were:

- Regular updates on General Practice visits and engagement
- Development of a Primary Care Dashboard / Assurance Report
- Enhanced Services review
- Review of Committee terms of reference
- Proposed bids for primary care estates investment
- Approval of rent reimbursement increases
- Primary Care Updates from NHS England
- Overseeing delivery of NHS England's General Practice Forward View Plan
- Overseeing delivery of improved access
- To manage the budget for commissioning of primary medical care services in the CCG
- Carry out the functions relating to the commissioning of primary medical services under Section 83 of the NHS Act
- Supporting practices wanting to work at scale and working towards PCN development
- Working closely with Unity Health to improve their CQC rating to allow the Practice to re-open their patient list

4. Summary

The Primary Care Commissioning Committee can confirm from evidence provided throughout the year and in this annual report that the CCG Board can be assured that the Committee has fulfilled its functions as set out in the terms of reference for the Committee.

APPENDIX 1

MEMBERSHIP OF PRIMARY CARE COMMISSIONING COMMITTEE

NHS England has delegated to NHS Vale of York CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

Prior to review of the terms of reference at the first meeting of the Committee in 2018/19:

The Chair of the Committee shall be the Lay Chair of NHS Vale of York CCG Governing Body.

The Vice Chair of the Committee shall be the Lay Representative and Chair of the Audit Committee of the NHS Vale of York CCG Governing Body.

Membership of the Committee is determined and approved by NHS Vale of York CCG Governing Body and will comprise:

Voting Members
Lay Chair of Governing Body
Lay Chair of Audit Committee
Lay Chair of Finance and Performance Committee
Accountable Officer
Chief Finance Officer
Executive Director of Quality and Nursing / Chief Nurse
Executive Director of Primary Care and Population Health
Representative of NHS England

Standing Non Voting Members
Up to two GPs from each locality
Chair of Clinical Executive
LMC representative
Director of Public Health
Healthwatch Representative
Health and Wellbeing Board Representative
Practice Manager

Following review of the terms of reference at the May 2018 meeting:

Voting Members
Lay Chair of Quality and Patient Experience Committee (Chair)
Lay Chair of Audit Committee
Lay Chair of Finance and Performance Committee

Accountable Officer
Chief Finance Officer
Executive Director of Director of Primary Care and Population Health
Representative of NHS England

The Chair of the Committee shall be the Lay Chair of the Quality and Patient Experience Committee**.**

The Vice Chair of the Committee shall be a Lay Member but not the Lay Chair of the Audit Committee.

Standing Non Voting Members

Up to two GPs from each locality
LMC representative
Director of Public Health
Healthwatch Representative
Health and Wellbeing Board Representative
Practice Manager

GPFV	High Impact Action (HIA)	Summary	Year	Funding	Deadline	Position November 2019
Improving Access in General Practice	5 Productive Workflows 7 Partnership Working	Plan delivery of extended access as per the requirements in the refreshed Planning Guidance - access to General Practice services in evenings to 8pm, plus some weekend provision to 100% of the population by October 2018. Commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1,000 population. Reinforce links into locality programmes - and the wider agenda around the development of Urgent Treatment Centres.	2019/20	£6.00 per head	Mar-20	Providers working to secure more consistent coverage from the available workforce to cover the required clinical hours. Additional services are being brought on stream from Physiotherapists, Nurses, HCA's – with some testing of Skype type consultations. Utilisation rates are currently good, and Providers are working to increase the number of available appointments, whilst maintaining good utilisation rates. Some additional work required in individual Practices to ensure that evening and weekend appointments are being offered to all patients.
Reception & Clerical Training	1 Active Signposting 4 Develop The Team 6 Personal Productivity	Funding for training of reception and clerical staff to undertake enhanced roles in active signposting and management of clinical correspondence. This innovation frees up GP time, releasing about 5 per cent of demand for GP consultations in most Practices. In previous years the Vale of York CCG has offered this funding through GP Alliance groupings to help train reception staff in signposting and to develop improved processes around clinical correspondence management.	2019/20	£239,682	Mar-20	NHSE have confirmed the following: Funding for four of the Primary Care Transformation Fund programme budgets will be going direct to Humber, Coast and Vale Health and Care Partnership in 2019/20. The funding for the GPFV programme areas will be allocated in June 2019 (i.e. the first accounting month when allocations are made) for the whole year, the allocation will be made to the Humber Coast and Vale and Health and Care Partnership rather than individual CCGs, as one budget and not by programme area. • General Practice Resilience Programme • GP Recruitment and Retention Programme • Reception and Clerical Staff Training • Online Consultations 2019/20 Allocation: - Practice Resilience - £201,020 - GP Retention - £319,080 - Reception & Clerical - £239,682 - Online Consultation - £391,006 **Total -£1,150,788** In April 2019 NHSE invited each CCG to submit proposals against each of the programme areas, which will be collated and taken to the Programme Board for consideration and prioritisation. Vale of York have submitted their proposals for consideration and await confirmation following the decision of the Programme Board. The Programme Board agreed the following Proposals: **Practice Resilience:** £18k - Jorvik and Gillygate Merger £5K - Stillington Surgery £5k - Priory Medical Group £25k - Pilot PM Support Lead **Online Consultation:** £25k to test video consultations across the York Locality and share the learning. **Reception and Clerical:** £9K - Thornfields Actice Signposting **GP Retention** £10K York Medical Group
Resilience Funding	5 Productive Workflows 10 Develop of QI Expertise	The purpose of the fund is to deliver support that will enable Practices to become more sustainable and resilient and better placed to take the challenges they face now and into the future and secure continuing high quality care for patients. The menu of support ranges from helping to stabilise practices at risk of closure through to more transformed support, including if appropriate, helping practices explore new models of care. This could include: • Specialist advice and guidance e.g. Human resource, IT • Coaching / Supervision / Mentorship • Practice Management Capacity Support • Rapid Intervention and management support for practices at risk off closure • Co-ordinated support to help practices struggling with workforce issues • Change management and Improvement Support to individual practices or group of practices. Support is available to individual practices as well as being available on a greater scale to group of practices in localities.	2019/20	£201,020	Mar-20	
GP Retention Scheme	4 Develop the Team	The fund will support local systems to develop innovative local retention iniatives for: • GPs who are newly qualified or within their first five years of practice. • GPs who are seriously considering leaving General Practice or are considering changing their role or working hours. • GPs who are no longer clinically practicing in the NHS in England but remain on the National Performers List (Medical). Within the Vale of York there are currently 3 GP Retainers (Sherburn, Scott Rd, Priory) already supported with finances agreed through the Primary Care Commissioning Committee. With a budget of just over £40k from the CCGs Primary Care Allocation, which is fully committed.	2019/20	£319,080	Mar-20	
Online Consultation	2 New Consultation Types 9 Support Selfcare 3 Reduce DNA's	The GP online consultation system fund was launched in 2017 This £45 million fund over 3 years 2017 - 2020 is available to support digital Funding from NHSE allocated from 2017/18 to CCG's on a weighted capitation basis. An STP wide procurement took place to commission an online consultation solution for GP Practices. The provider appointed is Wiggly Amps and the package is called engage system. NHSE employed a project manager to support all practices within the STP with deployment. To date the Vale of York have 6 practices who have gone live with the system, covering a population of 136,791 with a further 3 practices who have expressed an interest in going live covering a further population of 58,744.	2019/20	£391,006	Mar-20	

Clinical Pharmacists	4 Develop The Team	The Clinical Pharmacists in general practice scheme closed to new approvals effective from 31 March 2019 and will close for any appointments to approved posts made after 30 April 2019. The Enhanced Service for the current scheme will continue for those practices claiming for an employed clinical pharmacist, or which are received approval and appointed a Clinical Pharmacist prior to the 30 April 2019 until either. • The Clinical pharmacist is transferred to become part of a PCN's workforce team from 1 Jul 2019 onwards. • The reimbursement for the clinical pharmacist under the terms of ES comes to an end, e.g. at the end of the three year tapered funding period. A clinical pharmacist does not have to transfer from their current practice, to working across a PCN. Practices considering transferring staff are advised to read the Network Contract DES guidance at the earliest opportunity as strict workforce additionality rules will apply to the Network Contract DES which may affect the number of clinical pharmacists that can be transferred to the new network scheme. The Network Contract DES begins on 1 July 2019 and PCN's will be able to claim reimbursement for clinical pharmacists from this date, subject to specific rules. Employing practices will be responsible for supporting their staff through these transitional arrangements.	2019/20	£ -	Mar-20	In light of the introduction of the Network Contract Directed Enhanced service (DES) the Clinical Pharmacists in General Practice Scheme will close from 30 April 2019. The Enhanced Service (ES) for the current scheme will continue for those practices claiming reimbursement for an employed clinical pharmacist, or which have received approval and appointed a clinical pharmacist prior to the 30 April 2019, until either: •The clinical pharmacist is transferred to become part of a Primary Care Network's workforce team from 1 July 2019 onwards (and in accordance with the rules set out in Table 1 of the Network Contract DES guidance); or •The reimbursement for the clinical pharmacist under the terms of the current ES comes to an end, e.g. at the end of the three-year tapered funding period. Confirmation has been received that none of the Clinical Pharamcists currently on the NHSE scheme within Vale of York CCG wish to transfer into the networking agreements.
ETTF	5 Productive Workflows	The Estates and Technology Transformation Fund (ETTF) is a multi-million pound programme to accelerate the development of GP premises and make greater use of technology. The aim is to improve facilities, increase flexibility to accommodate multi-disciplinary teams and develop the right infrastructure to enable better services for patients as well as increasing staff training facilities.	2017-2021	Based on individual schemes	Mar-21	1.)Sherburn - Practice looking to develop an improvement grant rather than pursuing a new build due to ETTF timescales to complete before the end of March 2021 2.) Beech Tree Surgery, Carlton branch - Improvement Grant to expand and develop existing premises, due for completion before the end of 2019. 3.) Priory Medical Group Burnholme Health & Wellbeing Campus - New Build proposal awaiting NHS England support to develop the business case. 4.) Millfield Surgery - Improvement grant to expand existing surgery waiting for approval from NHS England 5.) Pickering Medical Practice - Improvement Grant to expand existing premises approved and close to completion
Patient Online	2 New Consultation Types	Work on uptake across Practices to meet national Aspirational targets. 30% coverage desirable to be achieved by March 2019		£ -	Aspirational Target	Currently 15 practices remain below 30% expectation and 11 practices achieving over 30%. Overall as a CCG 31.1% of all patients have access to online services.
Time For Care	4 Develop The Team 5 Productive Workflows	The Time for Care Programme is continuing beyond March 2019 with an offer of support that can be tailored to meet local needs. As well as the core elements of Time for Care that help practices to release time, improve collaboration and build improvement skills, there will be some new elements that are more relevant to primary care networks and working at scale.		£ -	2020	CCG had meeting with Charlie Keeney from NHSE Sustainable Improvement Care Team to ascertain what is currently available for General Practice under the GPFV Time for Care Programme. Discussed the national programme available of support which includes: • Primary Care Network Improvement Leader Programme • Early Career GP development Programme • Practice Nurse Development Programme • Vision to deliver - 6 - 9 month action focused workshop collaborative. A further meeting is scheduled on the 12 December 2019 to establish what offers are available at PCN level and which at Practice level to be able to communicate and raise awareness of the Time for Care Programme of support.
Practice Management	4 Develop The Team	The General Practice Development programme was established as part of the GPFV. The programme will: • Spread the best innovations, helping all practices to support mainstreaming of proven service improvements across all practices • Fund local collaboratives to support practices to implement new ways of working. • Provide free training and coaching for clinicians and manages to support practice redesign. In term tis will help practices lay the foundations for new models of Integrated care, and play their part in delivering a sustainable and high quality NHS as part of the sustainability and Transformation Plan process in which general practice has a key role.	2019/20	TBC	Mar-20	In previous years this was commissioned to the LMC to deliver a training programme around effective Practice Management and GPPR. NHSE are awaiting details, from the National Team, if there will be any available funding within 2019/20.

Apex Insight Workforce Tool	5 Productive Workflows 10 Develop QI Expertise	Apex Insight provides software and support to analyse workload and workforce capacity of Primary Care, GP Practices and Out of Hospital Services, providing Insights on demand, activity and utilisation levels. The software helps transform Service through better design and costing of resources, capacity, clinical case mix and new care models Features: • Captures Current workforce capacity • Identifies opportunities to Improve effectiveness, efficiency and resilience • Creates scenarios describing how practice workforce could change • Allows practices to compare workforce options and skill mix. • Provides Primary Care with information on current activity and workforce. • Provides population analysis to Improve access, efficiency and workload productivity • Forecasts future activity and models how to meet future demands • Supports decision making to design and cost new care models • Aggregates current and future activity, baseline and future workforce capacity • Connects to GP IT system and performs near real - time analysis.	2019/20	£ -	Mar-20	24 Practices across the Vale of York are at varying stages within the deployment with 5 of these practices having had the full workforce training session. The remaining 2 practices are in discussions with Apex Insight and Ithe CCG to discuss concerns and any underlying issues. York Medical Group are very keen to set up a detailed project group to utilise the tool effectively and share the subsequent learning across the patch.

Item Number : 13

Name of Presenter : Dr Andrew Lee

Meeting of the Primary Care Commissioning Committee **Date of meeting : 21 November 2019**	NHS Vale of York Clinical Commissioning Group

Report Title – Risk Update Report

Purpose of Report *(Select from list)*
To Receive

Reason for Report

For the Committee to review the corporate risk assigned to the management of the Primary Care Commissioning Committee and to confirm risks to be escalated / recommended for de-escalation to / from Governing Body. Regular review of risks by sub-committees ensures that appropriate assurance is provided to the Governing Body and that risks requiring review by Governing Body are appropriately escalated.

This report provides :

- Details of current events and risks managed by the Primary Care Commissioning Committee for consideration regarding effectiveness of risk management approach and application of corporate risk appetite approach; and
- An overview of programme risk.

The Committee should note that a full update of the CCG's Board Assurance Framework is in hand and that associated risks and those arising from the latest NHS England CCG Improvement and Assessment Framework (IAF) are being compiled.

Strategic Priority Links

☒Strengthening Primary Care
☒Reducing Demand on System
☒Fully Integrated OOH Care
☒Sustainable acute hospital/ single acute contract
☒Transformed MH/LD/ Complex Care
☒System transformations
☒Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks	Risk Rating
☒Financial ☒Legal ☒Primary Care ☒Equalities	

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

☐ Quality Impact Assessment
☐ Equality Impact Assessment
☐ Data Protection Impact Assessment
☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

N/A

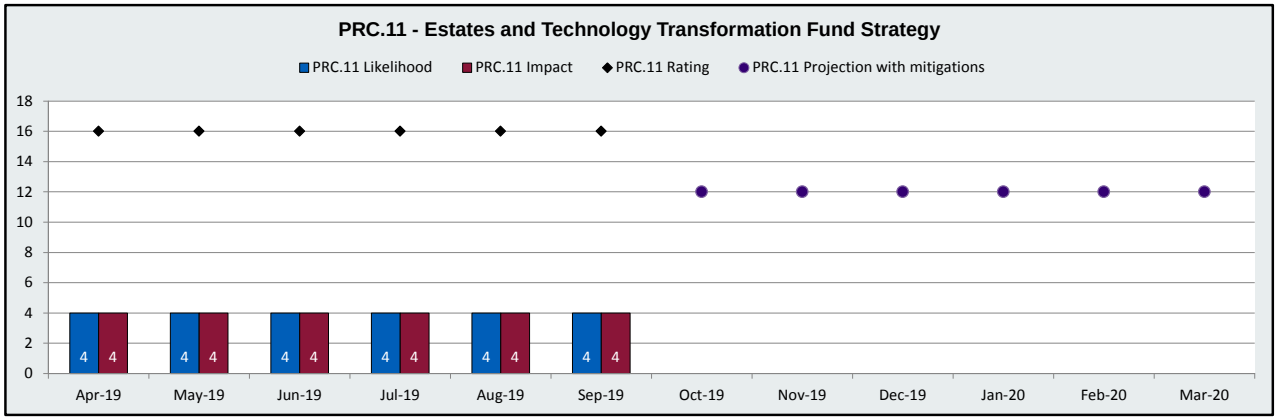
Recommendations

The Primary Care Commissioning Committee is requested to review all risks and risk mitigation plans for the cohort of risk under the management of the committee.

Decision Requested (for Decision Log)

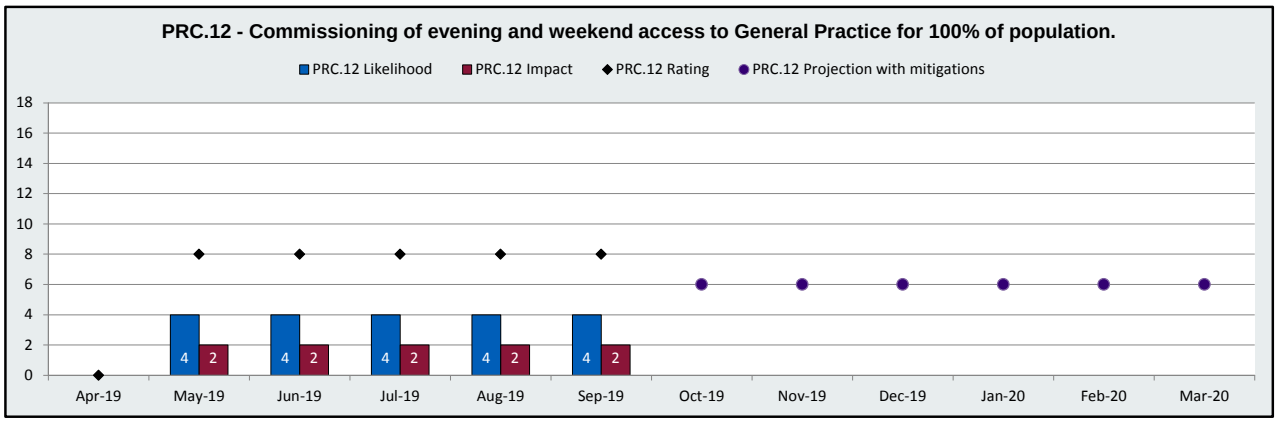
Responsible Executive Director and Title	Report Author and Title
Dr Andrew Lee Executive Director of Primary Care and Population Health	Abigail Combes Head of Legal and Governance

Risk Ref	**PRC.11**
Title	**Estates and Technology Transformation Fund Strategy**
Operational Lead	Stephanie Porter
Lead Director	Accountable Officer
Description and Impact on Care	The CCG has recognised through its estates strategy that investment is required in property to address the need to enhance estate to support service transformation. It has prioritised a small number of schemes it wished to see develop business cases to demonstrate deliverability and affordability. The schemes seek to secure capital grant funds to abate the revenue impact to the CCG. Three new build schemes have been supported by the CCG recognising the need to invest to address under capacity in physical infrastructure. The proposals are affordable taking into account a capital bullet payment via the Estates and Technology Transformation Fund.



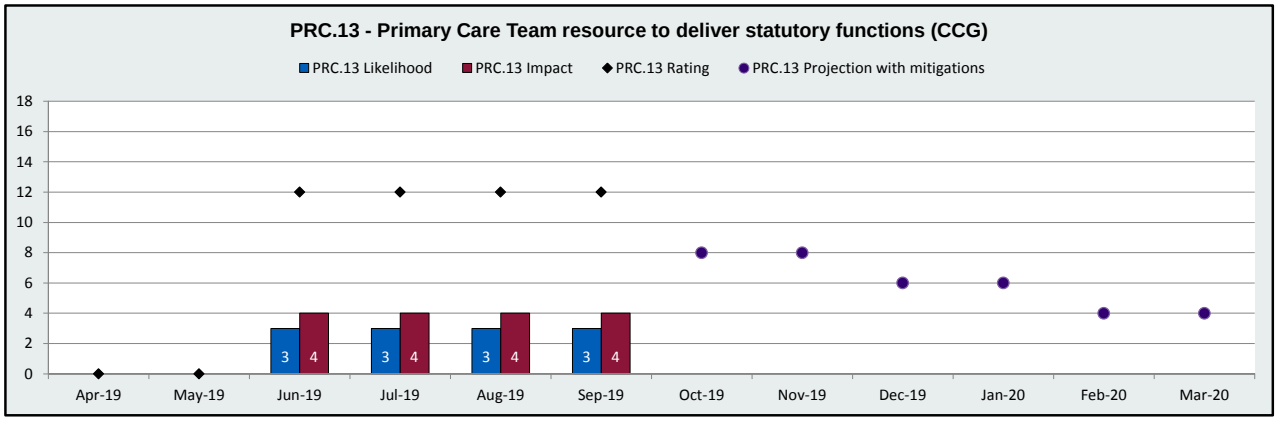
Mitigating Actions and Comments
Date: 12 September 2019
The financial position for two out of the three programmes should become clear in October 2019. If these are as anticipated the risk should reduce according to the predictions. In the event that the funding is not as anticipated the committee will be updated and the risk rating amended.

Risk Ref	**PRC.12**
Title	**Commissioning of evening and weekend access to General Practice for 100% of population.**
Operational Lead	Shaun Macey / Stephanie Porter
Lead Director	Executive Director of Primary Care and Population Health
Description and Impact on Care	Risk relates to the CCG's responsibility to commission evening and weekend access to General Practice services for 100% of its population. This is a national requirement from NHS England, with monthly returns on activity and utilisation rates. A procurement exercise was undertaken and contracts awarded for service provision in the North and Central localities. Currently, no service provision is formally contracted in the South locality.



Mitigating Actions and Comments
Date: 12 September 2019
Implementation of a new service in October 2019 should improve access and therefore improve the delivery of improved access outside of normal contracted working hours. In the event that this is not in place by October as anticipated this will need to be reviewed and the Committee made aware.

Risk Ref	**PRC.13**
Title	**Primary Care Team resource to deliver statutory functions (CCG)**
Operational Lead	Stephanie Porter
Lead Director	Dr Andrew Lee
Description and Impact on Care	The statutory contracting of primary care may be compromised leading to poorer care for the population if the CCG does not hold the appropriate resource including expertise within the CCG team.



Mitigating Actions and Comments
Date: 12 September 2019
The Assistant Director of Primary Care is working to migrate actions and staff to those functions currently supported by NHSE/I with support from the contracting and finance team. These skills need to be transferred into the CCG team. This appears to be improving month on month.