Vale of York
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

11 July 2019, 1.30pm to 3.30pm

Auden Room (GO47), West Offices, Station Rise, York YO1 6GA

AGENDA

Prior to the commencement of the meeting a period of up to 10 minutes, starting at 1.30pm, 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. 1.40pm	Verbal	Welcome and Introductions		
2.	Verbal	Apologies		
3.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
4.	Pages 3 to 10	Minutes of the meeting held on 9 May 2019	To Approve	David Booker Committee Chair
5.	Verbal	Matters Arising		All
6. 1.55pm	Pages 11 to 18	Primary Care Commissioning Financial Report Month 2	To Approve	Simon Bell Chief Finance Officer
7. 2.10pm	Pages 19 to 52	Care Quality Commission Ready Programme	To Receive	Dr Andrew Lee Executive Director of Primary Care and Population Health
8. 2.30pm	Pages 53 to 56	Estates Capital Investment Proposals – Progress Report	To Ratify	Stephanie Porter Assistant Director of Primary Care
9. 2.45pm	Pages 57 to 63	Primary Care Networks Update	To Receive	Stephanie Porter Assistant Director of Primary Care

10. 3.00pm	Pages 65 to 127	NHS England Primary Care Update	To Receive	David Iley Primary Care Assistant Contracts Manager, NHS England and NHS Improvement (North East and Yorkshire)
11. 3.15pm	Pages 129 to 134	Risk Update Report	To Receive	Dr Andrew Lee Executive Director of Primary Care and Population Health
12. 3.25pm	Verbal	Key Messages to the Governing Body	To Agree	All
13.	Verbal	Next meeting: 9.30am, 19 September 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

Vale of York
Clinical Commissioning Group

Item 4

Minutes of the Primary Care Commissioning Committee held on 9 May 2019 at West Offices, York

Present

Keith Ramsay (KR) - Chair	Lay Member and Chair of the Quality and Patient Experience Committee and Remuneration Committee in addition to the Primary Care Commissioning Committee
Simon Bell (SB)	Chief Finance Officer
David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Chris Clarke (CC)	Senior Commissioning Manager, NHS England North Region (Yorkshire and the Humber)
Dr Andrew Lee (AL)	Executive Director of Director of Primary Care and Population Health
Stephanie Porter (SP)	Assistant Director of Primary Care

In attendance (Non Voting)

Kathleen Briers (KB)	Healthwatch York Representative
David Iley (DI)	Primary Care Assistant Contracts Manager, NHS England and NHS Improvement North Region (Yorkshire and the Humber)
Shaun Macey (SM)	Head of Transformation and Delivery
Michèle Saidman (MS)	Executive Assistant
Sharon Stoltz (SS)	Director of Public Health, City of York Council

Apologies

Dr Aaron Brown (AB)	Division Liaison Officer for York and Selby, Yor Local Medical Committee
Dr Paula Evans (PE)	North Locality GP Representative
Phil Goatley (PG)	Lay Member and Audit Committee Chair
Phil Mettam (PM)	Accountable Officer

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

There was one member of the public in attendance.

The following matter was raised in the public questions allotted time.

Bill McPate
At last week's CCG meeting the Integrated Performance Report stated (page 60) that Primary Care Performance and specifically Primary Care Dashboard would be reported at the PCCC. There is no such report on this committee's current agenda.

The CCG concluded in January that it did not support the principle of a dashboard and preferred to rely on a process of "General Practice Intelligence". In making that assertion it was also stated that work was taking place towards routine information being available. It is believed that basic comparative information from GP practices, such as immunisation rates; date of last PPG, family and friends test, % of patients with a named GP; referral rates and 3rd next GP appointment available, would be helpful in assuring that quality in primary care was being delivered.

Could the PCCC please provide an update on primary care quality monitoring and reporting?

Response

AL advised that Public Health England's website https://fingertips.phe.org.uk/ provided data on all the areas referred to; further consideration could be given to additional information.

SP explained the CCG's principle of utilising "soft" intelligence and highlighted this in relation to identifying trends through regular data. She advised that meetings were now taking place with Practices on a six monthly basis to discuss data, including that relating to benchmarking information, from both a qualitative and quantitative perspective with a view to developing a dashboard.

In response to Bill McPate emphasising that his question related to seeking assurance about the CCG's demonstration of accountability for performance and quality, such as a high level quarterly assurance report to the Committee, SP noted that she would incorporate his comments in the ongoing discussions.

Agenda

1. Welcome and Introductions

KR welcomed everyone to the meeting. He particularly welcomed AL and SP to their first meeting since taking up appointment.

2. Apologies

As noted above.

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

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

4. Minutes of the meeting held on 1 March 2019

The minutes of the meeting held on 1 March were agreed.

The Committee

Approved the minutes of the meeting held on 1 March 2019.

5. Matters Arising

PCCC35 – Local Enhanced Services Review 2019/20: SP advised that the review was still ongoing; the Quality Team was currently contributing to the key performance indicators and a report would be presented at the next meeting.

With regard to the concerns about neonatal checks in hospital instead of the community, SS had provided the following response: "Unfortunately Michelle Carrington and I have not had an opportunity to discuss this yet but I have established with Public Health England (PHE) that they are rolling out a new IT system for the Newborn Infant Physical Examination which became operational on 1 April. They have focused on cascading the training on the new system in NHS Trusts. Currently GP Practices do not have access to this new system. I have flagged this as a concern with the PHE screening and immunisation co-ordinator but I suggest that the CCG also raise the issue as part of the maternity services contract review meeting with York Hospital to establish how they are intending to work in partnership with GP Practices on the roll out of the new system. Most infants will have their Newborn Infant Physical Examination done in hospital before discharge but if not they should still be able to access this routine examination in the community and not be required to return to hospital to have it done unless this is absolutely necessary." KR requested that Michelle Carrington be asked to provide an update to the next meeting.

The Committee

1. Noted the updates.
2. Requested that Michelle Carrington be asked to provide an update on neonatal checks for the July meeting.

6. Primary Care Commissioning Financial Report Month 12

SB referred to the report that presented the 2018/19 financial outturn position for delegated commissioning and other primary care and also the associated draft financial plan for 2019/20. He explained that, as a plan compliant with the delegated control total had not yet been agreed by the York and Scarborough system, the CCG's financial plan remained a draft and subject to ongoing discussion with NHS England and NHS Improvement. SB noted however that he did not anticipate any further impact on the primary care budget from these ongoing discussions.

SB reported that the delegated commissioning position in the draft accounts was an overspend of £54k and noted the overspend in Other Primary Care was largely due to the £514k for primary care prescribing. Despite the latter SB commended both the CCG's Prescribing Team and GPs for their management of the overall prescribing position referring to the context of the c£1.0m No Cheaper Stock Obtainable impact which had not been expected in 2018/19. He noted that NHS England had resourced approximately half.

SB advised that 2019/20 would continue to be financially challenging noting the emerging clarity of allocations and associated funding expectations. He also emphasised that despite this there were opportunities such as the development of Primary Care Networks. SB noted, however, particular concern about the primary care

prescribing savings target, particularly in the context of Brexit despite previous achievements and the fact that the CCG was the most effective and efficient in the North Region in this regard. . He explained that the £2.4m contingency reserve within the draft financial plan would be maintained to mitigate the prescribing challenge.

Members sought and received assurance regarding the work to maintain control over primary care prescribing, including medicines optimisation and focus on right medicines at the right time used correctly. Local variation in prescribing costs was also noted.

The Committee:

Received the month 12 Primary Care Commissioning Financial Report.

7. Primary Care Networks

AL referred to the report which updated on the Primary Care Team's progress in engaging with Practices in relation to Primary Care Networks in terms of the registration process and formation of groupings of populations between 30,000 and 50,000. The position to date was two proposed Primary Care Networks for the South Locality, one of which was just under 30,000 population; one for the North Locality; and potentially five for the Central Locality, expected to be confirmed within the requisite timescale of submission of registration documents to the CCG by 15 May and formal submission to NHS England by 31 May.

SP explained that the CCG was working with Practices to ensure the validation and submission dates were met, noting that the establishment of localities was assisting the process and that the CCG's role was one of validation rather than approval of Primary Care Networks. SP additionally explained that the CCG would have a governance role as the groups of GPs became established in working at scale to deliver services more efficiently and collaboratively in the community.

Discussion ensued in the context of the recent national reporting of reduced number of GPs; services being provided by other healthcare professionals, such as physiotherapists and health navigators; establishment of new roles, for example social prescribing; and the intention being to localise health care provision to suit populations but without raising expectations of Primary Care Networks before they had time to become established.

The Committee:

Received the update on Primary Care Networks registration noting that the requisite timescales were expected to be met.

8. Draft Humber, Coast and Vale Health and Care Partnership Primary Care Strategy

In presenting the draft Primary Care Workforce Strategy, which formed part of the supporting suite of documents within the Humber, Coast and Vale Partnership Primary Care Strategy, SP noted that this was an NHS England and NHS Improvement

requirement in the context of funding flows to Primary Care Networks and associated recruitment and retention of professionals. SP also noted it as one of a number of strategies being formulated, including an Estate Strategy, and explained that a data cleanse was required for some aspects of the draft Strategy presented.

SP explained that the strategy included the context of workforce at national, regional and local levels highlighting shared planning over a larger footprint as appropriate. She also noted that work had begun with the Nursing Team in terms of addressing vacancies through training opportunities and commended the work of Haxby Group as a training Practice.

DB expressed concern at the disparity between the guaranteed student placement tariffs for GPs and nurses noting the need for equity to recruit a workforce with wider skills. In response discussion ensued in the context of national training deficiencies, associated requirements for supervision by staff who were already struggling with capacity, the national context of GP recruitment, the fact that GP Practices are businesses and acknowledgement that many GPs work a 12 hour day. The need for patient education in terms of not always seeing a doctor was also emphasised.

SP confirmed that, following further engagement, the Primary Care Workforce Strategy would be presented at a future meeting of the Governing Body.

The Committee:

Received the draft Primary Care Workforce Strategy.

9. NHS England Primary Care Update

DI presented the report which provided updates under the headings of: contractual aspects relating to the GP Contract Five Year Framework, Special Allocation Scheme - including the Process for Patient Appeal, Provider Challenge or Exceptional Discharge Review Panel - and Primary Care Commissioning Activity Report; and, under the GP Forward View, the Funding Programme for 2019/20.

DI additionally reported, further to previous discussion and support for expansion of the Carlton Branch of Beech Tree Surgery through the Estates, Technology and Transformation Fund, work had now begun and the branch surgery would be closed for five months, until September 2019. DI detailed the processes undertaken by the Practice to assure members that patients had been informed of the closure and advised that community transport to Selby was being provided three times a week for them. He noted that the Committee would be kept informed about this development.

Members sought and received clarification on a number of aspects of the report.

The Committee:

Received the NHS England Primary Care Update noting the additional information on Carlton Branch of Beech Tree Surgery.

10. Risk Update Report

SP referred to the report which provided 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; an overview of programme risk was also included. A full update of the CCG's Board Assurance Framework was currently taking place and associated risks and those arising from the latest NHS England CCG Improvement and Assessment Framework were being compiled.

SP explained the *Risk PRC.11 Estates and Technology Transformation Fund Strategy* related to three new build schemes which were dependent on the CCG accessing capital to make the revenue affordable. This risk was being managed with support from NHS England and NHS Improvement and a positive resolution was expected.

The Committee:

Received the Risk Update Report.

11. Key Messages to the Governing Body

The Committee:

- Noted that despite the achievements of the Medicines Management Team the prescribing budget continued to pose concern and challenge
- Welcomed the update on Primary Care Networks
- Welcomed the draft Workforce Strategy but noted the associated challenges and the need for data cleansing

The Committee:

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

Additional Item

KB sought clarification about GP Practice cover arrangements during the protected learning time events in light of a patient having raised an issue with Healthwatch that the hospital had not been aware of the Practice closures. KR noted that no significant issues had been raised by GPs following the events to date but requested a report to the July Committee on communication of the arrangements. *Post meeting note: This matter was one of a number of matters for discussion at a meeting scheduled for 4 June between Siân Balsom, Manager, Healthwatch York, and PM.*

The Committee:

Requested an update on communication about GP Practice cover arrangements during closure for protected learning time.

12. Next meeting

1.30pm on 11 July 2019 at West Offices.

SB noted that this was KR's last meeting of the Committee and expressed appreciation on behalf of members and the CCG.

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 9 MAY 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 • SS to discuss with Michelle Carrington concerns about neonatal checks in hospital instead of the community • Update to be provided at next meeting	Head of Primary Care SS Michelle Carrington	9 May 2019 11 July 2019 1 March 2019 11 July 2019
PCCC36	1 March 2019	£3 per head Locality Updates	• Progress report to September meeting	SM	19 September 2019
PCCC37	9 May 2019	Additional Item	• Update on communication about GP Practice cover arrangements during closure for protected learning time	AL	11 July 2019

Item Number: 6

Name of Presenter: Simon Bell

Meeting of the Primary Care Commissioning Committee **11 July 2019**	NHS Vale of York Clinical Commissioning Group

Primary Care Commissioning Financial Report Month 2

Purpose of Report:
For Approval

Reason for Report

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

This paper also requests approval to support additional roles for each of the three Nimbuscare Primary Care Network (PCN) sub-networks and the distribution of the Personal Medical Services (PMS) premium monies.

To provide an update on the allocation for Improving Access to General Practice.

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

The Primary Care Commissioning Committee is asked to note the financial position of Primary Care Commissioning as at Month 2.

The Primary Care Commissioning Committee is asked to approve support for additional roles for each of the three Nimbuscare sub-networks.

The Primary Care Commissioning Committee is asked to approve the distribution of PMS premium monies to PCNs.

The Primary Care Commissioning Committee is asked to note the allocation and distribution of Improving Access to General Practice.

Decision Requested (for Decision Log)

To support additional roles for each of the three Nimbuscare sub-networks.

To approve the distribution of PMS premium monies to PCNs.

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

Appendix A – summary of funding due to PCNs

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

Report produced: July 2019

Financial Period: April 2019 to May 2019

Introduction

This report details the year to date financial position as at Month 2 and the forecast outturn position of the CCG's Primary Care Commissioning areas for 2019/20.

It also includes details on the 2019/20 PMS premium monies and how they could be distributed to practices as well as an update on the allocation for Improving Access to General Practice.

Delegated Commissioning Financial Position – Month 2

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

Delegated Primary Care	Month 2 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Primary Care - GMS	3,667	3,667	0	22,003	22,003	0
Primary Care - PMS	1,547	1,494	52	9,279	9,279	0
Primary Care - Enhanced Services	199	199	0	1,106	1,106	0
Primary Care - Other GP services	592	592	0	4,388	4,388	0
Primary Care - Premises Costs	739	739	0	4,434	4,434	0
Primary Care - QOF	728	728	0	4,367	4,367	0
Sub Total	**7,472**	**7,420**	**52**	**45,578**	**45,578**	**0**

- The draft plan included total expenditure for delegated primary care of £45,808k. A contingency of £229k (0.5%) as per the planning requirements is recorded within the CCG core budget, reducing the total above to £45,578k.

- Forecast outturn is £45,578k as per the plan.

- **GMS** contracts have been accrued to budget at Month 2. The budgets are based on current contract costs including an uplift of 1.09%. MPIG budget is as per current contract, which has reduced by 50% compared to 2018/19.

- **PMS** contracts have been accrued to budget at Month 2. The budgets are based on current contract costs including an uplift of 0.57%. List size adjustments were accounted for twice in error during the planning stage and as a result £77k has been moved to reserves. The year to date underspend relates to the PMS premium monies; the allocation for which will be transferred into the CCG core budget.

- **Enhanced Services** have been accrued to budget at this stage pending finalisation of 2018/19 costs.

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

Other GP Services	Month 2 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Dispensing/Prescribing Doctors	341	341	0	2,201	2,201	0
PCO Administrator	176	176	0	1,060	1,060	0
GP Framework	103	103	0	1,232	1,232	0
Needle, Syringes & Occupational Health	3	3	0	19	19	0
Reserves	(31)	(31)	0	(124)	(124)	0
Sub Total	**592**	**592**	**0**	**4,388**	**4,388**	**0**

The **Dispensing Doctors** budget has been re-profiled based on the seasonal phasing of 2018/19 actuals. The position is accrued to budget at this stage as payments are made two months in arrears.

PCO Administrator is accrued to budget pending locum claims.

GP Framework budgets are profiled based upon the number of Primary Care Networks confirmed by contracting and when the payments fall due. The original plan was based upon 10 PCNs and estimated staffing costs for the additional roles. Six PCNs have now been confirmed, with the Nimbuscare PCN made up of three sub-networks. The budgets have been updated for the additional roles in line with the national guidance for staffing costs and the final number of PCNs. NHS England guidance suggests that the Nimbuscare PCN should be allocated funding for two of each of the additional roles (as they have a patient list size over 100,000) but this is subject to local approval. The plan includes funding for additional roles for each of the three sub-networks. **The Committee is requested to approve the funding for additional roles for each of the three sub-networks.** The recalculation of costs in relation to additional roles has resulted in a £30k reduction which been moved to reserves. Network Participation and Clinical Director budgets remain unchanged. This has been accrued to budget pending further information on the take up of the additional roles.

Needle, Syringes & Occupational Health accrued to budget at Month 2 as no information for 2019/20 spend as yet.

The shortfall of £230k included in **reserves** during the planning stage has now been offset with £77k in relation to PMS list size adjustment duplication and £30k balance from the GP Framework.

- **Premises** budgets are based on current costs including any revaluations due this financial year. Business rates budgets are as per the forecast provided by GL Hearn. Premises costs have been accrued to budget at this stage.

- The **QOF** achievement for 2018/19 will be paid in Month 3 and has been accrued to budget in Month 2. The QOF accrual for 2019/20 will be based on 2018/19 points and prevalence at 2019/20 price with a 1.2% demographic growth assumption.

- **Other Primary Care**

Primary Care within the core CCG budget is included in this paper, to ensure the Committee has awareness of the wider spend in primary care.

Primary Care	Month 2 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Primary Care Prescribing	8,031	8,116	(85)	47,319	47,319	0
Other Prescribing	330	345	(15)	1,978	1,978	0
Local Enhanced Services	374	404	(31)	2,242	2,242	0
Oxygen	62	62	0	371	371	0
Primary Care IT	138	132	6	826	826	0
Out of Hours	541	558	(17)	3,247	3,247	0
Other Primary Care	11	95	(85)	63	63	0
Sub Total	**9,485**	**9,712**	**(227)**	**56,046**	**56,046**	**0**

The year to date prescribing position is overspent as no QIPP is expected in Month 1 and 2 (prescribing data is only available two months in arrears). Budgets for PIB 2 have been prepared and the Medicines Management team are working up QIPP plans with a view to achieving the QIPP target across the year. The year to date position of Other Primary Care is also overspent due to the phasing of the £600k QIPP.

2019/20 PMS premium monies

The delegated commissioning plan includes £313k in relation to PMS premium monies. This allocation should be used to benefit all of Primary Care but can be distributed as determined by the CCG. The table below shows the distribution of the monies by individual practice and PCN (based upon weighted list size as at 1 January 2019 – the measure used to calculate the Network Participation payment).

Practice Name	Weighted List Size 1st Jan 2019	Practice Level PMS Premium
Dalton Terrace Surgery	8,304.81	£ 7,430.12
Jorvik Gillygate Medical Practice	19,118.64	£ 17,105.00
East Parade Medical Practice	2,377.85	£ 2,127.41
Unity Health	14,652.79	£ 13,109.51
York City Centre PCN	**44,454.09**	**£ 39,772.04**
York Medical Group	40,219.95	£ 35,983.85
YMG PCN	**40,219.95**	**£ 35,983.85**
Old School Medical Practice	7,243.61	£ 6,480.69
Front Street Surgery	7,830.68	£ 7,005.93
Haxby Group Practice (incl. Gale Farm)	33,974.79	£ 30,396.45
Priory Medical Group	52,809.60	£ 47,247.52
Elvington Medical Practice	7,240.81	£ 6,478.18
MyHealth	19,581.07	£ 17,518.73
Pocklington Group Practice	16,736.49	£ 14,973.75
Nimbuscare PCN	**145,417.05**	**£ 130,101.25**
Central Locality PCNs	**230,091.09**	**£ 205,857.14**
Millfield Surgery	7,826.54	£ 7,002.22
Tollerton Surgery	3,273.16	£ 2,928.42
Stillington Surgery	3,959.35	£ 3,542.34
Pickering Medical Practice	11,799.70	£ 10,556.92
Helmsley Medical Centre	3,924.49	£ 3,511.15
Terrington Surgery	1,475.54	£ 1,320.13
The Kirkbymoorside Surgery	6,565.55	£ 5,874.04
SHAR South Hambleton & Ryedale PCN	**38,824.33**	**£ 34,735.22**
North Locality PCN	**38,824.33**	**£ 34,735.22**
Beech Tree Surgery	17,314.36	£ 15,490.75
Posterngate Surgery	17,862.91	£ 15,981.53
Scott Road Medical Centre	10,253.36	£ 9,173.44
Escrick Surgery	6,519.50	£ 5,832.84
Selby Town PCN	**51,950.13**	**£ 46,478.57**
Sherburn Group Practice	9,605.97	£ 8,594.24
South Milford Surgery	10,209.76	£ 9,134.43
Tadcaster Medical Centre	9,085.28	£ 8,128.39
Tadcaster & Selby PCN	**28,901.01**	**£ 25,857.06**
South Locality PCNs	**80,851.14**	**£ 72,335.63**
Total	**349,766.56**	**£ 312,928.00**

It is recommended that PMS Premium monies are distributed to practices via PCNs with no conditions on use to allow the PCNs to determine the best use of the funds.

Appendix A includes a summary of all funding due to PCNs for 2019/20 including the proposal above.

Improving Access to General Practice

Allocation of £2m for Improving Access to General Practice has been received in Month 3 and is based upon a population list size of 333,394 at £6 per head. NHS England has used the list size as at September 2016 uprated according to ONS forecast population increases to calculate the allocation. This list size differs significantly to current list sizes and as such the total allocation has been pro-rated across the localities according to the weighted list size as at 1st April 2019. The table below shows how the allocation will be distributed into contracts across the localities. Note that the population for Tadcaster is included in the allocation for the Central locality as agreed via a contract variation in 2018/19.

Locality	Weighted list size as at 01/04/19	Proportion of list size %	Improving Access allocation £
North	38,975.69	11.11	222,278
Central	239,704.95	68.34	1,367,033
South	72,076.77	20.55	411,053
Total	**350,757.41**	**100.00**	**2,000,364**

Recommendation

The Primary Care Commissioning Committee is asked note the financial position of the Primary Care Commissioning budgets as at Month 2, agree to support three additional roles for the Nimbuscare PCN, approve the allocation of PMS premium monies to PCNs and note the contract values for the Improving Access to General Practice scheme.

Appendix A - summary of funding due to PCNs

Allocation	Description	North	Central				South			Total
		South Hambleton and Ryedale PCN	York City Centre PCN	YMG PCN	Nimbuscare PCN	Total Central	Selby Town PCN	Tadcaster and Selby PCN	Total South	
Primary Care	Growth and uplifts	£ 100,939	£ 39,755	£ 26,635	£ 221,416	£ 287,807	£ 118,793	£ 64,542	£ 183,334	£ 572,080
Primary Care	£1.76/ head Network funding – engagement payments to practices	£ 68,369	£ 78,284	£ 70,827	£ 256,080	£ 405,191	£ 91,485	£ 50,894	£ 142,379	£ 615,939
Primary Care	£0.51/ head PCN clinical directors	£ 17,836	£ 27,445	£ 22,758	£ 76,133	£ 126,336	£ 25,396	£ 14,427	£ 39,823	£ 183,995
Core	£1.50/ head contribution to PCN effectiveness (continuation of 18/19)	£ 52,459	£ 80,723	£ 66,935	£ 223,922	£ 371,580	£ 74,694	£ 42,431	£ 117,125	£ 541,164
Primary Care	Clinical staff – pharmacist, social prescribing link worker (9 months)	£ 53,942	£ 53,942	£ 53,942	£ 161,826	£ 269,710	£ 53,942	£ 53,942	£ 107,884	£ 431,536
Primary Care (PMS)	PMS premium	£ 34,735	£ 39,772	£ 35,984	£ 130,101	£ 205,857	£ 46,479	£ 25,857	£ 72,336	£ 312,928
	TOTAL	£ 328,281	£ 319,921	£ 277,081	£ 1,069,478	£ 1,666,481	£ 410,788	£ 252,093	£ 662,881	£ 2,657,642

Item Number: 7

Name of Presenter: Dr Andrew Lee

Meeting of the Primary Care Commissioning Committee **Date of meeting: 11 July 2019**	NHS Vale of York Clinical Commissioning Group

Report Title – Care Quality Commission Ready Programme

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

Reason for Report

To inform the Committee of the ability of Practices to meet the core essential standards for registration with the Care Quality Commission (CQC) and to consider how the CCG can support practices to address the gaps identified.

This report was presented at the Quality and Patient Experience Committee on 11 April 2019.

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

N/A

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

N/A

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**
Dr Andrew Lee Executive Director of Primary Care and Population Health	Lynn Lewendon, Senior Manager Practitioner Performance (NHS England) Sarah Goode, CCG Quality Lead for Primary Care

Annexes

Appendix A. CQC Ready Self-Assessment

Appendix B. Anonymised Responses (all domains)

Appendix C: Safe

Appendix D: Effective

Appendix E: Caring

Appendix F: Responsive

Appendix G: Well Led

Index

1. Introduction and Background

As registered providers of healthcare, it is essential all GP practices meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). The Care Quality Commission (CQC) assesses every GP practice in England against a set of standards outlined in the Act, through a programme of inspections. This inspection then results in the practice being rated as Outstanding, Good, Requires Improvement or Inadequate.

If a practice is found to be in breach of these standards, i.e. given a rating of requires improvement or inadequate, then regulatory action is taken by CQC. This can take the form of:

- Issuing requirement notices or warning notices to set out what improvements the practice must make and by when.
- Making changes to a registration to limit what services they can provide, by imposing conditions for a given time.
- Placing a provider in special measures, which results in close supervision of the quality of care while working with other organisations to help them improve within set timescales.
- Issuing cautions or fines, and where people are harmed or at risk of harm through inadequate services they can prosecute.
- Withdrawal of registration.

Practices within the Vale of York are sub-divided into 3 localities - North, South and Central. All had been inspected by CQC between March 2015 and June 2017. All had received a rating of good with 14 practices being given a rating of outstanding in a specific domain.

The first round of repeat inspections started in May 2018 and the first practice inspected was given a rating of inadequate in all but one domain and rated inadequate overall, therefore being placed in special measures.

The aim of special measures is to

- Ensure that providers found to be providing inadequate care significantly improve in an agreed timescale.
- Ensure that commissioners and other organisations work together with the practice to guarantee that the required improvements are made and support is provided to the practice to achieve this.
- Provide a framework within which CQC use their enforcement powers in response to inadequate care.
- Make it clear to the provider that if the required improvements are not made CQC will take action to cancel their registration.

Practices that are given a rating of inadequate for a single key question or for a population group will not be paced in special measures but will be re-inspected

within six months. However, if there is still a rating of inadequate for any key question or population group after six months, the practice will then be placed into special measures.

Once a practice is placed in special measures they are given a full six months to make the required improvements, before any re-inspection. During this time the CQC is likely to take enforcement action in relation to the breaches in regulations of the Health and Social Care Act they have found. The practice is also required to display this rating within the practice and on their website and the published report of the CQC inspection is publicly available.

Notification to commissioners (NHS England) and other regulators is also made by CQC. NHS England and the General Medical Council (GMC) may wish to investigate further, dependent on the concerns raised as a result of the inspection.

Both the GMC and NHS England may consider there is a need for formal Performer List sanctions for the General Practitioners involved, or an interim order restricting their scope of practice.

If the practice has been found in breach of contract the CCG would also consider any requirement for contractual breach or remedial notices at this time.

Following this six-month period, the practice is re-inspected and if the CQC feel the practice has made sufficient progress, they will remove it from special measures.

If sufficient progress has not been made at re-inspection and a rating of inadequate is given for any key question, population group or as an overall outcome, further action to prevent the practice from operating, either by proposing to cancel its registration or vary the terms of its registration is commenced at this stage.

Any proposed action has a 28-day appeal period but sanctions at this stage can be swiftly enacted leaving commissioners with the responsibility to ensure any affected patients can still access the full range of services they are entitled to.

As demonstrated above, the consequences of an inadequate finding on inspection by the CQC are significant. The CCG therefore recommended this CQC Getting Ready programme be implemented to identify and support those practices that may be in a similar position to the one identified by CQC.

2. Methodology

Each practice was asked to complete a self-assessment questionnaire (see Appendix A) and return this to the CCG quality team within 4 weeks of it being sent out.

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

All practices were offered a table top review of the evidence they proposed to use to demonstrate compliance with the standards; but to assure validity of the submissions a 20% validation exercise was proposed, whereby visits to practices chosen at

random would be undertaken by a member of the quality team with NHS England support to review the evidence.

As a measure of the success of the programme 96% (25/26) of practices requested a table-top review, meaning that random audit was no longer required. Individual feedback was therefore given to every practice at the table-top review meeting.

Results of the self-assessments have been analysed and presented in both graph form and numerical data, with identified themes providing clear areas for development.

Percentage compliance rates were analysed as follows:

- A score of 1 was given for each criterion where the practice had self-assessed as being able to evidence full compliance.
- A score of 0.5 was given for each criterion where the practice had self-assessed as being able to evidence partial compliance.
- A score of 0 was given for each criterion where the practice had self-assessed as not being able to evidence compliance.
- The total score for each domain was then divided by the total possible score thus giving a percentage compliance score.

Areas of exemplar practice have been shared across the locality, along with the availability of features within clinical systems or support available through sources that are not widely known.

The findings of the programme will be fed-back through the Practice Manager's forum; GP Practice bulletin and individually, with each practice being given a unique identifier code to enable them to identify how they benchmark against their peers for each domain and/or criterion.

3. Findings

There was an evident lack of awareness amongst practices of the CQC powers to act and sanctions they can impose. Likewise, the triangulation of information between the CQC, the CCG and NHS England was generally not something many practices were aware of.

Specifically, the disclosure that the GMC would be notified if a practice was placed in special measures and information in relation to the performance of those GP partners would be sought from NHS England (as part of their Performer List status) was something that GPs were not aware of.

3.1 Self-assessments

The accuracy of these very much depended on who was involved in completing them, and as the programme progressed it was noticeable that there was a greater emphasis on accuracy with involvement of the wider operational and clinical teams.

A table showing all the self-assessments can be found at Appendix B.

As the CCG was aware of imminent visits for some practices it was felt important that they had the benefit of a table-top review if they wished this. However, without

being able to disclose a visit was imminent there was a need for some persuasion by the quality team that the review took place sooner than later.

This need for an early submission and review did put those practices at a slight disadvantage and this is demonstrated in their self-assessment scores, which were completed prior to the wider sharing of information. However, feedback at the table top reviews and support from the Primary Care Quality Lead to act on the gaps identified, ensured that each of these practices went on to have a successful CQC inspection and were found to be compliant across all domains.

3.2 Table top reviews

These reviews were almost always multi-disciplinary meetings with clinical and non-clinical operational staff present, with the exceptions noted above.

They generally took around two and a half to three hours and gave an opportunity for practice staff to share examples of proposed evidence; to discuss the form of their current processes in place to meet the requirements and for the quality team to signpost them to information generally available or to share specific information they were aware of through other quality programmes or previous reviews.

Feedback from those involved in these reviews was sought by email several days after the visit, to ascertain how useful this time away from front-line services had been. Without exception everyone had felt this had been a valuable use of their time and they had all learned something that they weren't aware of prior to the visit.

4. Compliance across the domains

Overall, compliance across all domains was found to be high although as previously noted practices who submitted their self-assessments earlier in the programme self-assessed lower than those who sent them in later.

This seemed to reflect a general loss of confidence in their own ability to show that they are meeting of all the standards and a general nervousness about the CQC process and how they could demonstrate they do what they say they do. Evidence at the table-top reviews demonstrated that practices had often marked themselves as non-compliant where a question had several elements to it and they were unsure if they could demonstrate compliance with each element of that criteria. A good example of this is the question about managing children at risk, with the three elements being

I. Can you demonstrate how children at risk are managed?
II. Is there a flag?
III. Do you attend meetings?

The table top review found that some practices had assessed themselves as non-compliant as they did not attend meetings, despite being able to show that they did have a flag on records and liaised very closely with health visitors and midwives as required, to ensure that children at risk are kept safe.

Where the table-top review did find a lack of evidence and non-compliance with specific criterion practices all acted on this feedback. It was often found that practices had implemented changes to their systems and processes from the time of

submitting their original self-assessment to the time we undertook the table-top review.

The table below shows the number of practices who self-assessed as achieving good, moderate or poor compliance within each domain.

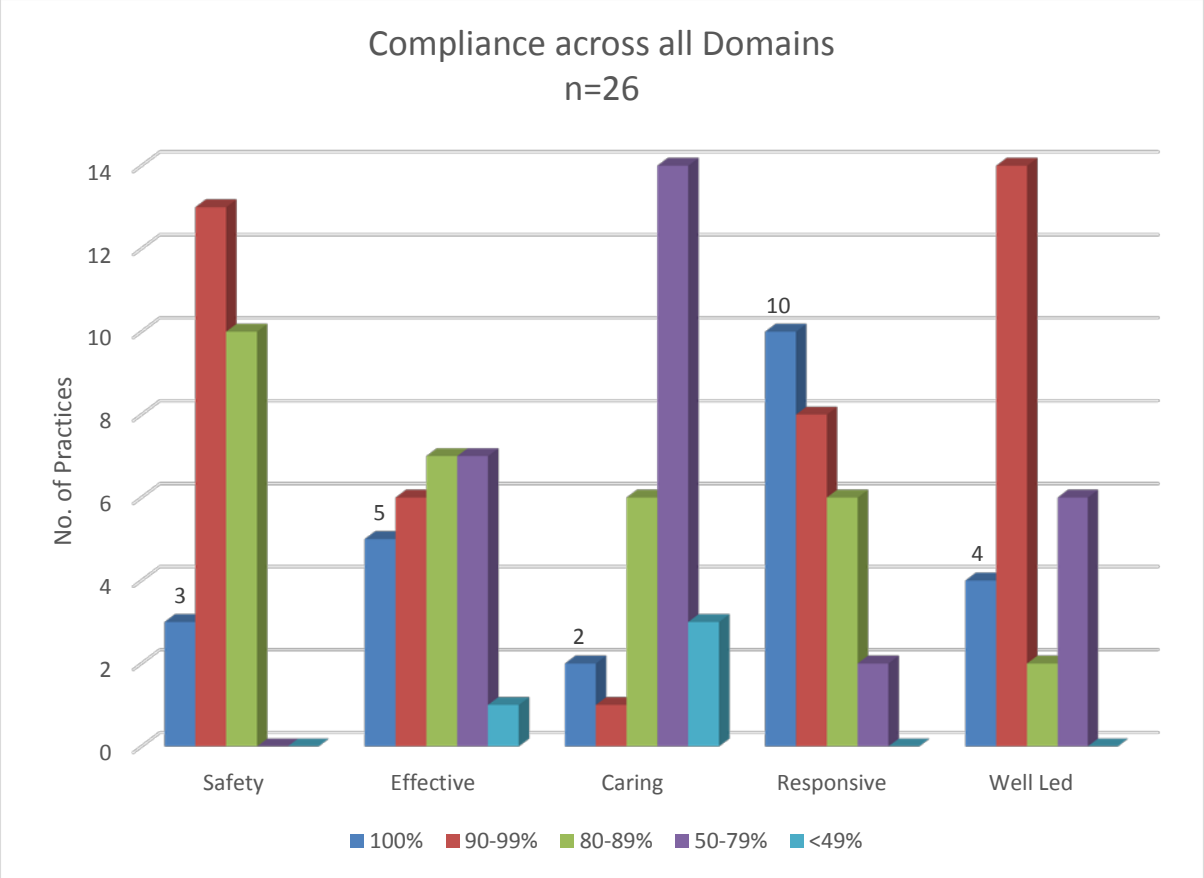
Domain	**Safety**	**Effective**	**Caring**	**Responsive**	**Well Led**
% compliance	**No. of practices**				
100%	3	5	2	10	4
90-99%	13	6	1	8	14
80-89%	10	7	6	6	2
50-79%	0	7	14	2	6
49% or less	0	1	3	0	0

Only two practices rated themselves high enough to be in the top 5 practices across all domains with a third practice doing so for 4 out of 5 domains. To be in the top 5 practices within any domain self-assessed scores ranged between 86% to 100%.

Practices rated themselves highest for the Responsive domain with 10 practices self-assessing as 100% compliant.

Scores of greater than 90% compliance were found in the following order across the domains:

Well-Led	18 practices
Responsive	18 practices
Safe	16 practices
Effective	11 practices
Caring	3 practices



4.1 Safety Domain

Reassuringly this domain was found to have the least variation and on the whole practices felt confident that they could demonstrate compliance with the requirements for this domain.

The scores ranged from 83% to 100% with 3 practices rating themselves as 100% compliant.

The most frequently cited criteria where practices were unsure were as follows, with a full breakdown shown at Appendix C:

A8: Can you demonstrate how you monitor and follow-up when children are not brought to appointments following referral to secondary care or for immunisation?

The gap here was primarily around not having the Did NOT Attend policy updated to reflect the more recent terminology of “child not brought”. Several practices were aware that a flag was placed on a record if a child was not brought but they were not able to explain fully what process was followed thereafter.

Non-attendance for immunisation was not routinely followed up at a practice level as this was thought to be managed by health visitors. Although we did hear some practices using the SystmOne clinical system (which is the same clinical system health visitors use) would send an internal message via the system to the health visitor informing that the child had not been brought.

A19: Can you demonstrate appropriate risk assessments have been completed for all substances that meet COSHH regulations?

All practices had risk assessments for some substances that met COSHH regulations but were unsure if they had them for all substances. Several practices used contract cleaners and so this was an area they would need to seek assurance from them.

A22: Can you provide an up to date infection control audit and demonstrate changes made as a result of the audit findings

Infection control audits seem to be forgotten when practices get busy and these were on most practices "to do" lists. These generally consisted of hand-washing audits and room inspections. Feedback was given that an audit of antibiotic prescribing could be used to support this criteria and would allow the practice to review their antibiotic stewardship at the same time.

A23: Do all privacy screens and flooring meet the required infection prevention and control standards?

Several practices were unsure of the requirements for clinical areas versus consultation rooms and had therefore marked themselves lower where in fact they did have the correct flooring in place.

Guidance on the cleaning and replacement of privacy screens had recently been amended to be less prescriptive and so had led to some hesitancy in practices feeling assured that they knew what the requirements are.

Areas of Good Practice

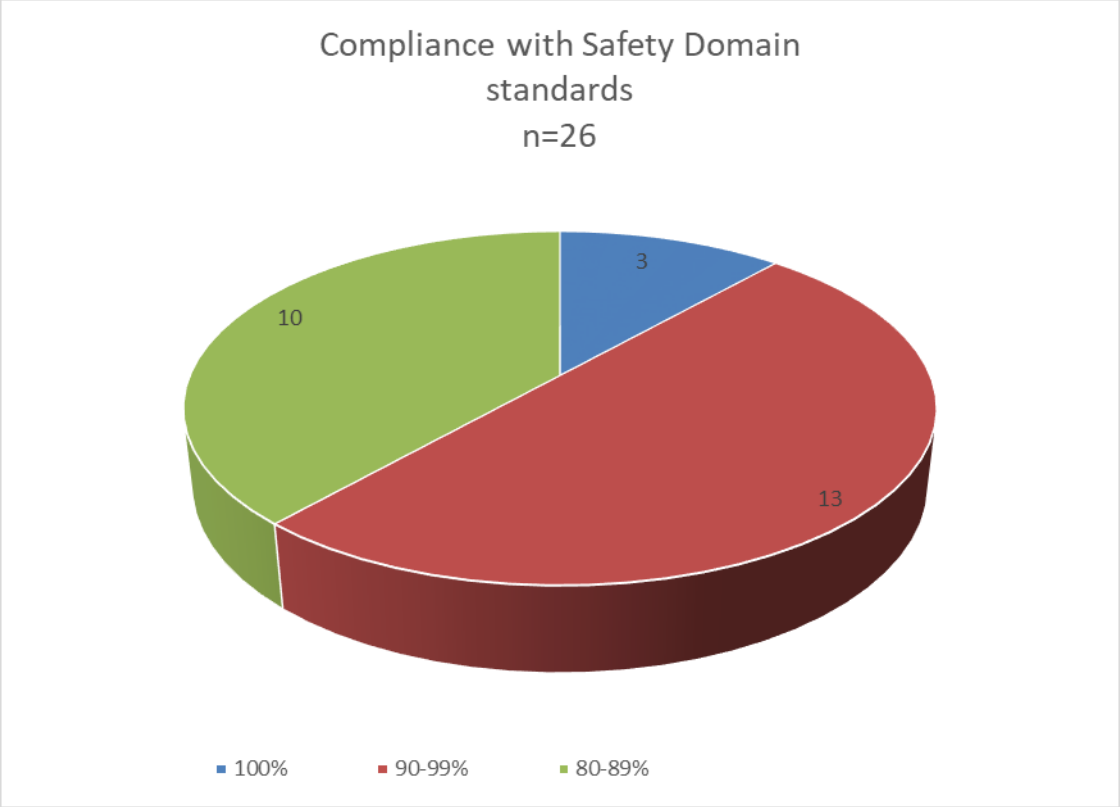
All practices had incident reporting procedures and systems in place as well as a mechanism for providing feedback within the practice, but there was no mechanism in place to share any learning at a wider level. The current Yor-Insight facility on the CCG web pages was not widely known about and very few practices had used it to report an incident.

Training on the management and recognition of sepsis was fully embedded in all practices and several practices told us about cases where reception staff had identified ill patients in the waiting areas and had arranged for them to be seen by a clinician immediately.

One practice we spoke to had introduced an "Interruption protocol" for reception staff to use, detailing specific scenarios when they should interrupt a clinician.

The management of safety alert bulletins (SABs) and updates from National Institute for Health and Care Excellence (NICE) or Medicines and Healthcare products Regulatory Agency (MHRA) has been strengthened as a result of the programme. In around half of practices these only went to one named person to distribute further, and so were only actioned if that person was at work. This has now been changed to come to a generic inbox or to more than one person thus ensuring these are actioned in a timely manner.

Another practice had sent a healthcare assistant (HCA) on infection prevention and control training course to enable her to undertake infection control audits and act as the Infection Control lead within the practice, resulting in up-to-date infection control audits.



4.2. Effective Domain

Self-assessments for this domain showed the most variation along with the responses for the caring domain. Scores ranged from 46% (where it was felt the practice could only evidence 6 of the 14 criteria) to 100%. Five practices scored themselves as 100%.

The lowest scoring practice had taken an “all or nothing” approach to the self-assessment for this domain as there was no clinical input into the self-assessment and therefore did not rate any area as “can partially evidence”.

At the table top review when further explanation of the types of evidence required to demonstrate compliance was discussed it was found that there was evidence to demonstrate compliance with the criteria.

All practices had said they felt confident they were able to demonstrate full compliance with the criteria (B14) Robust arrangements for revalidation and appraisal and clinical supervision for staff that require this are in place. However, at the table-top reviews nursing staff appraisals were often identified as not fully completed in contrast to other staff groups.

The most frequently cited criteria where practices were unsure were as follows, with a full breakdown shown at Appendix D:

B7. Do clinical staff have an appropriate tool to assess patients in pain?

This was a universal gap across all practices but those who submitted self-assessments later told us that they were now able to demonstrate this as a result of the information the Primary Care Quality Lead had distributed earlier in the programme when this was identified. This allowed them to show 100% compliance.

B8. Is this tool adapted to assess the level of pain in patients who have difficulties with communication?

Again this was a universal gap, but through undertaking table top reviews with practices we found that for those practices using Arden's templates (a clinical software add-on for SystmOne practices) these pain assessment tools are included in the templates. This was generally not known to the clinicians using the software beforehand and so has had a positive impact for patients who have difficulty with communication.

B11. Do you have a system in place to monitor and follow-up patients with poor mental health who fail to attend or fail to collect their medications, including for patients with dementia?

This was an identified gap across most practices and is an ongoing piece of work in progress to address this. It was found that dispensing practices had a system in place as they could physically see the medications that had not been collected and therefore a task would be sent to a clinician to follow up that patient.

With the wider use of e-prescribing this is becoming more difficult. Most practices are taking a pragmatic view to it by agreeing a list of "top ten medications" that they would be concerned about if a patient did not collect – for example Lithium and other anti-psychotic and mood stabilising medications, and having a discussion with their local pharmacy to alert them if such a prescription is not collected.

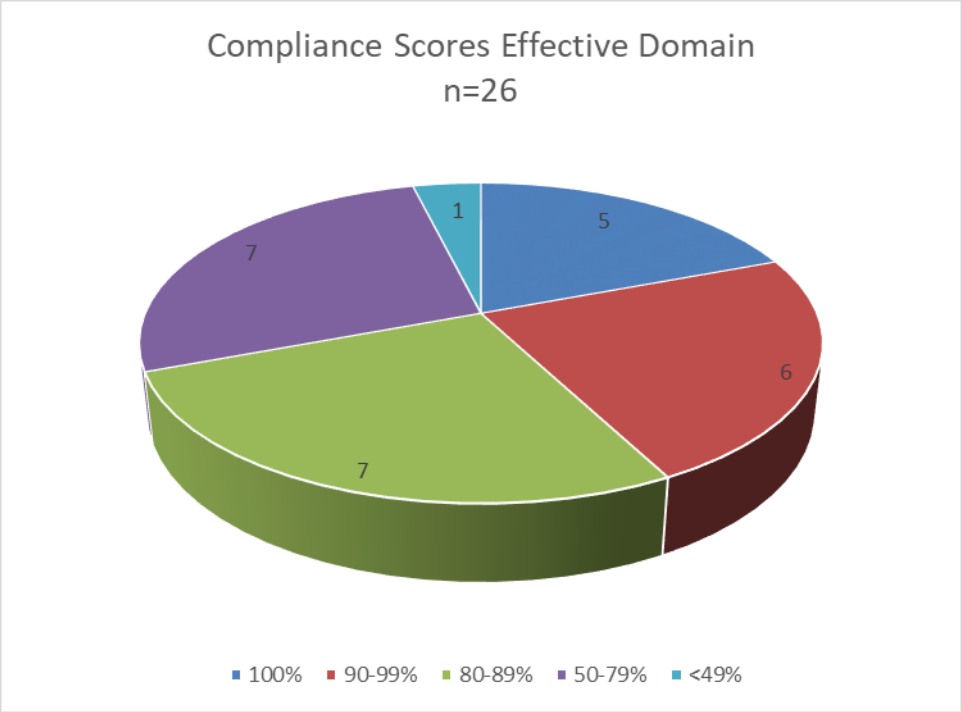
Whilst it is recognised this is not an entirely fail-safe process, without a technological solution which would enable feedback to the prescriber, alerting them that a medication has not been dispensed, this appears to be the most suitable way to do this currently.

Areas of good practice

All practices felt confident that care and treatment is delivered following evidence-based guidelines and that they have a robust process in place for ensuring all clinical staff are informed of new guidance.

Whilst staff were not always aware of all the clinical audits that had been undertaken within the practice they felt confident that they would be able to demonstrate how a clinical audit had resulted in change and better outcomes for patients.

As a result of the programme there is greater awareness of clinical audit and how the findings should be shared across the teams and not just used for appraisal and revalidation purposes.



4.2 Caring Domain

This was the lowest scoring domain with practices feeling less confident in being able to demonstrate they can meet the expected outcomes for this area. Out of the 9 criteria practices felt that 7 of these were areas they needed to work on to be confident they can evidence compliance.

Scores ranged from 33% to 100% with 2 practices confident enough to self-assess as meeting all the requirements for this domain.

The most frequently cited criteria where practices were not able to evidence compliance are as follows, with a full breakdown shown at Appendix E:

C1. Are all unexpected deaths reviewed as part of your Significant Event Audit programme?

This is not something that is routinely undertaken within practices across the locality. Clinicians told us that they may look in the notes to see who last saw the patient and perhaps discuss in a non-formal way but the review of unexpected deaths was not a standard agenda item for any clinical governance/incident management meeting for the majority of practices.

As a result of the programme this has now been added to all clinical governance meetings.

C2. Can you describe how do you identify people who may be in the last 12 months of their lives?

This was a significant gap identified across most practices, with most not having systems and processed in place to identify the 1% of patients expected to die in the next 12 months. The Dying Matters coalition has identified the following benefits for doing this as:

- Patients and their carers have time to deal with the news and realign their priorities.
- Patients are less likely to be subject to treatments of limited clinical value.
- Clinicians, patients and carers can plan appropriate end of life care rather than deal with a series of crises.
- Well-organised community support can halve the cost of hospital admission and result in 70% of people realising their choice to die at home – over twice the number in the general population.

Practices were directed to a range of resources on the dying matters website (https://www.dyingmatters.org/gp) to help them identify their 1% and it is hoped that they will take part in the Dying Matters awareness week due to take place in May.

C3. Are you confident all patients who were expected to die in the last year were included on your palliative care/GSF/QOF register?

Practices told us that their palliative care register is primarily used for patients with cancer however this is slowly evolving and including more non-cancer patients. Practices that were including non-cancer patients were fairly prescriptive about who was included and this tended to be patients with severe degenerative neurological conditions such as motor neurone disease. It was rarely found that a patient with severe COPD or end-stage heart failure or dementia were included on these registers.

C4. Do you know how many of these had non-cancer conditions?

This was generally not something that had been considered by practices but as a result of the programme they were all now actively considering this.

C7. Can you describe how you identify carers and do you have a carer register?

The identification of carers was also something that practices are finding difficult and something that they are all working on to improve. All practices ask new patients at registration if they are a carer and all have a carers register.

Practices were directed to the Carers Trust Professionals website which has a lot of useful resources to help them address this gap. (https://professionals.carers.org/identifying-carers)

Identifying carers via their Long-Term Conditions register was also recommended as those patients with, for example severe COPD, could be asked who helps them with activities of daily living thus identifying a previously unrecognised carer.

C8. Can you give examples of how you are supporting carers to remain healthy?

Although practices struggled to give examples of how they do this at the table top reviews it was identified that they can provide examples, such as reassuring mothers with disabled children that they would make arrangements for children to be supervised to enable them to have a consultation if they had to bring their child with them.

C9. Can you demonstrate progress with delivery of the Enhanced Service for patients with a Learning Disability?

There is slow progress being made with this and feedback from practices is that it is a hard to engage group and it is taking time to find suitably skilled staff to undertake these reviews.

Areas of good practice:

One federation has employed a Macmillan Cancer and Community Care Coordinator. The non-clinical role is split between cancer care and the community care coordinator role which has a remit of ensuring that frail, elderly and vulnerable older people are supported and enabled to remain as healthy and independent as possible in their own home (for as long as possible), whilst supporting those individuals in a crisis to ensure that there is a timely and efficient multi-agency response.

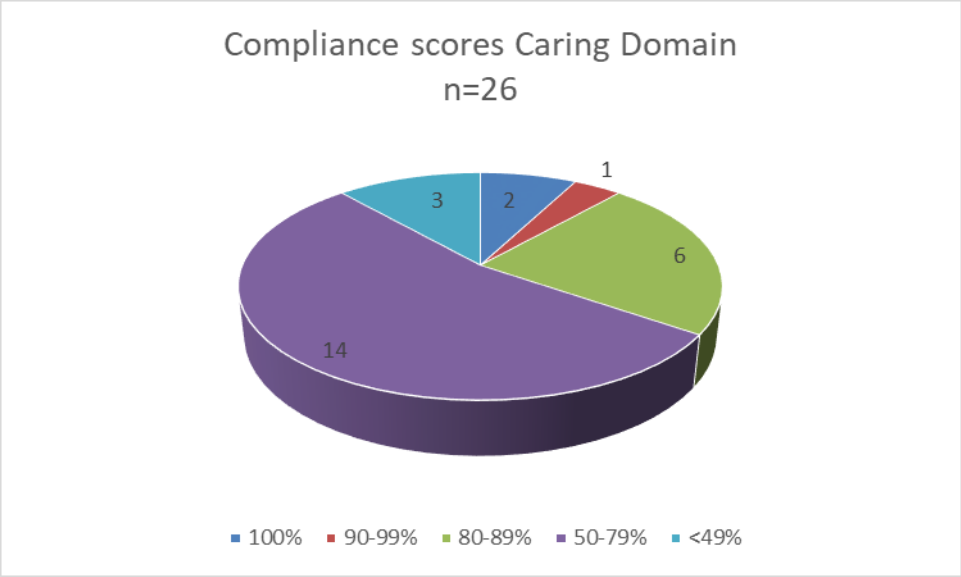
The coordinator runs the electronic risk stratification tool (eFI) and disseminates the information to the clinical teams through a regular multi-disciplinary team (MDT) meeting, where care needs are re-assessed and care plans updated. Patients whose eFI changes from one band to another are automatically given a GP consultation for further review.

The Coordinator maintains a list of at risk patients and monitors the patient's care pathway to ensure all information that becomes available or decisions that are made are acted on in a reliable and timely fashion.

As well as providing better, more coordinated care, closer to home, the implementation of this post has helped those practices identify their 1% of patients expected to die in the next 12 months.

The success of this programme is also being measured through other primary care work streams and is showing evidence that avoidable admissions are reducing and readmissions within 90 days are also reducing.

Practices are also working together to employ a specialist nurse with the right skills to support the delivery on the enhanced service for patients with a learning disability. In one area that has done this they have seen an increase in uptake of health screening from 20-70% for this cohort of patients.



4.3 Responsive Domain

This domain is the domain that practices rated themselves highest in being able to demonstrate compliance with (along with the well led domain), with 18 practices self-assessing as more than 90% compliant.10 practices rated themselves as 100% compliant.

Scores ranged from 61-100%.

The most frequently cited criteria where practices were not able to evidence compliance are as follows, with a full breakdown shown at Appendix F:

D9. Can you demonstrate support for carers and do you have a carers register?

Whilst all practices could demonstrate they have a carers register some had not progressed beyond identifying carers and adding them to a register. However, some practices had implemented several ways they support carers (discussed in more detail below) and this information has now been shared with all practices.

D8. Is training in consent given for all staff and is this in line with current legislation relating to Gillick competency and Fraser guidelines?

At all table top reviews, it was found that this is happening but without clinical input into the self-assessment practices answered no. Some practices had added this as

refresher training as a result of the programme and to ensure new staff were up to date.

D11. Can you describe a robust process for the registration and treatment of asylum seekers, homeless, travellers and gypsies?

This is a bit of a trick question as there is no separate process for managing this cohort of patients. All practices knew this when we reviewed the self-assessments with them but had felt that perhaps there had been new guidance that they were unaware of.

Areas of good practice

Several practices had identified Dementia Champions and sent staff on the relevant training to support patients with dementia and their carers. One practice has dedicated drop-in clinic sessions where patients can meet with a representative from the Alzheimer's Society who can signpost them to further services and support they can access.

Another practice had arranged for a blind volunteer to "walk through" the surgery building with their guide dog to identify any areas of potential cause for concern, which had identified the dog did not have confidence in the electric doors being sufficiently wide for both dog and handler to get through, resulting in these being reviewed.

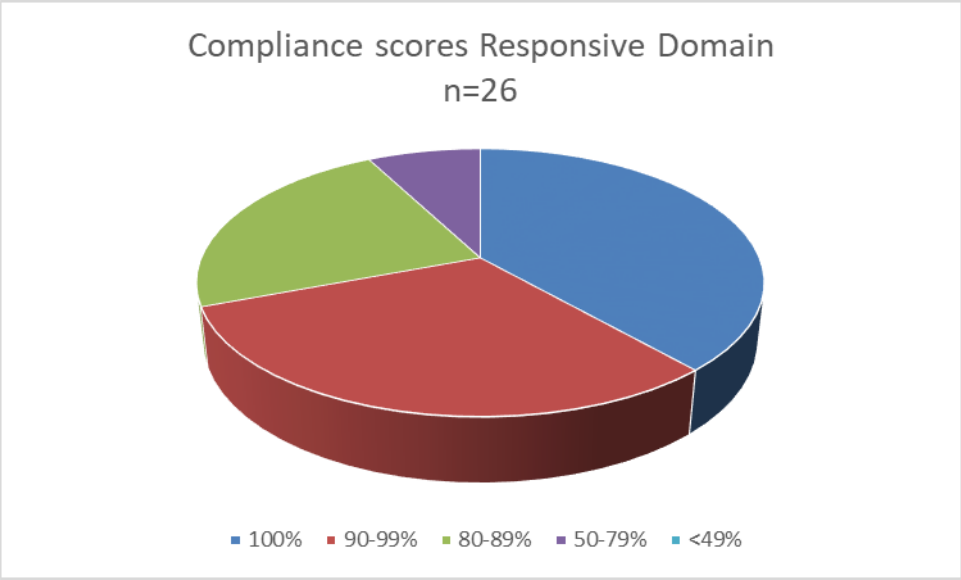
Several practices had recently started using the APEX Insight tool with more requesting implementation which will mean about two thirds of practices across the locality will be using this. The aim of the APEX Insight tool is to revolutionise workload and workplace planning in primary care, by collating data from the clinical systems which shows the complexity of patient case load, how this is spread across the available clinicians and who their frequent attenders are.

The tool can also help predict demand and increasing staffing needs thus supporting practices to demonstrate evidence that access to appointments is sufficient and meets the needs of their practice population.

One rural practice shared an example of the usefulness of the tool, which allowed them to show a high demand for physiotherapy. This resulted in the provision of a full-time physiotherapist based at the surgery fully funded by the secondary care trust. It has also resulted in reduced waiting times for other patients to access a GP appointment as they are no longer using consultations to see those patients with musculoskeletal problems.

Another practice told us how their clinical and dispensing staff worked with a patient who could not read to find a safe way for him to understand his medication regime. This resulted in his medication boxes being colour-coded and rather than instructions

given to take a named medication his medication regime was described by colour-coded box, allowing him to self-administer his medications safely.



4.4 Well-led Domain

Alongside the responsive domain this was the other highest rated domain with 18 practices rating themselves as 90% or more compliant with the criteria for this domain.

Scores ranged from 66-100% with 4 practices self-assessing as 100% compliant with the criteria in this domain.

The most frequently cited criteria where practices were not able to evidence compliance are as follows, with a full breakdown shown at Appendix G:

E5. Can you evidence a practice strategy and how this is monitored?

Practices told us that they did have a practice strategy and a mission statement and were able to describe the contents of the strategy, but there weren't able to evidence how this is monitored.

E6. Can you describe how you use other local assessments such as the Joint Strategic Needs Assessment (JSNA), or CCG Priority Areas to understand your population needs?

Practices were unsure of what the JSNA related to or where they could find it. They were conversant with the CCG priority areas and at the table-top reviews it was evident that this was an area for development for most practices.

E11. Do you know the percentage of patients in your practice who have consented to a summary care record?

Most practices had responded no to this question, however at the table top reviews they had reviewed this on their system and were more familiar with their practice data. Practices told us that they actively encourage patients to consent to a summary care record and that this is discussed routinely as part of registration.

E12. Do all patients identified through case finding and risk stratification have a summary care record?

Practices told us that this is an ongoing piece of work as it is often the elderly frail patients who would benefit most from this and yet they are the cohort of patients who are more concerned about data sharing.

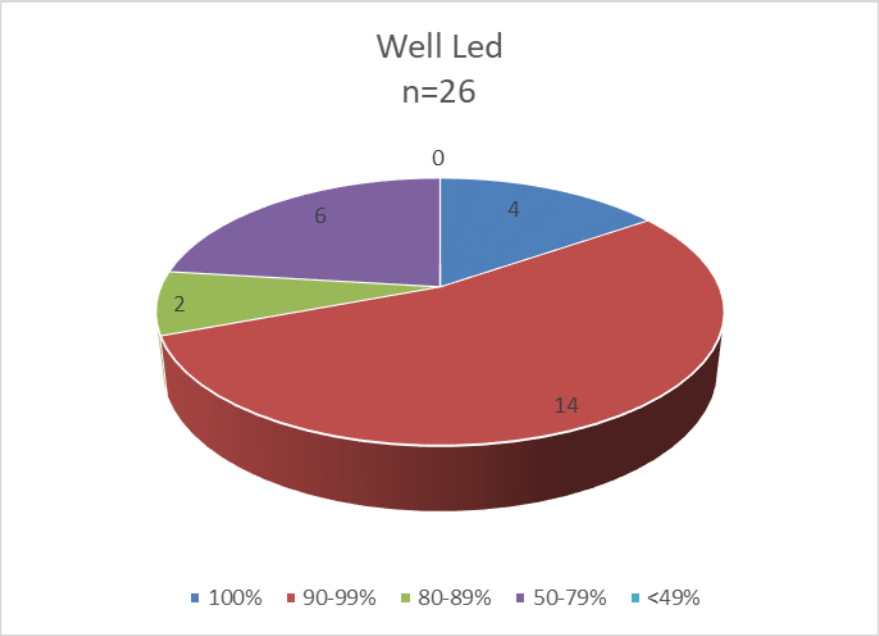
Practices told us they have ongoing discussions with these patients when they attend surgery and particularly if a change in their individual circumstances make this more relevant.

Areas of good practice:

All practices had been working on clarifying their governance arrangements and making it clear how responsibilities are shared within the practice so that any member of staff knew where to go with an issue.

Practices had developed a buddy system within their locality for whistle-blowers so that they could go to a person external to their own practice if they felt they needed to.

All practices were able to demonstrate a very clear and detailed induction programme, streamlined for particular staff groups for new starters. This demonstrated a very close monitoring and mentoring period and robust evidence that staff were competent to fulfil their role.



Conclusion

The programme has shown that practices within the Vale of York are able to meet the requirements for registration with CQC. The gaps they have identified as a result of the self-assessment are areas for development that we found all practices were actively addressing.

For the majority of practices, being CQC ready was a role that the Practice Manager had overall responsibility for with limited input from the registered manager and other staff groups unless a CQC inspection visit was imminent.

We heard at the table top reviews that this was something that would change and practices would structure their clinical governance meetings to include a review of compliance with the CQC essential standards. One practice we spoke to had taken the approach of having one domain discussed at each clinical governance meeting, which allowed all staff to review where the gaps in compliance may be and put these items on their work plan to ensure they are addressed and not forgotten.

With the exception of nursing appraisals and supervision, practices were able to identify their gaps. All practices had said they felt confident they were able to demonstrate full compliance with the criteria (B14) Robust arrangements for revalidation and appraisal and clinical supervision for staff who require this are in place. However, at the table-top reviews nursing staff appraisals were often identified as not fully completed in contrast to other staff groups.

Similarly, we were told that nursing supervision does happen on an informal basis, but when things go wrong this can take up a lot of GP time to address and provide enhanced supervision. Whilst this does not happen very often it does have an impact on clinician availability.

Next Steps

The new CQC annual regulatory reviews (ARR) will commence 1 April 2019.

If a practice is rated as good or outstanding, CQC will inspect at least every 5 years. Every year, CQC will carry out a formal review of the information CQC hold about each practice.

The formal ARR will help CQC to prioritise their inspections where the information suggests that the quality of care at your practice has changed since our last inspection. This can be either a deterioration or improvement. It will enable CQC to carry out more focused inspections that concentrate on the areas with the most change. This also allows CQC to focus where there is the most risk while supporting practices to improve. An ARR forms part of the ongoing monitoring but it cannot change your rating, only an inspection can do this.

CQC will request information once a year rather than before an inspection (through what was previously known as the provider information return (PIR)). This is to ascertain whether there are any changes at the practice since the last inspection or ARR. CQC gather this information by talking with practice staff via telephone call. The local inspector will contact the practice four weeks beforehand to arrange a mutually convenient time for this call.

If a practice is rated as requires improvement or inadequate, the ARR process and provider information collection call does not apply. CQC will continue to inspect:

- within six months for a rating of inadequate
- within 12 months for a rating of requires improvement.

CQC will send a provider information request before the inspection. This is to help CQC gain information that is not available through national data collections, which will inform the inspection. CQC will not send an annual provider information request or carry out a formal annual review of the information they hold about each practice.

An improved relationship between the CCG and general practices has enabled support from the CCG to continue.

Recommendations

- All practices should add “monitoring of compliance with CQC core essential standards” as a standing agenda item to their clinical governance meetings, to ensure all staff are engaged in the process and that this is embedded as “business as usual”.

- The CCG should explore how they can support practices to share the learning from incidents across the whole locality – this should include the learning from reviews of unexpected deaths.

- Practices should liaise with health visitors to ensure that there is a robust process in place to follow up children who are not brought for immunisation, and add this information to their child not brought policy, ensuring that all relevant staff are made aware of how this is managed.

- Practices should consider reviewing the infection control lead role and consider the most suitable person to undertake this role may not always be a qualified nurse. We found variation in the statutory and mandatory training requirements across all practices, which we were told can have a considerable impact on staff availability when time is required to complete multiple courses as well as undertaking other roles within the practice, which impacts on their availability to see patients.

- The CCG should consider how they can support practices to have an agreed standardised statutory and mandatory training schedule.

- Practices should consider systems and processes they can implement to help them identify the 1% of patients expected to die in the next 12 months. This should include the consideration of a care coordinator role and implementation of the newly approved “Daffodil Standards” to improve end of life care for all patients.

- Practices should consider prioritising the employment of a specialist nurse with the right skills to support the delivery on the enhanced service for patients with a learning disability, in order to increase the uptake of health screening for this cohort of patients.

- Practices should consider prioritising ways to identify and support carers. This should include developing staff to become Dementia Champions and consider adopting the best practice example of drop-in clinic sessions where patients can meet with a representative from the Alzheimer’s Society who can signpost them to further services and support they can access.

- Practices should consider ways in which they can encourage patients to agree to an enhanced summary care record. The use of a care coordinator has been shown to increase uptake of this.

- The CCG should consider how best to support practices to meet these recommendations and the role the Quality Lead for Primary Care can play in this.

Appendix A: CQC Ready Self-Assessment					
	Domain		**Can Evidence**	**Can Partially Evidence**	**Cannot Evidence**
	Section A: Safe				
A1	Do you have an incident reporting process in place within the Practice?				
A2	Do all staff know how to use it?				
A3	Do you have a process for giving feedback and learning from incidents and significant events?				
A4	Do you have examples of incidents you have managed within the practice and the changes as a result of these ?				
A5	Do you have a practice lead accountable for SEA's and serious incidents?				
A6	Do you have a Safeguarding Lead within the Practice?				
A7	Can you demonstrate how children at risk are managed? Is there a flag? Do you attend meetings?				
A8	Can you demonstrate how do you monitor and follow-up when children are not brought to appointments following referral to secondary care or for immunisation?				
A9	Can you demonstrate a robust system to identify vulnerable patients on their record?				
A10	Can you demonstrate how do you keep patient information secure, e.g. remove smart card when you leave the room or lock your PC?				
A11	Do you have a locum induction pack and can evidence what checks you undertake for new locums? E.g. are they on the Performers List/do they have adequate indemnity?				
A12	Can you clearly describe the procedure and arrangements in place for dealing with medical emergencies?				
A13	Do you feel assured that the practice is able to promptly identify people who have or are at risk of developing sepsis so that they receive timely and appropriate treatment				

A14	Do you have a robust process for managing safety alerts/updates (medicines, medical devices, patient safety alerts), from NICE, MHRA, GMC?				
A15	Are all chaperones trained and had appropriate DBS checks?				
A16	Do you have robust arrangements in place for supervision and appraisal for all staff; is this documented clearly and are all staff aware of this and how they can access support and training?				
A17	Can you describe the recruitment procedures, including how you ensure staff are and remain suitable for their role?				
A18	Do you have up to date records of portable appliance testing and calibration for all required equipment ?				
A19	Can you demonstrate appropriate risk assessments have been completed for all substances that meet COSHH regulations?				
A20	Do you have a robust Fire procedure in place, that includes checks for fire extinguishers, alarms, staff training and details requirements for drills and logs?				
A21	Do you have a robust infection control risk assessment and policy in place?				
A22	Can you provide an up to date infection control audit and demonstrate any changes made as a result of the audit findings?				
A23	Do all privacy screens and flooring meet the required infection prevention and control standards?				
A24	Are you confident that all relevant information needed for the ongoing care of patients using multiple services is shared appropriately in line with relevant protocols?				
A25	Do you have a robust documented process for managing test results and incoming mail to the practice that ensures all documentation is dealt with efficiently and effectively?				
A26	Can you demonstrate that individual care records are written and managed in line with current guidance and relevant legislation?				

	Section B: Effective				
B1	Can you demonstrate that care and treatment is delivered following evidence based guidelines? Can you give examples of their use?				
B2	Do you have examples of how staff follow care pathways and protocols?				
B3	Can you evidence how all clinical staff are informed of new guidance?				
B4	Can you provide an example of how a clinical audit resulted in change and better outcomes for patients?				
B5	Can you describe how audit topics are chosen and give examples of 2 clinical audits undertaken in the last year?				
B6	Do you have examples of care plans/templates which reflect best practice?				
B7	Do clinical staff have an appropriate tool to assess patients in pain?				
B8	Is this tool adapted to assess the level of pain in patients who have difficulties with communication?				
B9	Can you demonstrate what assessments are used to detect for possible signs of dementia?				
B10	Can you describe clearly how you refer individuals suspected of dementia for diagnosis?				
B11	Do you have a system in place to monitor and follow-up patients with poor mental health who fail to attend or fail to collect their medications, including for patients with dementia?				
B12	Can you describe how the practice monitors its performance re patient outcomes and what action is taken to make improvements?				
B13	Can you describe how staff are involved in QOF and how the monitoring is shared with the team?				

B14	Are you confident you have robust arrangements in place for appraisal and revalidation and clinical supervision for staff who require this?				
	Section C : Caring				
C1	Are all unexpected deaths reviewed as part of your Significant Event Audit programme?				
C2	Can you describe how do you identify people who may be in the last 12 months of their lives?				
C3	Are you confident all patients who were expected to die in the last year were included on your palliative care/GSF/QOF register?				
C4	Do you know how many of these had non-cancer conditions?				
C5	Can you demonstrate how you use the palliative care register and team meetings to improve coordination and communication with others involved in a person's care?				
C6	Can you share examples of care where Advanced Care Planning is evident				
C7	Can you describe how you identify carers and do you have a carers register?				
C8	Can you give examples of how you are supporting carers to remain healthy ?				
C9	Can you demonstrate progress with delivery of the Enhanced Service for patients with a Learning Disability?				
	Section D: Responsive				
D1	Can you describe how you identify and support patients (such as those who are non English speaking/hearing or visually impaired/learning disabled or a carer) who might need extra support to access your services?				
D2	Can you describe what information is used to assess people's views or experiences of the practice?				
D3	Do you support patients to access same sex doctors where this is requested?				
D4	Are you assured that your complaints process is robust and in line with up-to-date complaint legislation?				
D5	Are you assured your access to appointments is sufficient and meets your patient population?				

D6	Can you describe how you make changes and inform staff as a result of patient feedback and patient survey results				
D7	Can you evidence training in MCA/DoLS for all clinical staff who require it?				
D8	Is training in consent given for all staff and is this in line with current legislation relating to Gillick competency and Fraser guidelines?				
D9	Can you demonstrate support for carers and do you have a carers register?				
D10	Can you identify patients aged 65 and over who are living with moderate or severe frailty?				
D11	Can you describe a robust process for the registration and treatment of asylum seekers, homeless, travellers and gypsies				
	Section E: Well-led				
E1	Can you evidence any systems that have been put in place to manage identified risks?				
E2	Do you have any examples where complaints have resulted in actions taken to improve the practice and/or outcomes for patients?				
E3	Can you evidence information available to assist people who wish to make a complaint?				
E4	Can you describe a clear governance structure within the practice?				
E5	Can you evidence a practice strategy and how this is monitored?				
E6	Can you describe how you use other local assessments such as the Joint Strategic Needs Assessment, or CCG Priority Areas to understand your population needs?				
E7	Can you describe how the practice encourages continuous learning, improvement and innovation?				
E8	Can you describe how you ensure staff protect patient confidentiality?				
E9	Are you confident all staff know how to access practice policy and procedures?				
E10	Can you evidence a clear process that is followed when concerns are raised or things go wrong?				

E11	Do you know the percentage of patients in your practice who have consented to a summary care records?				
E12	Do all patients identified through case finding and risk stratification have a summary care record?				
E13	Can you evidence a robust Induction pack for new starters?				
E14	Can you provide evidence that all staff have been offered appropriately immunisations to protect them against blood borne viruses?				
E15	Can you demonstrate all staff are suitably qualified and trained for the full scope of their role?				
E16	Can you demonstrate whether staff are respected, valued and enjoy their employment?				

Appendix B: Anonymised Responses (all domains)

UI	Safe	Effective	Caring	Responsive	Well Led
A	83%	54%	33%	73%	75%
B	96%	89%	78%	91%	97%
C	96%	75%	67%	82%	91%
D	88%	96%	78%	95%	84%
E	96%	93%	83%	100%	100%
F	98%	100%	94%	100%	100%
G	94%	93%	89%	95%	94%
H	94%	96%	72%	95%	75%
I	85%	85%	44%	82%	77%
J	92%	79%	44%	100%	91%
K	85%	93%	56%	82%	75%
L	88%	46%	86%	61%	77%
M	100%	100%	72%	100%	100%
N	87%	86%	78%	95%	97%
O	88%	86%	78%	100%	91%
P	85%	79%	78%	86%	97%
Q	94%	82%	67%	91%	94%
R	100%	96%	56%	100%	80%
S	96%	96%	83%	100%	94%
T	88%	86%	78%	100%	91%
U	98%	100%	100%	100%	100%
V	88%	86%	83%	86%	91%
W	94%	64%	50%	100%	94%
X	100%	79%	100%	82%	66%
Y	92%	100%	67%	91%	97%
Z	94%	75%	83%	95%	97%

Appendix C: Safe

	A1	A2	A3	A4	A5	A6	A7	A8	A9	A10	A11	A12	A13	A14	A15	A16	A17	A18	A19	A20	A21	A22	A23	A24	A25	A26		
M	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	26	100%
R	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1		1	1	1	25	100%
X	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	26	100%
U	1	1	1	1	1	1	1	1	0.5	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	25.5	98%
F	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1		1	1	1	0.5	1	1	1	24.5	98%
C	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.5	1	0.5	1	25	96%
E	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.5	0.5	1	1	1	25	96%
B	1	1	1	1	1	1	1	0.5	0.5	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	25	96%
S	1	1	1	1		1	1	1	1	1	1	1	0.5	1	1	1	1	1		1	1	1	0.5	1	1	1	23	96%
G	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.5	0.5	1	1	1	1	1	1	1	0.5	1	24.5	94%
Q	1	1	1	1	1	1	1	0.5	0.5	1	0.5	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	24.5	94%
W	1	1	1	1	1	1	1	0.5	1	1	1	1	1	1	1	1	1	1	1	1	1	0.5	1	0.5	1	1	24.5	94%
Z	1	1	1	1	1	1	1	1	1	1	1	1	0.5	1	1	1	1	1	0.5	1	1	1	1	0.5	1	1	24.5	94%
H	1	0.5	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.5	1	1	1	0.5	24.5	94%
Y	1	1	1	1	1	1	1	1	0.5	1	0	1	1	1	1	1	0.5	1	1	1	1	1	1	1	1	1	24	92%
J	1	1	1	1	1	1	1	0.5	1	1	1	1	0.5	1	1	1	1	1	1	1	1	1	1	1	0	1	24	92%
O	1	1	1	1	0.5	1	1	1	1	1	1	1	1	0.5	1	0.5	1	1	1	1	1	1	1	0.5	0.5	0.5	23	88%
D	1	1	1	1	1	1	1	0.5	0.5	1	1	0.5	0.5	1	1	1	1	1	0.5	1	0.5	1	1	1	1	1	23	88%
T	1	1	1	1	0.5	1	1	1	1	1	1	1	1	0.5	1	0.5	1	1	1	1	1	1	1	0.5	0.5	0.5	23	88%
V	1	1	1	1	1	1	1	0.5	1	1	1	1	0.5	1	1	1	1	1	0.5	1	1	0.5	0.5	0.5	1	1	23	88%
L	1	1	1	1	1	1		0.5		1	1	0.5	1	1		1	1	1	1	1	0.5	1		0	1		18.5	88%
N	0.5	0.5	1	1	1	1	1	1	1	0.5	1	1	1	0.5	1	1	1	1	0.5	1	0.5	1	1	1	1	0.5	22.5	87%
I	1	1	1	1	1	1	1	1	0.5	1	0	0.5	1	1	1	1	0.5	1	1	1	1	1	1	0.5	1	0	22	85%
K	1	1	0	1	0	1	1	1	0.5	1	1	1	1	0.5	1	0.5	1	1	1	1	1	1	1	1	0.5	1	22	85%
P	1	1	1	1	0	1	0.5	0.5	0.5	1	1	1	0.5	0.5	1	1	1	1	1	1	1	0.5	1	1	1	1	22	85%
A	1	1	1	1	1	1	0.5	0.5	1	1	0.5	1	1	0.5	1	0.5	0.5	1	0	1	1	1	0.5	1	1	1	21.5	83%

Appendix D: Effective

L	0	0	0	1	1		0	0	1	1	0	0	1	1	6	#DIV/0!
M	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14	100%
U	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14	100%
Y	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14	100%
F	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14	100%
R	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14	100%
S	1	1	1	1	1	1	1	1	1	1	0.5	1	1	1	13.5	96%
D	1	1	1	1	1	1	1	1	1	1	0.5	1	1	1	13.5	96%
H	1	1	1	1	1	0.5	1	1	1	1	1	1	1	1	13.5	96%
E	1	1	1	1	1	1	1	0	1	1	1	1	1	1	13	93%
G	1	1	1	1	1	1	0.5	0.5	1	1	1	1	1	1	13	93%
J	1	1	1	1	1	1	1	0.5	1	1	0.5	1	1	1	13	93%
B	1	1	1	0.5	1	1	1	0	1	1	1	1	1	1	12.5	89%
O	1	1	1	1	1	1	0.5	0.5	1	1	0.5	1	1	0.5	12	86%
T	1	1	1	1	1	1	0.5	0.5	1	1	0.5	1	1	0.5	12	86%
V	1	1	0.5	1	1	1	0.5	0.5	1	1	0.5	1	1	1	12	86%
N	1	1	1	1	1	1	0.5	0	1	1	0.5	1	1	1	12	86%
I	1	1	1	1	1	1	0.5	0.5		0.5	0.5	1	1	1	11	85%
Q	1	1	1	1	1	1	0.5	0.5	0.5	1	0	1	1	1	11.5	82%
J	1	1	1	1	1	1	0	0	1	1	0	1	1	1	11	79%
P	1	1	0.5	1	1	1	0	0	1	1	1	0.5	1	1	11	79%
X	1	1	1	1	1	1	1	0	1	1	1	0	0	1	11	79%
C	1	1	0.5	0.5	0.5	1	0	0	1	1	1	1	1	1	10.5	75%
Z	0.5	0.5	0.5	1	1	1	0.5	0.5	1	1	0	1	1	1	10.5	75%
W	1	1	0.5	0.5	0.5	1	0	0	1	1	0	1	0.5	1	9	64%
A	1	1	1	0.5	0	0.5	0	0	0.5	0.5	1	0	0.5	1	7.5	54%
	B1	B2	B3	B4	B5	B6	B7	B8	B9	B10	B11	B12	B13	B14		

Appendix E: Caring

		C1	C2	C3	C4	C5	C6	C7	C8	C9		
U		1	1	1	1	1	1	1	1	1	9	100%
X		1	1	1	1	1	1	1	1		8	100%
F		0.5	1	1	1	1	1	1	1	1	8.5	94%
G		1	1	1	1	1	1	0.5	0.5	1	8	89%
L		1	1	1		1	1	0.5	0.5		6	86%
E		1	1	1	1	1	0.5	1	1	0	7.5	83%
S		1	1	1	1	1	1	0.5	0	1	7.5	83%
Z		0.5	1	0.5	0.5	1	1	1	1	1	7.5	83%
V		1	0.5	0.5	0.5	1	1	1	1	1	7.5	83%
O		0.5	0.5	0.5	0.5	1	1	1	1	1	7	78%
B		1	0.5	0.5	1	1	1	0.5	0.5	1	7	78%
D		0.5	0.5	0.5	1	1	1	0.5	1	1	7	78%
P		0	1	0.5	1	1	1	1	0.5	1	7	78%
T		0.5	0.5	0.5	0.5	1	1	1	1	1	7	78%
N		0.5	0.5	0.5	0.5	1	1	1	1	1	7	78%
M		0.5	0.5	0.5	0	1	1	1	1	1	6.5	72%
H		1	1	0	0	1	0.5	1	1	1	6.5	72%
C		1	0.5	1	1	1	0	1	0.5	0	6	67%
Q		0.5	0.5	0.5	0	1	1	1	1	0.5	6	67%
Y		1	0.5	0	1	1	1	0.5	0.5	0.5	6	67%
J		0	1	0	0	1	1	0.5	0.5	1	5	56%
R		1	0	0	0	1	1	1	1	0	5	56%
W		0	0	0	0	1	1	1	1	0.5	4.5	50%
J		0	0	0	0	0	1	1	1	1	4	44%
I		0	0.5	0.5	0.5	0.5		0.5	0.5	0.5	3.5	44%
A		0	0	1	0	0	0	1	0	1	3	33%

Appendix F: Responsive

		D1	D2	D3	D4	D5	D6	D7	D8	D9	D10	D11		
E		1	1	1	1	1	1	1	1	1	1	1	11	100%
M		1	1	1	1	1	1		1	1	1	1	10	100%
O		1	1	1	1	1	1	1	1	1	1	1	11	100%
S		1	1	1	1	1	1	1	1	1	1	1	11	100%
U		1	1	1	1	1	1	1	1	1	1	1	11	100%
W		1	1	1	1	1	1	1	1	1	1	1	11	100%
F		1	1	1	1		1		1	1	1	1	9	100%
J		1	1	1	1	1	1	1	1	1	1	1	11	100%
R		1	1	1	1	1	1	1	1	1	1	1	11	100%
T		1	1	1	1	1	1	1	1	1	1	1	11	100%
G		1	1	1	1	1	1	1	1	0.5	1	1	10.5	95%
Z		1	1	1	1	1	1	1	1	0.5	1	1	10.5	95%
D		1	1	1	1	1	1	1	1	0.5	1	1	10.5	95%
H		1	1	1	1	1	1	1	1	1	1	0.5	10.5	95%
N		1	1	1	0.5	1	1	1	1	1	1	1	10.5	95%
Q		1	1	1	1	1	1	0.5	0.5	1	1	1	10	91%
Y		1	1	1	1	1	1	1	1	0.5	0.5	1	10	91%
B		1	1	1	1	1	0.5	1	1	0.5	1	1	10	91%
P		1	1	1	1	1	1	1	1	0.5	1	0	9.5	86%
V		0.5	1	1	1	1	1	1	1	0.5	1	0.5	9.5	86%
C		0.5	1	1	1	1	1	1	0.5	1	0.5	0.5	9	82%
I		1	1	1	1	0.5	0.5	1	1	0.5	1	0.5	9	82%
J		1	1	1	1	1	1	1	0.5	0.5	1	0	9	82%
X		0	1	1	1	1	1	1	1	1	1	0	9	82%
A		1	1	1	1	0	1	0	0	1	1	1	8	73%
L		0.5	1	1	1	0.5			0	0.5	1	0	5.5	61%

Appendix G: Well-led

		E1	E2	E3	E4	E5	E6	E7	E8	E9	E10	E11	E12	E13	E14	E15	E16		
E		1	1	1	1	1		1	1	1	1	1	1	1	1	1	1	15	100%
M		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	16	100%
U		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	16	100%
F		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	16	100%
Y		1	1	1	1	0.5	1	1	1	1	1	1	1	1	1	1	1	15.5	97%
Z		1	1	1	1	1	0.5	1	1	1	1	1	1	1	1	1	1	15.5	97%
B		1	1	1	1	1	0.5	1	1	1	1	1	1	1	1	1	1	15.5	97%
P		1	1	1	1	1	0.5	1	1	1	1	1	1	1	1	1	1	15.5	97%
N		1	1	1	1	1	1	1	1	1	1	1	1	1	0.5	1	1	15.5	97%
G		1	1	1	1	1	1	1	1	1	1	0.5	0.5	1	1	1	1	15	94%
Q		1	1	1	1	1	0.5	1	1	1	1	1	0.5	1	1	1	1	15	94%
S		1	1	1	0.5	0.5	1	1	1	1	1	1	1	1	1	1	1	15	94%
W		1	1	1	1	1	1	1	1	1	1	1	0.5	1	0.5	1	1	15	94%
C		1	1	1	1	0.5	1	1	1	1	1	1	0.5	1	0.5	1	1	14.5	91%
O		1	1	1	1	1	1	1	1	1	1	0.5	0.5	1	1	1	0.5	14.5	91%
J		1	1	1	1	0.5	1	1	1	1	1	0	1	1	1	1	1	14.5	91%
T		1	1	1	1	1	1	1	1	1	1	0.5	0.5	1	1	1	0.5	14.5	91%
V		1	1	1	1	1	0.5	1	1	0.5	1	1	1	0.5	1	1	1	14.5	91%
D		1	1	1	1	0.5	0	1	1	1	1	1	0.5	1	0.5	1	1	13.5	84%
R		1	1	1	1	0	0	1	1	1	1	1	0	1	1	1		12	80%
I		1	1	1	1	0.5		0.5	1	1	1	0.5	0.5	0.5	0.5	0.5	1	11.5	77%
L		0.5	1	1	1	0.5	0	1	1	1	1	0.5		1	0.5	1	0.5	11.5	77%
A		1	1	1	0	1	0	1	1	1	0	1	0	1	1	1	1	12	75%
J		1	1	1	1	0.5	0.5	1	1	1	0.5	0.5	0.5	0.5	0.5	0.5	1	12	75%
H		1	0.5	1	1	0.5	0.5	1	1	1	1	0.5	0	1	1	0	1	12	75%
X		1	1	1	0	0	1	1	1	1	1	1	0	0	0.5	0.5	0.5	10.5	66%

Item Number: 8

Name of Presenter: Stephanie Porter

Meeting of the Primary Care Commissioning Committee

Date of meeting: 11 July 2019

NHS
Vale of York
Clinical Commissioning Group

Report Title – Estates Capital Investment Proposals – Progress Report

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

Reason for Report
The report forms part of the regular updates to PCCC, supporting the decisions made to invest in primary care estate. The report highlights progress on schemes and where changes have been made to original proposals as part of the normal scheme development.

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

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

The Committee is asked to note the contents of the report, and where required ratify changes to the proposals for estates investment.

Responsible Executive Director and Title	Report Author and Title
Simon Bell Chief Finance Officer	Stephanie Porter Assistant Director Primary Care

Estates, Technology and Transformation Bids

The CCG supported a number of bids to go forward to seek funding via ETTF from NHS England (NHSE).

The list below confirms progress on the schemes and where there have been changes.

Beech Tree – expansion of the branch surgery at Carlton. An improvement grant was approved and the scheme is progressing well. This will result in additional space at the Carlton branch practice, giving additional clinical capacity in a rural area seeing significant residential housing growth.

Pickering Medical Practice – An improvement grant has been approved to support minor changes within existing property to create more clinical space and refurbishment of newly acquired neighboring property. This work is well progressed and the practice have now confirmed that Harrogate Foundation Trust will move services into the refurbished practice premises. This will allow the NHSPS owned property which HDFT were occupying to be closed down releasing resources back into the system.

Millfield Surgery, Easingwold the CCG originally supported a new build bid via ETTF for the surgery. This scheme has been worked through and the practice and CCG have concluded that the benefits to the system, to create more physical capacity to support housing growth can be achieved via an improvement grant, which supports the redevelopment and expansion of the practice owned property. This decision was supported for a number of reasons, primarily about the risk of the new build being delivered with the budget timescales for ETTF – namely that if the scheme took too long, the ETTF monies would be withdrawn and also the practice can deliver an extension in their existing property for lower revenue impact, there by offering improved value for money on the scheme overall.

As the scheme has moved from an ETTF new build proposal to an improvement grant, the progression and approval of the revised bid will be managed by NHSE at a local level.

PCCC are asked to note and ratify this change in approach for the proposal to expand Millfield Surgery

Burnholme Health Campus remains a new build proposal, and the scheme has not changed since submitted to NHSE a year ago. We have continued in dialogue with both the national and regional team and there is general support of the proposals. The risk remains that the scheme will need to be completed by Dec 2020 – March 2021 which are very challenging timescales. To date the practice and the CCG have met all timescales given to them. We await confirmation by NHSE that the scheme is approved – which will be to the next business case gateway.

Sherburn Group Practice new build ETTF proposal

As previously reported, the original scheme has changed and the proposal now includes a new build for Sherburn Group practice only. The ETTF team at Region remain supportive of the scheme.

Like Burnholme the timescales to deliver a new build remain challenging but the practice and their development partner remain confident that it is achievable, subject to region progressing with approval in a timely manner.

With the scheme now being one practice only, the revenue impact has increased as the existing budget for two practices has reduced so the net increase is greater. However, the impact to the CCG remains lower than the total approved previously for all our ETTF bids overall, as the Millfield surgery revenue increase has decreased due to the proposed change.

PCCC are asked to note and ratify this change in approach for the proposal to for the new build for Sherburn Group Practice

Tollerton Surgery New Build

The project to progress the new build at Tollerton has started following the CCG support of the business case. The Agreement to Lease has been concluded and the developer is on time to progress the application for planning permission. The scheme is on programme to open October 2020.

Primary Care Estates Strategy

The primary care estates strategy has commenced. The initial phase has been data capture and validation, and our consultant partner Shared Agenda has commenced discussions with practices. We anticipate an early draft of the output in September 2019.

Item Number: 9

Name of Presenter: Stephanie Porter

Meeting of the Primary Care Commissioning Committee **Date of meeting: 11 July 2019**	NHS Vale of York Clinical Commissioning Group

Primary Care Networks Update – July 2019

Purpose of Report
For Information

Reason for Report

To update the Primary Care Commissioning Committee regarding developments around Primary Care Networks, including the NHS England approval process and confirmed financial arrangements.

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

N/A – for information only

Decision Requested (for Decision Log)

N/A

Responsible Executive Director and Title	**Report Author and Title**
Andrew Lee Executive Director of Primary Care and Population Health	Shaun Macey Head of Transformation & Delivery

PRIMARY CARE COMMISSIONING COMMITTEE: 11 JULY 2019

1. Background and Process

"Investment and Evolution: A five-year framework for GP contract reform to implement the NHS Long Term Plan"[1], describes how General Practice will take the leading role in every Primary Care Network (PCN) under the Network Contract Directed Enhanced Service (DES).

The key dates for this process are as follows:

Date	Action
Jan-Apr 2019	PCN's prepare to meet the Network Contract DES registration requirements
By 29 Mar 2019	NHS England and GPC England jointly issue the Network Agreement and 2019/20 Network Contract DES
By 15 May 2019	All Primary Care Networks submit registration information to their CCG
By 31 May 2019	CCGs confirm network coverage and approve variation to GMS, PMS and APMS contracts
Early Jun	NHS England and GPC England jointly work with CCG's and LMC's to resolve any issues
1 Jul 2019	Network Contract DES goes live across 100% of the country

[1] https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

Date	Action
Jul 2019-Mar 2020	National entitlements under the 2019/20 Network Contract start: • the additional roles reimbursement scheme • funding for each PCN Clinical Director • recurrent £1.50/head from CCG allocations • Practice participation payment • extended hours DES
Apr 2020 onwards	National Network Services start under the 2020/21 Network Contract DES

NHS Vale of York CCG can confirm that all requirements leading up to the 1 July 2019 Network Contract DES go-live have been successfully met.

- All Primary Care Network registration documents, including signed Mandatory Network Agreements, were received by the CCG by 15 May 2019. These proposed PCN configurations were supported to go forward for NHS England approval at the meeting of the CCG's Executive Committee on 15 May 2019.

- A summary of proposed PCN configurations was taken to the STP Primary Care Programme Board on 30 May 2019 and approved by NHS England.

- All 26 NHS Vale of York CCG member Practices are members of a PCN, and the CCG can therefore confirm 100% coverage of PCN's as per the NHS England requirement.

- All PCN's have appointed a named Clinical Director.

- The boundaries of all NHS Vale of York PCN's are contiguous.

2. NHS Vale of York CCG Primary Care Network Configurations

There are 6 approved PCN's across Vale of York CCG covering a total population of 360,758 (based on 01/01/2019 registered list sizes). Details of the PCN's are as per the tables below:

PCN Name	Practice ODS code	Practices	PCN size
Selby Town PCN	B82041	Beech Tree Surgery	**49,792**
	B82074	Posterngate Surgery	
	B82097	Scott Road Medical Centre	
	B82018	Escrick Surgery	

PCN Name	Practice ODS code	Practices	PCN size
Tadcaster & Selby PCN	B82073	South Milford Surgery	**28,290**
	B82031	Sherburn Group Practice	
	B82105	Tadcaster Medical Centre	

PCN Name	Practice ODS code	Practices	PCN size
South Hambleton And Ryedale	B82002	Millfield Surgery	**34,967**
	B82064	Tollerton Surgery	
	B82079	Stillington Surgery	
	B82068	Helmsley Surgery	
	B82619	Terrington Surgery	
	B82033	Pickering medical Practice	
	B82077	Kirkbymoorside	

PCN Name	Practice ODS code	Practices	PCN size
York City Centre PCN	B82098	Jorvik/Gillygate	**53,807**
	B82103	East Parade	
	B82047	Unity	
	B82021	Dalton Terrace	

PCN Name	Practice ODS code	Practices	PCN size
York Medical Group	B82083	York Medical Group	**44,615**

PCN Name	Practice ODS code	Practices	PCN size
Nimbuscare Ltd	B81036	Pocklington Group Practice	**149,287**
	B82081	Elvington Medical Practice	
	B82080	MyHealth	
	B82026	Haxby Group Practice	
	B82071	Old School Medical	
	B82100	Front Street Surgery	
	B82005	Priory Medical Group	

3. Additional Points to Note

The Central locality group of PCN's (i.e. York City Centre, York Medical Group, and Nimbuscare Ltd) has confirmed that, in addition to addressing their individual PCN requirements, they will continue to work together across the six geographical neighborhoods of the previously established Primary Care Home.

Nimbuscare Ltd (PCN significantly over the recommended 50,000 size) has stated that, although it is registered as a single network for the DES, the PCN will operate around smaller, Practice sub-groupings as follows, with clinical directors for each of the neighbourhoods.

Neighborhood 1 - Pocklington, Elvington, My Health – population of 42,852
Neighborhood 2 - Old School, Front Street, Haxby – population of 48,039
Neighborhood 3 - Priory Medical Group – population of 58,396

Tadcaster & Selby PCN (rationale for PCN being under 30,000 size) is agreed on the basis of the specific geography and health needs of that population, together with the anticipated growth in local housing which is expected to increase the total number of supported patients to over 30,000 within 2 years.

4. Primary Care Network Budgets 2019/20

Budgets include:

- PCN Clinical Director funding (0.25WTE)
- £1.50 per /head from CCG allocations
- Extended Access (with a requirement for 100% coverage)
- Network Participation Payment
- Additional Roles Reimbursement (available on recruitment of additional staff)

Primary Care Network	Budget 2019/20
Selby Town PCN	**£300,242**
Tadcaster & Selby PCN	**£192,782**
South Hambleton And Ryedale	**£231,039**
York City Centre PCN	**£299,537**
York Medical Group	**£263,503**
Nimbuscare Ltd	**£882,020**

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Item Number: 10

Name of Presenter: David Iley

Meeting of the Primary Care Commissioning Committee

Date of meeting: 11 July 2019

NHS
Vale of York
Clinical Commissioning Group

Report Title – Primary Care Update

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

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
- ☒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

N/A

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 note

Decision Requested (for Decision Log)

No Decisions Requested

Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam Accountable Officer	David Iley Primary Care Assistant Contracts Manager NHS England – North

Annexes (please list)

Annex 1.) HCV Primary Care Strategy
Annex 2.) Primary Care Strategy Slides
Annex 3.) PCN Additional Roles Reimbursement Scheme
Annex 4.) GPFV Reporting

Vale of York
Delegated Commissioning
Primary Care Update
July 2019

Prepared by David Iley

Primary Care Assistant Contracts Manager

NHS ENGLAND – North (Yorkshire and The Humber)

1st July 2019

1. Items for Approval

No items for approval

2. Items for Noting

2.1 Contractual

2.1.1 Primary Care Commissioning Activity Report

The primary care activity report (PCAR) was introduced in 2016/17 to support greater assurance and oversight of NHS England's primary care commissioning responsibilities. It collects information on local commissioning activity regardless of the commissioning route (e.g. NHS England or CCGs with delegated authority).

The guidance covering the collection for the annual reporting period 1 April 2018 – 31st March 2019 was published earlier this year and can be found through the following link https://www.england.nhs.uk/wp-content/uploads/2019/03/primary-care-activity-report-guidance-notes-for-completion.pdf

The key areas of interest for the 2018/19 reporting round include:
- Management of contractual performance
- Financial assistance to providers
- Procurement and expiry of contracts
- Availability of services, including closed lists.
- Assurance of policy compliance and implementation

The return was submitted by the CCG for the deadline of Friday 17th May 2019 and detailed that 3 procurements had taken place, 1 breach notice had been issued and 1 application to close patients' list had been received during 2018/19.

2.1.2 Assurance of General Practice

Following the collation of the results from the 2018/19 annual electronic GP Practice self-declaration CCGs were notified by NHS England of any Practices who are regularly closed for half a day, an extended period on any day or a significant number of hours across the week. The report received by NHS England regarding VoY CCG Practices indicated the following;

Terrington Surgery declared that they are routinely closed for at least half a day a week. The CCG asked the Practice to confirm the arrangements that are in place during these periods. Having received the following update, the CCG felt assured the needs of patients were being met.

- The Practice have a sub-contracting arrangement for patients to be seen at Helmsley Medical Practice during the period the Practice indicated they are

closed. Access is good at the Practice with patients being able to access appointments daily. The Practice engages with their PPG on a quarterly basis where any issues regarding the Practices opening arrangements can be discussed. The Practices have received no complaints from patients in 2018/19 regarding their opening hours. This approach also supports collaborative working at scale as Terrington Surgery and Helmsley Medical Practice continue to work together to ensure a more resilient primary care service.

2.2 Estates

No items for discussion

2.3 GP Forward View / Transformation

2.3.1 Humber, Coast and Vale Healthcare Partnership Primary Care Strategy

The Humber, Coast and Vale Healthcare Partnership have finalised their Primary Care Strategy for 2019-2024. The plan and supporting slides are included as appendix 1 and 2. The strategy covers the following areas to ensure primary care services meet the needs of patients over the next 5 years

- Component 1: Investment plans for local primary care transformation based on their local identified priorities
- Component 2: Primary Care Network Plan
- Component 3: Local Workforce Plan
- Component 4: Digital and Technology
- Component 5: Population Health Management
- Component 6: Estates Technology Transformation
- Component 7: Quality and Digital Standards
- Component 8: Patient Empowerment and Personalised Care
- Component 9: Local Professional Networks for Dental, Eye Health and Pharmacy Services

2.3.2 Primary Care Network Additional Roles Reimbursement Scheme: Establishing the workforce baseline and assessing additionality

The Network Contract DES sets out an entitlement for PCNs, subject to meeting agreed requirements, to receive payments set out under the Additional Roles Reimbursement Scheme. The 5 additional roles are clinical pharmacists, social prescribing link workers, physician associates, physiotherapists and paramedics.

The intention of the scheme is to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage. It is not to fill

existing vacancies or subsidise the costs of employing people who are already working in primary care.

Therefore, CCGs will be responsible for agreeing the workforce baseline with PCNs as part of the DES registration process. This involves the submission of a workforce baseline collection template to NHS England by 28th June 2019 which will fix the workforce baseline for a period of 5 years.

Further details can be found in appendix 3

2.3.3 General Practice Forward View

The CCG continues to be actively involved with the NHSE 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 4.

2.4 Other

No items for discussion

Humber Coast and Vale Healthcare Partnership

Primary Care Strategy- Background

2019-2024

Requirement:

Every Sustainability and Transformation Partnership (STP) / Integrated Care System (ICS) must a Primary Care Strategy covering 2019/20 to 2023/24; in place and approved through their local STP governance structure/programme board and assured by the region by 1 June 2019.

Background

In 2017/18 every STP across the North Region was asked to develop and submit GP Forward View (GPFV) delivery plans highlighting how the various chapters of the GPFV would be delivered over the five years of the programme.

In Humber Coast and Vale (HCV), the Healthcare Partnership decided to develop a Primary Care Delivery Plan which not only described how the GPFV programme would be delivered across HCV but set a vision for Primary Care Transformation and how the GPFV would be used as a catalyst for transformation.

The Healthcare Partnership Primary Care delivery plan was signed off by all CCGs across HCV, NHS England and finally the ICS in February 2018 and articulated a vision for transformed primary care services over the next five years.

Therefore, the HCV Healthcare Partnership Primary Care Strategy 2019/20 – 23/24 will build on the ambitions and vision described in the Healthcare Partnership Primary Care Delivery Plan to achieve and exceed the commitments made in all key recent publications, Long Term Plan, GPFV, GP Partnership Review, and the GP Contract Reforms.

The Vision for Primary Care

Primary Care has embarked on a process of transformation to provide a service that is sustainable, efficient, effective and attractive to work in. It will play a central role in primary and community care operating at scale to close the three gaps identified in the 5 Year Forward View (i.e. health and wellbeing; care and quality; finance and efficiency) and deliver the commitments set out in the NHS Long Term Plan through the five-year framework for the GP services contract (Investment and evolution: A five year framework for GP contract reform to implement The NHS Long Term Plan).

The HCV Primary Care Strategy (HCVPCS) will encourage and support Primary Care Networks (PCNs) (which in this context includes General Practice, other independent practitioners and all community health and care services and the voluntary sector) to fulfil their roles in emerging ICS's.

The following combines not only a list of some of the **key principles and components** of a transformed primary care system but **key components** of the PCS;

- Primary Care working at scale in PCNs forming the list based operational building block for larger system delivery and progression towards Integrated Care Providers and Integrated Care Systems.
- The 4 characteristics of PCNs are: -
    - Provision to a defined registered population of approximately 30 – 50,000[1].
    - An integrated workforce, with a strong focus on partnerships spanning primary, secondary social and voluntary care
    - A combined focus on personalisation of care with improvements in population health outcomes
    - Aligned clinical, quality and financial drivers

Key Aims and Aspirations for (Clinical) Services in PCNS

Primary Care Medical Services –

- For GPs to diagnose earlier and to manage complex disease including multi-morbidity, they need to spend more time with patients. This will require longer consultations, potentially up to 20 minutes and increased support from a wider clinical and administrative team to facilitate this. Attention must be given to transforming how and when patient access primary care, the use of digital solutions must be maximised.

- Every patient who needs a same day intervention will be able to get one. This intervention will not necessarily be face to face and with a GP, with online access and advice, telephone consultations and alternate practitioners increasingly available. In order to improve productivity and quality, some larger practices and integrated systems have separated acute from routine care to ensure patients are seen by the most appropriate health care professional and to minimise disruption of core primary care.

[1] *local variation on the upper limit*

- All professionals involved in a patient's care will contribute to an electronic shared care record, with access appropriate to their role. All Providers will commit to sharing their data for direct care and ensure their systems are interoperable with the shared care record. Patients will be informed about information sharing and given choices about how their data is used.

- Patients will be able to access their electronic shared care record and use a range of online tools for managing aspects of their care.

- All services that can be delivered safely and according to best practice in the community will be provided within a primary care network, thereby ensuring that patients can access care closer to where they live, avoiding the need to attend hospital unnecessarily. This includes both elective and non-elective care.

- Population Health Management and prevention will be a central feature of primary care and indeed be a golden thread throughout the Integrated Care System. This includes primary, secondary and tertiary prevention and also education around self-care and promotion of wellbeing.

- Social prescribing and community empowerment will be a key feature of primary care delivery which will enable more self-care and more resilient communities.

- The primary care workforce will have expanded to include a number of new roles, some of which will qualify for reimbursement through the national additional role reimbursement scheme which will be implemented from 2019 to 2021. Whilst the national role reimbursement scheme includes 5 roles (clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and community paramedics) other new roles will also be in place such as medical assistants and care navigators and all staff will be up-skilled to work at the "top of their licence".

- The important interdependencies between mental health, cancer and urgent and emergency care will be addressed through more integrated working within PCNs.

<u>Eye Health Services</u>

- Patients will be able to access a consistent and integrated Primary Eye Care Service within each Primary Care Network across the Healthcare Partnership. The evidence based schemes in terms of improved outcomes and cost effectiveness are: -

- Glaucoma Referral Refinement
- Pre and Post Cataract Service
- Minor Eye Conditions Service
- Children's post screening eye test service
- Low vision service

- Further community based eye care services in primary care will be developed within each Accountable Care System to shift secondary care activity closer to home.

Pharmacy Services

- Community pharmacy will act as the facilitator of personalised care and support for people with, long term conditions maximising services within the national contract, locally commissioned services and the pharmacy integration fund to work more closely with and reduce the workload of General Practice.
- Community pharmacy will become a trusted, convenient first port of call for self-care, healthcare advice and treatment and will be integrated with NHS111 for services such as NUMSAS and DMIRS and providing similar services on a "walk in" basis.
- Community pharmacy will be seen as an equal and integral partner in delivery of neighbourhood health and wellbeing services provided by PCNs
- Community pharmacy will become a hub for lifestyle advice building on the Healthy Living Pharmacy programme and providing the opportunity to detect conditions such as Hypertension, Atrial Fibrillation and Diabetes through screening services as signalled in the NHS long term plan.
- Community pharmacy will be an integral partner in the HCV medicine optimisation strategies, combatting waste and ensuring patients get the most from their medicines in general and when transferring across care settings and helping them retain their independence.

Oral Health Services

- Dental care services will be accessible, clearly signposted, supporting prevention and daily patient care. Pathways from primary care to specialist dental services will be clear and easy for practices and patients to navigate.

- Dental and oral health services will be integrated with wider primary care systems working in PCNs and emergency care systems ensuring benefits to patient's oral health, also linking to wider health and social care provision where appropriate.

- Through these developments, practices will be able to transform and enhance their services for example "Starting Well", increasing patient satisfaction and making maximum use of their staff skill mix.

Introduction

The NHS Long Term Plan provides the foundation of our strategic plan and supports our vision of delivering improved health outcomes for patients as well as providing high quality and safe patient care. Primary Care will be the critical component of delivering integrated Health and Social Care within PCNs across HCV focussing on population health and inter-professional partnership working spanning organisational boundaries.

Integrated working will be core to the PCNs based around populations of approximately 30-50,000. PCNs will see GP practices working in clusters based on local populations and their needs with a redesigned primary care workforce to support access and sustainability of Primary Care. New roles of clinical pharmacists, physician associates, first contact physiotherapists, first contact paramedics and social prescribing link workers are to be introduced in a phased approach with increased funding to support new ways of working in Primary Care and enable patients to be seen at the right time in the right place by the right person.

The following strategic workstreams will underpin and be the core enablers in the delivery of the Primary Care strategy; PCN development aligned to the GP contract reforms, Estates, Digital and Technology, Workforce, Communication and Engagement, Finance & Investment.

Enablers to support implementation include: -

- A secure and improved funding path for the NHS, averaging 3.4% a year over the next five years, compared with 2.2% over the past five years.
- Wide consensus about the changes now needed, confirmed by patients' groups, professional bodies and frontline NHS leaders.
- An acknowledgement that work that commenced after the NHS Five Year Forward view is now beginning to bear fruit, providing practical experience of how to bring about the changes set out in the Plan.

The five-year framework for GP Contract Reform translates commitments in the NHS Long Term Plan into a five-year framework for the GP services contract and confirms the direction for primary care for the next ten years. The five main goals are: -

- Secure and guarantee the necessary extra investment;
- Make practical changes to help solve the big challenges facing general practice, not least workforce and workload;
- Deliver the expansion in services and improvements in care quality and outcomes set out in The NHS Long Term Plan, phased over a realistic timeframe;
- Ensure and show value for money for taxpayers and the rest of the NHS, bearing in mind the scale of investment;
- Get better at developing, testing and costing future potential changes before rolling them out nationwide.

This primary care strategy sets out a detailed, costed package of investment and reform for primary care now through to 2024. It is a strategy that delivers real opportunity to deliver a sustainable shift in care and activity out of hospital and develop how services are provided within local PCNs. The plan utilises the funding and resource available within the GPFV and GP contract reform in addition to additional local investment in primary care from commissioners across the ICS. Its implementation will mean more convenient access to care and advice, a stronger focus on population health and prevention, more GPs and a wider range of practice staff, operating in more modern buildings, and better integrated with community and preventive services, hospital specialists and mental health care.

The HCV Primary Care Programme Board will own the primary care strategy and monitor progress against implementation.

Components of the Primary Care Strategy

There are 9 components that make up this Strategy: -

Component 1: Investment plans for local primary care transformation based on their local identified priorities;

Component 2: PCN development plan

Component 3: Workforce

Component 4: Digital and technology

Component 5: Population Health Management

Component 6: Estates Technology Transformation

Component 7: Quality and Digital Standards

Component 8: Patient Empowerment and Personalised Care

Component 9: Local Professional Networks for Dental, Eye Health and Pharmacy Services

Each Component is considered in greater detail in the following sections of the strategy

Component 1: Primary Care Investment

Our Vision for Primary Care Investment is that we make full use of all monies available for the support and development of Primary Care

The NHS commitments regarding Primary Care originally detailed in the GPFV were to invest a further £2.4 billion a year by 2020/21 compared to the baseline year of 2015/16. The HCV Healthcare Partnership Primary Care Delivery Plan 2017/18 – 20/21 was produced identifying an investment of 388 million across 9 GPFV programmes.

Table 1

Professional	2016/17 (£m)	2017/18 (£m)	2018/19 (£m)	2019/20 (£m)	2020/21 (£m)	Total (£m)
General Practice Resilience Programme	3.79	1.98	1.98	2.01	2.12	**11.88**
The Vulnerable Practices Programme	2.57	-	-	-	-	**2.57**
ETTF					289.8	**289.8**
Training care navigators & medical assistants	-	2.43	2.43	-	-	**4.86**
Online Consultation	-	3.65	4.85	3.91	3.79	**16.2**
Access Funding			47.67	TBC	TBC	**47.67**
Career Plus Scheme	-	1.0	-	-	-	**1.0**
GP Retention	-	-	2.06	3.19	3.18	**8.43**
Reception and Clerical Training	-	-	2.40	2.93	-	**5.33**
Total	**6.36**	**9.06**	**61.39**	**12.04**	**298.89**	**387.74**

The above investment only identifies NHS England funding.

In January 2019 the NHS published "The NHS Long Term Plan" which committed to increase investment in primary medical and community health services as a share of total NHS revenue spend across five years from 2019/20 to 2023/24. Spending in these areas will be at least £4.5billion higher in five years' time.

In support of the NHS Long Term plan a revised set of CCG allocations have been published which both demonstrates the NHS' intention to continue to invest heavily in Primary Care Services and to take the investment in Primary Care beyond the levels originally detailed in the GPFV.

The main source of funding is detailed in the Delegated Commissioning allocations detailed in table 2 below: -

Table 2

CCG	2019/20 (£m)	2020/21 (£m)	2021/22 (£m)	2022/23 (£m)	2023/24 (£m)
Hull CCG	47.45	49.04	51.25	52.96	54.76
East Riding CCG	44.49	46.16	48.45	50.32	52.32
Vale of York CCG	47.17	49.75	52.43	54.58	56.79
Scarborough and Ryedale CCG	18.31	18.98	19.89	20.62	21.39
North Lincolnshire CCG	25.59	26.99	28.63	29.98	31.39
North East Lincolnshire CCG	29.59	30.33	31.39	32.09	32.80
HCV Total	**212.6**	**221.25**	**232.04**	**240.55**	**249.45**

In addition to the delegated commissioning allocations, We expect that CCG's will want to invest further in Primary Care services from within their Core CCG allocations and will continue to receive and invest in year allocations for Primary Care from the GPFV programme which has a further two years remaining.

As part of NHS England's new operating model, increasingly more responsibility and ability to take decisions locally, will sit at an ICS level. This approach empowers and enables the ICS and CCGs to decide collectively, how best to deploy primary care funding including GPFV funding. HCV will develop an investment plan as required as part of the planning guidance to enable the Healthcare Partnership to receive funding at a system level for the 4 GPFV programmes, for which funding will be allocated in June 2019.

The 4 programmes are: -

- Practice Resilience
- GP Retention
- Reception and Clerical Staff Training
- Online Consultation

The care partnership will consider how best to utilise these monies using the following principles that the 6 CCG's within HC&V Healthcare Partnership are committed to regarding Primary Care investment: -

- Each CCG will invest in full 100% of their Delegated Commissioning allocations on Primary Care Services.
- Each CCG will invest in full 100% of their GPFV allocations or another specific primary care allocation in accordance with the National Directives pertaining to those allocations.

- Each CCG will invest on a recurrent basis £1.50 per head of population from their CCG Core Allocations in accordance with the planning guidance.
- Each CCG will maintain their existing investment in Primary Care and where financially viable invest further in Primary Care using CCG Core Allocations.
- The CCG's collectively agree to pool resources when and where appropriate across HCV.
- The CCG's collectively agree to support the ICS Digital lead and the NHSE Digital lead to develop Technology developments and investments for and across the HCV Healthcare Partnership as a whole to ensure the Healthcare Partnership footprint has parity in its IT infrastructure.

Table 3 below provides details of total resources planned to be utilised across the Healthcare Partnership Primary Care system: -

Table 3

Allocation Description	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m	2023/24 £m	Total £m
Delegated Commissioning	212.60	221.25	232.04	240.55	249.45	**1,155.89**
Core CCG £1.50 per head	2.16	2.18*	2.20*	2.22*	2.25*	**11.01**
Core CCG GPFV Access Included in Recurrent Baselines	3.63	8.72*	8.80*	8.89*	8.98*	**39.02**
PCN Clinical Director Investment	0.73	0.99*	1.00*	1.01*	1.02*	**4.75**
GPFV Programme Investment	1.15	1.25	1.25	1.26	1.26	**6.17**
CCG Primary Care Investment (if known)	1.27	0.50	TBC	TBC	TBC	**1.77**
International Recruitment	0.41	TBC	-	-	-	**0.41**
Clinical Pharmacist Investment	1.91	1.76	1.85	1.97	2.14	**9.63**
Total	**223.86**	**236.65**	**247.14**	**255.90**	**265.10**	**1,228.65**

** Based on 1% population increase across the Healthcare Partnership*

Component 2: **PCN development plan**

Our vision for PCNs is: -

- Networks will deliver tangible benefits for patients and clinicians resulting in:
    - improved outcomes for patients;
    - an integrated care experience for patients;
    - more sustainable and satisfying roles for staff, promoting development within multi-professional teams.
- Networks will assess population health - focusing on prevention and anticipatory care - and operate in partnership with other agencies to address the wider determinants of health.
- Care will be delivered as close to home as possible, with networks and services based on natural geographies, population distribution and need rather than organisational boundaries.
- Seamless care (for both physical and mental health) across primary care and NHS community services, will remove the historic separation of these parts of the NHS.
- Integration across PCNs and secondary care/place-based care will reduce demand for hospital-based care, with more clinically-appropriate secondary care in primary care settings.
- Joined up care planning, coordination and delivery will take place between primary care, community care, voluntary sector, social care, and other parts of local government, including public health, with NHS and social care teams working together in multidisciplinary teams (MDTs) and hubs. Services will respond to the needs of the communities they serve.
- Networks will fully harness the opportunities available from technology, including digital provision of care for patients (e.g. a digital front end), real time-shared care records and business intelligence systems.
- Staff will have a more sustainable workload and more attractive, structured career pathways, that enable multidisciplinary working, portfolio careers and the ability to move between care sectors.
- Integration and partnership working with wider partners will help to address wider determinants of health.
- A business model to incentivise networks, with a contract for outcomes based commissioning, appropriate payment models and removal of potential barriers to integration, including estates and indemnity.

PCNs (PCNs) are an essential building block of every Integrated Care System, and under the new Network Contract DES, general practice takes the leading role in every PCN. This will mean much closer working between PCNs and their Integrated Care System (including ICPs and CCGs).

To support the on-going development of PCNs, HC&V will utilise the Lancashire and South Cumbria local Primary Care Network and Neighbourhood Development Support Tool which has been developed to build on the NHS England PCN Maturity Matrix. The tool forms the basis of development discussions between CCGs and Neighbourhoods/Networks to understand their current progress and future ambitions. The tool provides simple ladders of maturity across six development themes: -

1. Leadership and Corporate Governance
2. Population Health Management and Care Models
3. Empowering People and Communities
4. Care Teams and Clinical Governance
5. Resource Management
6. Provider Collaboration

The tool is accompanied by an action planning template and identifies what support products will be developed and provided to PCNs/Neighbourhoods. The Healthcare Partnership will agree a timescale for completion of an initial assessment following the national requirements to agree PCNs and be in place for 1st July 2019, the likely timescale for roll out is in Quarter 3 of 19/20.

HCV has 29 PCNs as shown in Table 4 below

Table 4

CCG	Population @ 31/12/2018	No of PCNs
North East Lincolnshire	170,398	5
North Lincolnshire	180,064	3
Hull	301,099	5
East Riding of Yorkshire	305,584	7
Vale of York	360,758	6
Scarborough and Ryedale	120,844	3
Total	**1,438,226**	**29**

Component 3: Growing the Workforce

Our vision for primary care workforce is: -

- Develop our existing workforce to deliver place based person-centred care. Changing the conversation to personal strengths and assets;
- Create more learning opportunities for all professions to work together in Primary Care;
- To ensure that there is a sustainable, efficient, productive workforce sufficient to meet demand;
- Offer more career opportunities by working with partners to ensure that the workforce is representative of the population it serves;
- Ensure that HCV have a Primary Care workforce that is fit for purpose, fully supported and empowered to deliver the care required by the local population.

The workforce contribution is key to delivering service transformation and high-quality care within financial constraints. In HCV, the challenges of recruiting and retaining a skilled primary care workforce are a growing concern. There is an ageing workforce and simply put, not enough younger replacements coming through. What's more, a growing ageing population with complex needs, poor health outcomes and deprivation levels that place some localities at the top of the Index of Multiple Deprivation rankings, underline the fact that "doing nothing" is not an option.

Workforce is a crucial part of delivering the NHS Long Term Plan. CCGs across HCV are developing individual workforce strategies in Primary Care settings covering the lifespan of a career in Health and Social Care provision. We will continue to support the development of the workforce over the next five years. We will work in collaboration with Health Education England to look at innovative new roles to attract the best people into the health service, whatever stage of their career they are at.

Figures released by Health Education England (HEE) in October 2018 revealed the highest ever number of people accepting an offer of GP training in NHS history. The figure of 3473 meant the annual target of 3250 had been surpassed for the very first time with more than 300 additional trainees successfully choosing specialty training compared to the previous year, an increase of over 10% and a 30% increase since 2014. However, the current attrition rate of doctors leaving general practice is such that overall increase in GP numbers (FTE) will not be achieved simply by this increased future supply.
We will plan to deliver our commitment to increase our clinical workforce in line with our Workforce Strategy that will be available in Summer 2019.

We will ensure our current workforce are recognised, supported and developed by providing access to training and development programmes for example, Building Bridges, GP Mentorship, Training Hubs, GP Fellowship and support growing our own workforce through the HCV Excellence Centre.

We will support the development of Clinical Leadership and succession planning.

We will work with our partners to deliver on our commitment through the Primary Care Workforce Development Group

The local position for 2019 placements is detailed in the table 5 below: -

Table 5

Region	Rotations Available	Rotations filled August 2019
York	17	15
Scarborough and Ryedale	4	2
Northern Lincolnshire	4	4
Hull	25	25
Total	**50**	**46**

Whilst 92% or rotations have been filled for August 2019 this is short of the estimated need for 86 trainees to be appointed in HCV any one year. This is based on HEE Yorkshire and Humber target of recruiting 351 trainees and the HCV programmes share of this based on patient population.

HCV Workforce Board, Partnership forum are continuously reviewing data to understand the current supply (availability of new GPs) and need (demand both to fill existing or expected vacancies to meet future out-of-hospital provision) to be able to deliver an increase in medical workforce working within general practice, with the new Long-Term plan and contract reform we have an opportunity to plan more coherently.

Working with the local Primary Care Workforce Development Group we will maximise all opportunities from all national programmes and build on the excellent local work that is already underway and detailed in the table below.

Other workforce initiatives

In addition the defined workforce programmes listed above there are also several other workforce programmes being progressed as set out in the table below: -

Description	Progress to date
Care Navigators	CCGs have rolled out a series of training sessions across the Healthcare Partnership to support the development of care navigators who will relieve pressure on GPs by signposting patients to the most appropriate solution for their need.
Practice Managers Training	A series of Practice Management sessions have taken place across the Healthcare Partnership with further sessions planned for 2019/20 led by Humberside LMC and North Yorkshire LMC
Reception and Clerical Training	CCGs have rolled out a series of training sessions across the Healthcare Partnership to support the development of reception and clerical staff to play a greater role in navigation of patients and handling clinical paperwork to free up GP time
Workforce Planning	The Healthcare Partnership has signed up to roll out Apex Insights workforce tool across all GP practices and extended access providers with the deployment expected to be completed by end of Quarter 1 2019/20
Non-medical Prescriber Course	Partnership working with Hull University and York University to secure as many places for primary care staff to support career development
Online Consultation	The Healthcare Partnership has undertaken a procurement to secure a provider for online consultation across the STP with deployment underway 51% of patients can currently access online services

Medicines Optimisation in Care Homes	HCV was successful in NHS England have introduced a Medicines Optimisation in Care Homes (MOCH) programme, the focus being on care home residents using the Pharmacy Integration Fund (PhIF) to support the deployment of expert pharmacy teams to work in care homes from 2018/19 to 2019/20. The Medicines Optimisation in Care Homes programme focuses on care home residents, across all types of care home settings and aims to deploy dedicated clinical pharmacy teams. This scheme has been rolled out across the Healthcare Partnership in 2018/19
Cervical Cytology Training	NHS E has funded training for 80 nurses across the Healthcare Partnership including additional mentorship. The programme has now commenced with cohort 1. The programme has been developed in partnership with Haxby ATP
Leadership and Management Development Programme – Junior Managers	Funding for 25 places onto the programme aimed at supporting junior managers who work in a healthcare environment with the skills and supporting theory that will help them perform well in their role. It is suitable for new managers or team leaders in either non-clinical or clinical roles.
Social Care Prescribing Link Workers	Individual CCG support to bids from all practices for a Community Link service to navigate patients into social prescribing pathways. This was ahead of the national announcement for every primary care network to be fully funded for 1 social prescribing link worker with effect from 1st July 2019 as part of the network DES
Complex Care Team – Supporting frail and vulnerable people in care homes	This service is commissioned to support frail and vulnerable people in care homes with advanced care planning

Primary Care Mental Health	Improving quality of services to patients with mental health conditions. The service provides joined up working and case management of patients with complex mental health needs or particular vulnerability which affects their ability to study and/ or remain at University.
Falls	The project helps people remain independent in their own homes, and provide a rapid and effective response to any patients who do experience a fall, with a view to helping to avoid unnecessary hospital attendances/admissions
Learning Disability	Project to improve numbers of learning disability patient checks in the city of York to:- • Improve the quality of these checks • Develop a team to act to signpost resources for LD patients and carers • Improve patient screening • Run clinician and carer training events annually
Integrated Care Team	The Integrate Care Team will review each patient to understand what intervention is required and use an MDT approach to develop care plans or signpost the patient to the most appropriate option. The aims of the service are: - • To put service users at the centre of hub delivery • To improve defined population-based health and care outcomes • To reduce population-based healthcare costs, social care costs and associated costs • To improve the quality and equity of health and care services for the hub population as measured through defined information/outcomes • To provide proactive and preventative healthcare and health promotion through, for example, self-care and measures of patient independence

Mental Health Training	As part of the North Lincolnshire Out of Hospital Transformation Programme, partners recognised that there was a shortage of low level mental health training available. In order to increase confidence in what to do if someone is distressed or in a crisis situation, and help individuals with personal resilience, North Lincolnshire CCG and RDaSH have teamed up to offer free Mental Health First Aid training. General practice, commissioning staff, PPGs and local hospice staff have been invited to access the training. Initially 48 training places have been offered.

Component 4: **Digital Transformation in Primary Care**

Our vision for Digital Transformation

This component of the strategy sets out the vision for the digital transformation of primary care across HCV and will be accompanied by a HCV Digital Strategy, a draft is planned to be produced for June 2019.

We live in a digital age, when many of the services we use on a daily basis are provided or enabled by the use of technology.

However, we are also working in the world of health and care, where people come first, and the very essence of care is human contact and involvement.

Digital must never be seen as a replacement for face to face care when it is needed, but should be seen as a way to extend and enhance care offerings, support clinicians and other staff to deliver the care workload more effectively, sharing that workload to the most appropriate healthcare setting for the patient, enabling clinicians to focus more time on those who really need their skills, and to give patients and their carers options about how they access health and care services, specifically in this case, primary care services.

Digital can also provide new insights with the better use of analytics to support population health management, and the introduction of artificial intelligence to speed clinical decision making (not replace it).

There are, however, many situations where face to face consultations may not be needed, or those face to face discussions can take place away from a GP, with other practice staff, or other primary care practitioners.

Digital can help to enable this, giving patients choice in how and when they access services, supporting clinicians to deliver the services they need to, and helping to relieve some of the primary care, especially GP, workload pressures that are faced.

HCV has developed a digital roadmap prioritising IT workstreams for the coming years.

The following programmes relevant to Primary Care have been prioritised for deployment: -

- GPIT - Project to replace devices 4-5 years old as funding allows
- Windows 10 roll out - all Devices must be upgraded to Windows 10 by Mid Jan 2020
- Health and Social Care Network
- GPIT Contract Changes
    - Practices will be expected to make 25% of appointments bookable online, 'improve their online presence' and give new patients access to their digital records as standard.
    - By July 2019
    - Practices to improve online presence
    - All patients will have the right to digital-first primary care, including web and video consultations in 2021;

  - Give newly registered patients **FULL** access to their digital records as standard
  - Patients should also have digital access to their full records & clinical correspondence from 2020 - with the ability to add to the record;
  - Patients required to opt-out rather than opt-in;
  - All patients should be able to order repeat prescriptions electronically from April 2019;
  - From 2020 onwards, resources will be available to enable practices to offer online and video consultations;
  - NHS England has said there will be additional funding of IT to help patients make use of these technologies;
  - NHS 111 will begin direct booking in to practice appointments. Practices will be expected to make one appointment per 3,000 patients available each day for this;
  - *NHS111 will only book the appointment after Clinical triage*;
  - Practices will have access to a data protection officer through their CCG to provide support on GDPR issues;
  - Appointing a DPO remains a practice's legal responsibility;
  - With appropriate governance in place recognising patients' preferences, practices will be expected to share data for digital services as outlined in the NHS Long Term Plan, like the NHS App and including contributing data to Local Health and Care Record initiatives as they come online to support information sharing with other services, in line with LHCR expectations for timeliness of data sharing;
  - Practices will also have the critical role in creating and updating care plans for all appropriate patients, in as near to real-time as possible, to the Summary Care Record and to Local Health and Care Records when they are available. This will enable patients, their carers and professionals involved in their care are able to see the same information;
  - No Fax machines to be used by April 2020;
  - From October 2019, practices will register a practice email address with MHRA CAS alert system and monitor the email account to act on CAS alerts;
  - Digitalisation of Lloyd George notes to be completed by 2022.
- IT Service Procurement Process
  - About to start final year of existing LPF contract;
  - Need to formally procure new service;
  - Procurement team formed;
  - Mobilisation expected Jan 2020.
- Record Sharing
- Care Homes IT

Approach

The programme of work to support delivery of Digital Roadmap for the HCV will facilitate and support the implementation of the NHS Long Term Plan and GP Contract Reform document and also build on what has been achieved to date.

A key priority is to ensure that we move the whole Healthcare Partnership forward, with all practices and all PCNs benefiting from Digital First. It is acknowledged however that different areas will be at different stages on their digital journey, both technically, but also culturally, and a priority will be to ensure that there are minimum standards, but also enabling digital innovation by those who are further advanced.

Component 5: **Population Health Management**

Our Vision is that the particular needs of local populations are fundamental considerations in the delivery of services through PCNs

Taking a whole population approach means working collaboratively beyond the boundaries of health and care services to support people to stay healthy and avoid complications from existing illnesses. This is one of the key new ways of working outlined in the NHS Long Term Plan, published earlier this month. It will enable care to be delivered in the right place and at the right time for local people and their families

Through Population Health Management, we can use information which is already held about people to look at the best way to help people live longer, providing personalised care tailored to their needs. One example is using data to identify people who have multiple long-term conditions and understanding the ways in which they can be supported to prevent complications and live independently. This approach will be developed across HCV to make a real difference to people's lives.

Nearly half a million pounds is going to be spent in local communities across HCV, tackling the factors which have the greatest impact on people's health.

Component 6: Estates Technology Transformation Fund

Our Vision for the ETTF is to maximise the use of the funds available to us to produce infrastructure improvement across the Primary Care landscape

Humber, Coast and Vale Healthcare Partnership have continued to work with Practices and CCGs to best utilise capital for estates and technology investments.

The details of the Humber, Coast and Vale Healthcare Partnership Primary Care Capital Investments are detailed in Table 6 below:

Table 6

Programme	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m	2023/24 £m	Total £m
Estate & Technology Transformation Fund	4.18	2.78	-	-	-	**6.96**
Business as Usual	0.31	0.31	0.31	Tbc	Tbc	**0.93**
Total Capital Plans	**4.49**	**3.09**	**0.31**	**-**	**-**	**7.89**

Estate and Technology Transformation Fund (ETTF) – it is the intention to utilise this resource initially to invest in the development of the Primary Care premises infrastructure across Humber, Coast and Vale. Initial plans are to invest this capital resource to progress a number of new Primary Care Health Centres and to develop a number of existing Practices through premises improvements and extensions. There is uncertainty around the ability to support New Build schemes through ETTF however the Healthcare Partnership would be keen to develop the business cases for these schemes to ensure they're progressing and in a better position to access future Healthcare Partnership capital.

If it is financially viable, investments in Technology benefitting Primary Care across the whole of the Healthcare Partnership will be undertaken to utilise any slippage in spend. The Technology schemes will be developed and held in reserve pending the identification of local slippage or the release of regional and or national slippage.

It must be noted that the ETTF programme is due to be completed by 31st March 2021, at this stage it is unconfirmed whether a further similar scheme will be implemented.

Business as Usual – this resource will be used to invest in the cyclical refresh of GP IT equipment and to invest in Primary Care premises by way of Improvement Grants to

practices. Further investments in the Learning Disabilities Transformation Fund schemes will also be undertaken.

At this stage capital plans for 2019/20 to 2021/22 have been submitted to the NHS England Northern Region. Further plans will be developed on an on-going basis to ensure a pipeline of schemes is in place for when future capital funding routes are known.

Component 7: Quality and Digital Governance Standards

Our vision is that all service users accessing Primary Care Services in the HCV area can be assured that provision is underpinned by the most robust and comprehensive governance and quality structures

Within HCV Healthcare Partnership there are examples of local quality schemes developed by CCGs, the aims of the schemes are to: -

- Provide the opportunity to shift the balance of resource in the system from Acute to Out of Hospital;
- Ensure the best use of NHS resources and clinical skills within the care networks to avoid unnecessary referral. This includes the use of Advice and Guidance;

As part of continuing to improve outcomes the scheme is regularly under review and will be shared as part of sharing best practice across the Healthcare Partnership through the Primary Care Programme Board Committee.

Primary Care Quality Assurance and Improvement Framework – there are examples of a set of quality standards for primary care being developed across the Healthcare Partnership with the aim of having a consistent quality assurance approach being established which is driving improvements and enhancing safety within the practices across the region.

The standards cover a wide range of areas including traditional clinical quality markers, prevention, access etc and also describe what the team feel are key enablers of quality improvement such as shared decision making, information technology etc.

We will monitor the progress of PCNs through the network dashboard and share best practice.

We will monitor PCNs development across the six development themes covered within the maturity matrix.

We will work closely with the HCV Quality Improvement Group to develop robust systems of reporting and quality improvement that are consistent across the whole HCP. We will work with individual CCGs to support them with their research and quality improvement work and work in partnership with the RCGP and academic institutions to embed quality initiatives with PCNs.

Component 8: Patient Empowerment and Personalised Care

Our Vision is that Patients and Service users are fully involved in decisions with services commissioned at CCG and HCV level and the means by which the services are delivered to them

Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences. This is one of the five major practical changes to the NHS service model in the NHS Long Term Plan. It recognises that personalised care is central to a new service model for the NHS, including working through PCNs, in which people have more options, better support, and properly joined-up care at the right time in the optimal care setting.

This shift represents a new relationship between people, professionals and the health and care system. It provides a positive change in power and decision making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities.

Personalised care takes a whole-system approach, integrating services including health, social care, public health and wider services around the person. It provides an all-age approach from maternity and childhood, through living with frailty, older age and end of life, encompassing both mental and physical health and recognises the role and voice of carers. It recognises the contribution of communities and the voluntary and community sector to support people and help build resilience.

The Comprehensive Model for Personalised Care has been co-produced with people with lived experience and a wide range of stakeholders and brings together six evidence-based and inter-linked components, each of which is defined by a standard, replicable delivery model. The components are:

1. Shared decision making;
2. Personalised care and support planning;
3. Enabling choice, including legal rights to choose;
4. Social prescribing and community-based support;
5. Supported self-management;
6. Personal health budgets and integrated personal budgets.

Through these standard models we seek to create the balance between specifying a national, consistent standard and enabling flexibility for local adaptation and implementation. We also seek to align to or build on existing personalised approaches that have been adopted by both social care and health in the HCV area.

We will educate the population to choose appropriate treatments and enable them to manage their long-term condition and what self

Component 9 – Local Professional Networks for Dental, Eye Health and Pharmacy Services

Our Vision is that Dental, Eye Health and Pharmacy Services will be fully integrated members of the PCNs

In 2012 securing Excellence in Primary Care committed to the development of the Local Professional Network (LPNs) for Dentistry, Pharmacy and Eye Health, to provide local clinical leadership working with key stakeholders/Partners on the development and delivery of local priorities to deliver the National Strategy and Policy.

Integrated working with partners in Dental, Pharmacy and Eye Health is a key theme within the Primary Care strategy to ensure the best use of collective skills and knowledge are maximised to meet the challenges, reduce duplication and maximise opportunities for early intervention to improve patient outcomes. Primary Care services including dental, eye care, pharmacy and general practice are central to bringing care closer to home, managing long term conditions, preventing unnecessary hospital admissions and helping people stay well and healthy. Our patients want better access to GP and wider primary care services; to be better informed about self-care and health services generally and wrap around joined up care when needed.

HCV do not currently have any Local Professional Networks Pharmacy in place and haven't done for a number of years. The Primary Care Programme Board will consider a key role for itself over the next twelve months to promote the establishment of these networks and integrate these within PCNs (through their Clinical Directors) to promote full integration.

Signed

Dan Roper – Chair, Hull CCG

Geoff Day – Head of Co-Commissioning, NHS England

Primary Care Strategy 2019-2024

HUMBER COAST AND VALE HEALTH CARE PARTNERSHIP

SUMMARY OVERVIEW

GEOFF DAY – PRIMARY CARE PROGRAMME DIRECTOR

DR DAN ROPER-PRIMARY CARE CLINICAL LEAD

HELEN PHILLIPS –PRIMARY CARE PROGRAMME LEAD

Why Does HCV Need a Primary Care Strategy?

- To ensure primary care is able to act as a system leader to deliver the best outcomes for patients
- To provide a foundation on which to build a clear purpose and vision to act as roadmap for system partners to drive forward new service models and integrated pathways that are focussed on patient outcomes not organisational priorities
- To ensure we have a resilient, robust and vibrant primary care sector working together to meet the needs of the local population

Our strategic aspirations:

- Patients and service users will be empowered to make the right choice for them and supported to take greater control of their health and wellbeing
- To create an environment that supports innovation and makes best use of new technologies
- To support the development of clinical leaders capable of leading system change locally and nationally
- We will prioritise long term investment plans to support the delivery of transformational programmes aimed at improving outcomes for patients and greater job satisfaction
- To create a system locally that people will choose to work and feel valued in
- To promote the introduction of and support the development of triple integration within PCNs

Components:

- **Component 1**: Investment plans for local primary care transformation based on their local identified priorities
- **Component 2**: Primary Care Network Plan
- **Component 3**: Local Workforce Plan
- **Component 4**: Digital and Technology
- **Component 5**: Population Health Management
- **Component 6**: Estates Technology Transformation
- **Component 7**: Quality and Digital Standards
- **Component 8**: Patient Empowerment and Personalised Care
- **Component 9**: Local Professional Networks for Dental, Eye Health and Pharmacy Services

Component 1: Investment

Our Vision for Primary Care Investment is that we make full use of all monies available for the support and development of Primary Care

- The introduction of the GP Contract Reforms 19/20 will see a minimum of £388m invested into primary medical care locally over the next 5 years, this is in addition to £1.16 billion core funding that is already committed over the 5 year period

Component 2: Primary Care Networks

Our vision for Primary Care Networks is: -

- Networks will deliver tangible benefits for patients and clinicians resulting in:
    - improved outcomes for patients;
    - an integrated care experience for patients;
    - more sustainable and satisfying roles for staff, promoting development within multi-professional teams;
    - Strong clinical leadership;

Component 2: Primary Care Networks

CCG	Number of PCNs
East Riding of Yorkshire	7
Hull	5
North Lincolnshire	3
North East Lincolnshire	5
Scarborough and Ryedale	3
Vale of York	6
TOTAL	29

Component 3: Local Workforce Plan

Our vision is to : -

- Develop our existing workforce to deliver place based person-centred care
- Create more learning opportunities for all professions to work together in Primary Care
- Ensure that there is a sustainable, efficient, productive workforce sufficient to meet demand
- Offer more career opportunities by working with partners to ensure that the workforce is representative of the population it services
- Ensure that HCV have a Primary Care workforce that is fit for purpose, fully supported and empowered to deliver the care required by the local population
- Ensure that the HCV area is known as a great place to work and live
- Support the development of a programme for GPs wishing to enter into a partnership model
- Support the development of clinical leadership and succession planning

Component 4: Digital and Technology

Our Vision for Digital and Technological Innovation is to use it to give patients choice in how and when they access services, support clinicians to deliver the services they need to, and help to relieve some of the primary care, especially GP, workload pressures that are faced

- A Digital Strategy will be available in summer 2019 and will support the national drive of going digital first

- Key priorities for the over the next 5 years may change as technology develops, initial focus will include : -
  - IT service re-procurement;
  - Promote use of the summary care record;
  - Implement the local health record to enable the sharing and updating of patient records;
  - To enable the integration of clinical systems within care homes;

Component 5: Population Health Management

Our Vision is that the particular needs of local populations are considered fundamental in the delivery of services through Primary Care Networks

- Taking a whole population approach means working collectively beyond the boundaries of health and care services to support people to stay healthy and avoid complications from existing illnesses
- Using our PCNs as a building block for service planning and delivery we will tailor services to ensure care and advice is delivered in the right place at the right time for local people and their families
- Through our Population Health Management approach, we will enable PCNs to proactively support the local population to make choices that help them achieve their health goals, manage their existing long term conditions, retain their independence and have a good quality of life

Component 6: Estates Technology Transformation Fund

Our Vision for the ETTF is to maximise the use of the funds available to us to produce infrastructure improvement across the Primary Care landscape

- We are committed to spending £10.3m from ETTF to support the development of primary care medical estates and increase capacity
- We will continue to work across HCV to develop a capital pipeline that will aim to secure sufficient funding to ensure emerging service models can be delivered in an appropriate setting

Component 7: Quality and Digital Standards

Our vision is that all service users accessing Primary Care Services in the HCV area can be assured that provision is underpinned by the most robust and comprehensive governance and quality structures

- We will support the national drive of going digital first
- We will monitor the progress of primary care networks through the network dashboard and share best practice
- We will take a consistent approach to monitoring Primary Care Quality Assurance and Improvements based on a set of quality standards for primary care being developed across the Healthcare Partnership
- We will monitor PCNs development across the six development themes covered within the maturity matrix

Component 8: Patient Empowerment, Engagement and Personalised Care

Our Vision is that Patients and Service users are fully involved in decisions with regard to the nature of services commissioned at CCG and HCV level and the means by which the services are delivered to them

- We will develop a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes
- Recognising that personalised care is central to a new service model for the NHS, including working through primary care networks we will provide people with more options, better support, and properly joined-up care at the right time in the optimal care setting
- We will deliver this through the adoption and implementation of the Comprehensive Model for Personalised Care
- We will educate the population to choose appropriate treatments and enable them to manage their long-term condition and what self care means to them through engagement across the Healthcare Partnership

Component 9: Local Professional Networks

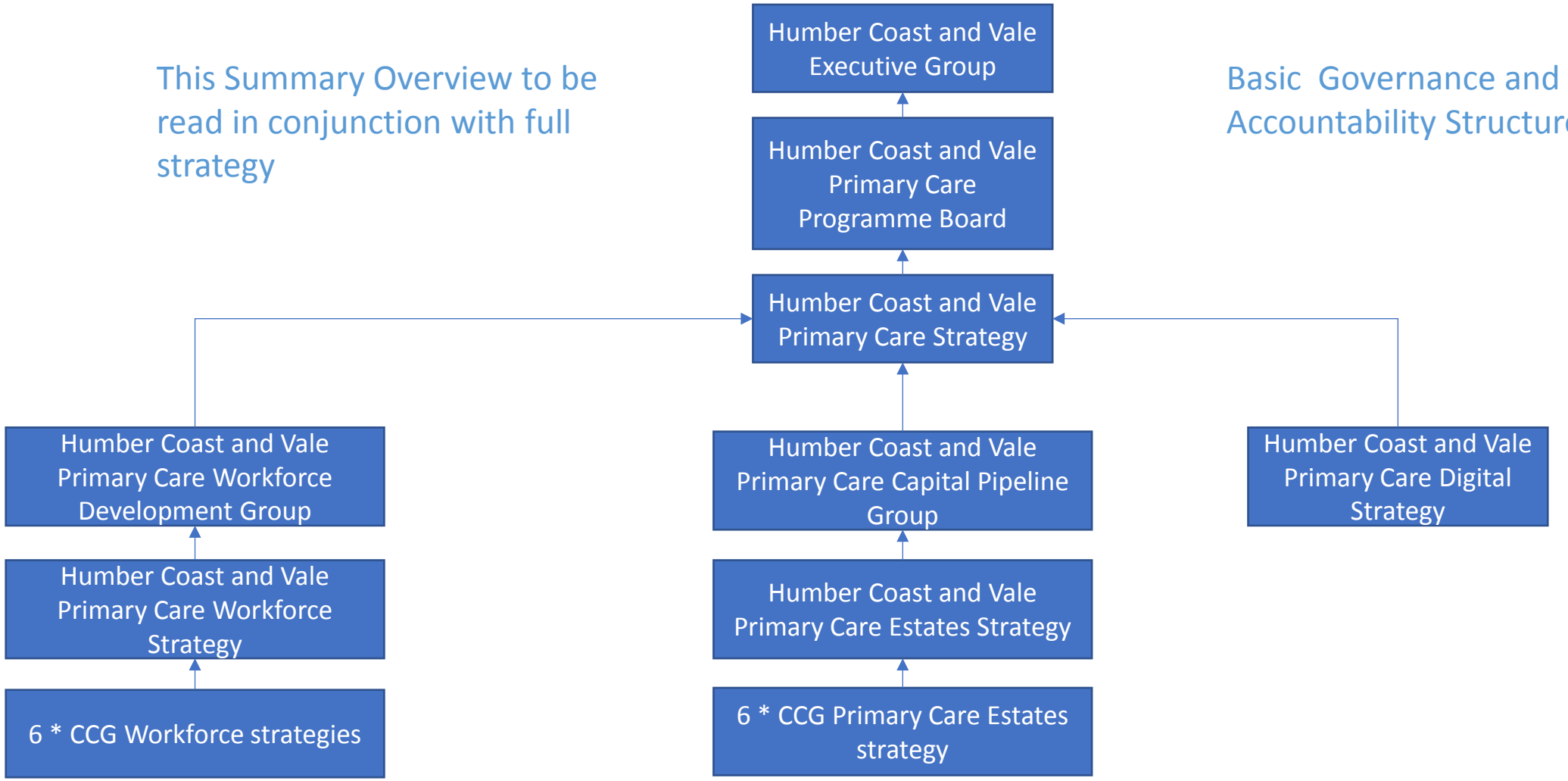
Our Vision is that Pharmacy, Dental and Optometry networks will be fundamental in the delivery of services through PCNs

- We will establish a network of professional colleagues to support the future planning of healthcare services
- We will fully involve professional colleagues in the planning decisions for future healthcare services

Humber Coast and Vale Primary Care Strategy

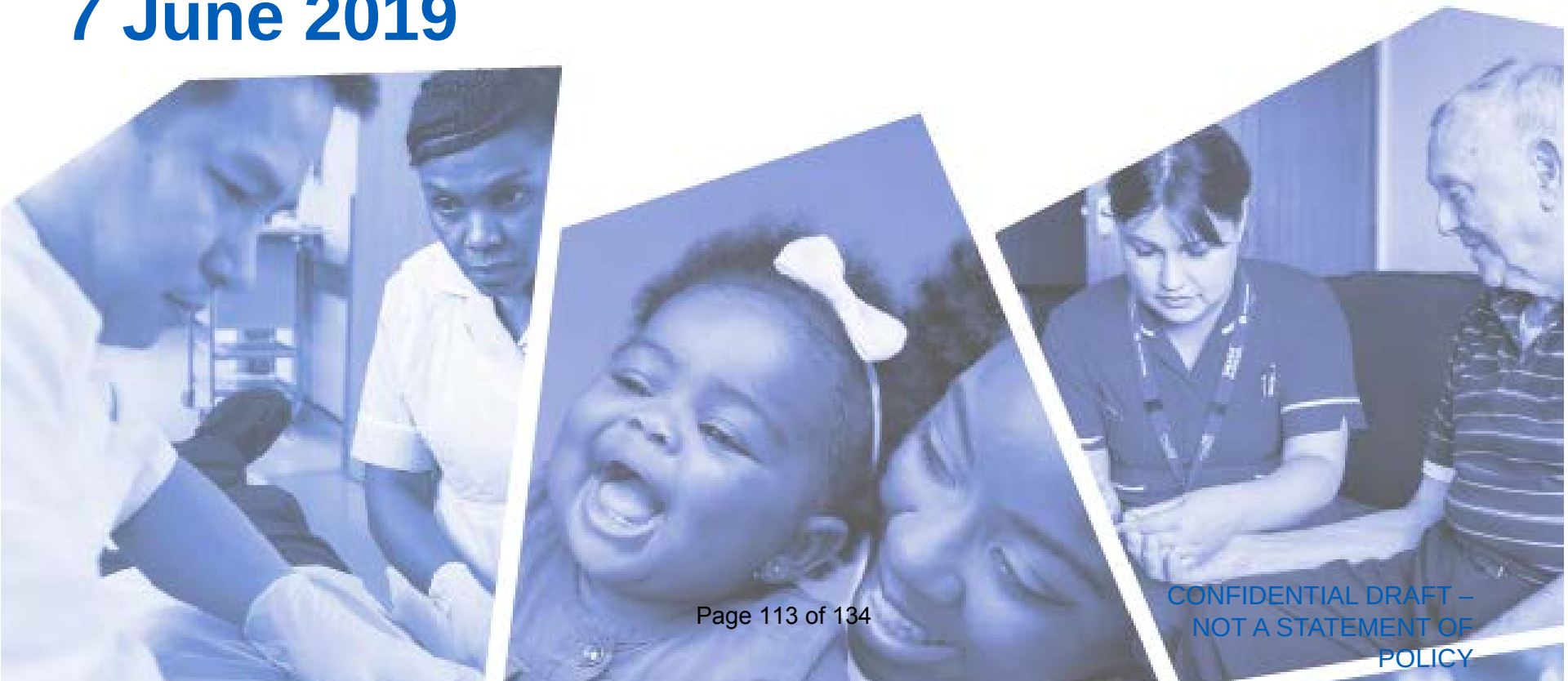
This Summary Overview to be read in conjunction with full strategy

Basic Governance and Accountability Structure



PCN Additional Roles Reimbursement Scheme: Establishing the workforce baseline and assessing additionality

7 June 2019



CONFIDENTIAL DRAFT – NOT A STATEMENT OF POLICY

"The intention of the scheme is to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage. It is not to fill existing vacancies or subsidise the costs of employing people who are already working in primary care, whether funded by a practice, a CCG or a local NHS provider. ***Reimbursement through this route will only be for demonstrably additional people*** *(or, in future years, replacement of those additional people as a result of staff turnover). This additionality rule is also essential for demonstrating value for money for the taxpayer".*

Investment and evolution: A five-year framework for GP contract reform to implement the NHS Long Term Plan (Jan 2019)

Additional Roles Reimbursement Scheme

NHS England

Reimbursement

Scheme will meet a recurrent 70% of the costs of additional clinical pharmacists, physician associates, physiotherapists, and paramedics; and 100% of additional social prescribing link workers.

- Through a new ***Additional Roles Reimbursement Scheme***, Networks will be guaranteed funding for an up to estimated 20,000+ additional staff by 2023/24:
  - **Clinical pharmacists** (from 2019/20)
  - **Social prescribing link workers** (from 2019/20)
  - **Physiotherapist** (from 2020/21)
  - **Physician associates** (from 2020/21)
  - **Paramedics** (from 2021/22).
- Funding cannot be used for any other staff groups.
- Funding will be set nationally based on Agenda for Change scales, but there is no requirement locally to employ on the AfC contract.
- Network can agree how the new workforce is employed and deployed across the Network.

Transitional year 2019/20:

- All PCNs can claim reimbursement for 1 FTE Clinical Pharmacist and 1 FTE Social Prescriber (2 of each if PCN over 100k population). Can substitute between them with CCG agreement.
- Practices/PCNs can transfer existing clinical pharmacists on the NHS England national schemes from 1 July 2019 to claim ongoing 70% reimbursement but staff must be a network resource.

April 2020 onwards

- Each PCN will be able to draw down in a flexible way from a total reimbursement sum available to them under the scheme, calculated according to weighted population.

Principles (1)

I. The Network Contract DES sets out an entitlement for PCNs, subject to meeting agreed requirements, to receive payments set out under the Additional Roles Reimbursement Scheme;

II. Reimbursements are available for PCNs via a payee that has a GMS, PMS or APMS contract, for FTEs or part FTEs, in the specified (five) roles that are additional to the agreed PCN baseline as at 31 March 2019.

III. CCGs will be responsible for agreeing the workforce baseline with PCNs as part of the DES registration process no later than 30 June 2019.

IV. Baseline posts should be recorded against the individual workforce groups rather than the total number of staff in all five roles.

V. CCGs will submit the baseline report for national monitoring which should include:
- the PCN baselines in their area for staff employed by general practice;
- the CCG baseline for staff funded by CCGs and not employed by general practice.

Principles (2)

VI. The process of agreeing the baseline should include a signed declaration from the PCN Clinical Director and CCG Accountable Officer that the baseline reflects an accurate assessment to the best of their knowledge. So there is transparency, the PCN baseline should also be shared with LMCs and potentially, other PCNs in the same patch. Breach of the rules may result in regulatory and legal action.

VII. Once agreed, the PCN and CCG baselines are fixed for five years. Baseline posts cannot be substituted with posts in other staff groups and all PCN reimbursement claims should only be for staff additional to the PCN baseline.

VIII. Practices will continue to record workforce via National Workforce Reporting System (NWRS), which is being developed to also record PCN staff from the 30 September extraction. CCGs will submit six-monthly returns to enable the measuring of the prevailing aggregate position against the PCN workforce expansion.

IX. PCNs and CCGs are encouraged to have ongoing dialogue in relation to PCN and CCG workforce strategies, to ensure these are consistent with broader STP/ICS workforce strategies.

Establishing the baseline (1)

PCN baseline

1. Roles with staff in post in the five reimburseable groups which are employed or paid for by general practices as at 31 March 2019 should be included in the PCN baseline and cannot be reimbursed under the scheme at any point in the future.
2. The PCN baseline should include actual FTE or part FTE staff in post on 31 March 2019 to include: clinical pharmacists, physician associates, physiotherapists and paramedics. Social prescribers should be included in the PCN baseline only if employed/funded by general practice and in post on 31 March 2019.
3. CCGs will agree with PCNs the workforce baseline as a requirement of the PCN registration process by no later than 30 June and use this to assess additionality thereafter. The published NHS Digital report (sourced from practice reported NWRS) will be available to inform those discussions.

CCG baseline

1. Staff in the five reimburseable groups which are funded by CCGs – either directly or indirectly e.g. as a service – and deployed to support general practice/primary medical care, with an element of patient-facing / first contact care time in specific practices or in the wider neighbourhood/community as at 31 March 2019, should be included in the CCG baseline and cannot be reimbursed under the scheme at any point in the future. This should include:
    i) social prescribers where funded by CCGs and not employed by GP practices.
    ii) Staff funded by CCGs but employed by PCNs

   Only the FTE associated with patient facing/first contact time should be included in the baseline.
2. Where CCGs currently fund staff working across practices indirectly via a commissioned service, they should calculate the appropriate FTE associated with the service and include them in the CCG baseline.
3. CCGs will be obliged to continue to fund baseline posts and will be subject to audit. All CGGs have been fully funded for GP contract costs in their primary medical services allocations. CCG baseline posts will have no bearing on PCN additionality claims.
4. CCGs may wish at a local level to attribute CCG baseline posts to PCNs to support transparency as to the resource available to individual PCNs. However these posts should continue to be included in the CCG baseline for reporting purposes.

Establishing the baseline (2)

NHS England

Clinical pharmacists on the national reimbursement schemes

1. Clinical pharmacist posts receiving funding via the current national schemes and in post as at 31 March 2019 should be included in PCN baselines where employed by GP practices or the CCG baseline where not employed by GP practices. (Specific rules for how these pharmacist posts can transfer to receive reimbursement via the Additional Roles Reimbursement Scheme are set out in the Network Contract DES Guidance. See slides 13 and 14 for further information).

LA/Voluntary sector funded posts

2. Staff in the five reimburseable roles which are established and supporting general practice/primary medical care but funded by an organisation outside the NHS - either directly or as a service - with an element of patient-facing / first contact care time in specific practices or in the wider neighbourhood/community as at 31 March 2019 (e.g. Social Prescribers funded by LAs or charitable organisations at no cost to the NHS) should be recorded by CCGs as part of the baseline exercise but should not be included in the PCN or CCG baseline. Only the FTE associated with patient facing/first contact time should be included in the baseline.

3. CCGs will be responsible for liaising with non-NHS organisations to obtain information on the numbers of staff in this category and should work with these organisations to ensure that these roles continue to be funded.

Training posts

4. Any post/individual that is in a training placement should be excluded from the baseline.

Pharmacy Technicians

5. Pharmacy technicians are not one of the five reimbursable roles working in PCNs in 2019/20, but their potential future inclusion has been flagged in the contract documentation. These posts should be recorded in the CCG baseline to inform future strategy.

Example scenarios – Establishing the baseline

Scenario One
A social prescribing link worker is jointly funded by multiple CCGs and the STP commissions the County Council to provide the staff. The County Council sub-contracts provision of SPLWs out to a voluntary sector organisation.
The SPLWs should be recorded in the relevant CCG baselines.

Scenario Two
A clinical pharmacist reimbursed via the national Clinical Pharmacists in General Practice scheme and employed by a CCG was in post as at 31 March 2019 but will transfer to a PCN from 1 July 2019.
The Clinical Pharmacist will be included in the CCG baseline but should be reported via NWRS by the PCN/practice from 1 July onwards.

Scenario Three
A CCG employed medicines optimisation pharmacist works across practices on general prescribing matters but does not undertake patient facing work.
The pharmacist should not be included in the CCG baseline as he/she has no patient-facing element to their role.

Scenario Four
A clinical pharmacist employed by a practice resigns and their contract ends on 22 March 2019.
The post should be excluded from the PCN baseline as the baseline should only include staff in post as at 31 March 2019.

Scenario Five
A social prescribing link worker is funded by a CCG on a fixed-term contract ending on 31 August 2019
The post should be included in the CCG baseline as the staff member was in post as at 31 March 2019

Baseline survey

I. The reporting template will collect the PCN and CCG baseline position – as at 31 March 2019 – which has been agreed between CCGs and PCNs for the five roles.

II. The baseline should comprise:

- Practice employed staff – which are recorded by practices through NHS Digital's National Workforce Reporting System (NWRS). We will include the 31 March figures for each practice in the reporting template. The data should be validated, any changes marked in the template and the NWRS updated by practices. Please note that social prescribers were not included in the March survey, but will be included from June onwards.
- CCG funded staff working in practices (where not *employed* by practices and recorded in NWRS) or supporting primary medical care with a patient facing / first contact element to their role. Only the FTE associated with patient facing/first contact time should be included in the baseline.

III. The baseline survey will be distributed and returned to a central mailbox through NHSE regional teams.

Process map

End March 2019

- NHS Digital Extract NWRS data
- Network Contract DES Guidance published

May 2019

- NHS England produce and test scheme principles and draft baseline survey

End May 2019

- CCGs finalise PCN registration
- NHS Digital publish 31 March workforce data
- CCGs discuss PCN workforce baseline as part of PCN registration process

June 2019

- NHS England circulate baseline reporting template (early June)
- CCGs submit PCN and CCG workforce baseline template returns to Regions (28 June)

1 July 2019

- Regions review and return to NHSE mailbox (5 July)
- Application open for PCNs to apply to CCGs for reimbursement, including transferring clinical pharmacists from existing national schemes.
- CCGs assess reimbursement applications against PCN baseline

End Dec 2019

- FIRST SUBMISSION
- CCGs submit updated workforce tables

Assessing additionality

1. Applying strict additionality criteria secures pre-existing funding for general practice.

2. Additionality should be assessed against the PCN FTE baseline only as CCGs will continue to provide the current level of support identified in the CCG baseline.

3. It should be assessed against individual workforce groups e.g. a claim for a physiotherapist should be assessed against the number of baseline physiotherapist posts rather than the total number of staff in the PCN baseline in all five roles.

4. Additionality claims should only be approved if the number of FTE staff in post in the specific workforce group matches the agreed 31 March 2019 baseline position e.g. 2 FTE clinical pharmacists in post vs 2 FTE clinical pharmacists in PCN baseline. Reimbursement claims will not be authorised where there are vacancies in the relevant baseline posts.

5. The scheme cannot distinguish between staff with different job descriptions e.g. a MSK physiotherapist is the same as a non-MSK physiotherapist for the purposes of the baseline and additionality so long as both roles have an element of patient-facing / first contact care time in specific practices or in the wider neighbourhood/community.

6. Commissioners may claim back reimbursement monies where it becomes apparent that a PCN was not eligible to claim reimbursement under the Network Contract DES e.g. because it failed to declare a vacant baseline post.

7. Further guidance on assessing additionality will be issued shortly.

Example scenarios – Assessing additionality

The following scenarios are designed to assist CCGs in assessing applications from PCNs for reimbursement.

Scenario One
Clinical pharmacist employed by a practice funded directly by the partnership commenced work on 1 January 2019. In August 2019 the clinical pharmacist resigns and a replacement takes up post in December 2019.
The post is in the baseline and the PCN cannot apply for reimbursement for the new pharmacist.

Scenario Two
Clinical pharmacist working in a practice as 31 March 2019 retires in October 2019. The PCN recruits an additional two clinical pharmacists who will commence work in January 2020 and applies for reimbursement.
The PCN receives reimbursement for one pharmacist as the second pharmacist is replacing a baseline post.

Scenario Three
In October 2019 a practice decides to disestablish a clinical pharmacist post because they have decided to appoint an advanced nurse practitioner to provide services in a different way. 12 months later the practice, as part of a PCN decide to appoint a clinical pharmacist as a result of expanding demand and to support delivery of new Network service specifications.
The PCN cannot claim reimbursement for the new clinical pharmacist as this post is replacing the baseline clinical pharmacist post. Workforce baseline posts cannot be substituted with staff in non-reimburseable roles.

Scenario Four
The CCG is currently funding clinical pharmacists to support the delivery of medicines optimisation across the local practices. These posts were logged in the CCG baseline. One of the pharmacists resigns and exits. In the meantime, the PCN recruits a clinical pharmacist with a broader JD and applies to the CCG for reimbursement.
The new pharmacist is additional and the PCN can claim reimbursement as CCG baseline posts have no bearing on PCN additionality claims. CCG should continue to fund baseline clinical pharmacist posts.

Scenario Five
A social prescribing link worker is funded by a local authority but the funding is halted in December 2019 as a result of a LA decision. The PCN decides to fund a SPLW from January 2020 to provide a service in the same area.
The post is additional and the PCN can claim reimbursement as LA funded posts are excluded from the PCN baseline.

Implications for Clinical Pharmacists on the national General Practice scheme

- *Investment and Evolution* confirmed the only exception to the additionality principles would be existing clinical pharmacists reimbursed under either the *Clinical Pharmacists in General Practice Scheme* or *Medicines Optimisation in Care Homes Scheme*. As such, GP practices and their PCNs will be able to transfer **all** clinical pharmacists employed via the *Clinical Pharmacists in General Practice Scheme* to receive reimbursement under the Network Contract DES providing that the clinical pharmacist(s) were:

  I. already employed and in post prior to the baseline as set at 31 March 2019 (see section 4.5.3 of the Network Contract DES Specification); AND
  II. will be working across the PCN, as part of the PCN workforce, and carrying out the same duties as described in section 4.5.15 of the Network Contract DES Specification; AND
  III. the transfer takes place before 30 September 2019.

- In 19/20, in addition to transferring clinical pharmacists on the national scheme, PCNs may also be able to claim reimbursement for an additional 1 FTE Clinical Pharmacist. See *Network Contract Directed Enhanced Service: Guidance for 2019/20 in England (May 2019)* fur further information.

- In transferring more than one clinical pharmacist, PCNs will need to be mindful that the Network Contract DES reimbursement arrangements will be changing from year two to a weighted capitation sum. The weighted capitation sum will provide a single combined maximum reimbursement sum covering all five staff roles, including any pharmacists transferred from the current national scheme. The PCN will have the flexibility to decide how many of each of the reimbursable staff they wish to engage from within their Additional Roles Reimbursement Sum.

- GP practices who have clinical pharmacists employed under the *Clinical Pharmacists in General Practice Scheme* may choose not to transfer them to the Network Contract DES and instead, to continue the employment of their clinical pharmacist(s) under the terms for the existing scheme. The GP practice will continue to receive tapered funding as set out in this scheme, following which there will be no further national funding for their role.

Assessing additionality for Clinical Pharmacists transferring from the national scheme

Scenario One
Clinical pharmacist employed under current national scheme and in post prior to 31 March 2019.
The post is included in the PCN or CCG baseline. Providing the clinical pharmacist is transferred prior to 30 September 2019 then they will count as an exception to the additionality principles and be eligible for funding under the Network Contract DES. In 19/20, the PCN will also be able to claim, in addition to any clinical pharmacist(s) transferred, reimbursement for one additional FTE clinical pharmacist under the Network Contract DES (or two additional FTEs if PCN is over 100,000).

Scenario Two
Clinical pharmacist approved and appointed by 30 April 2019 but clinical pharmacist was not in post under current scheme as at 31 March 2019 (appointed in this context means that the clinical pharmacist has a signed contract of employment).
The post is not included in the baseline and the PCN can claim reimbursement for the pharmacist. In 19/20, the PCN will not be able to claim for a further additional FTE clinical pharmacist in 19/20.

See *Network Contract Directed Enhanced Service: Guidance for 2019/20 in England (May 2019)* fur further information.

For more information visit www.england.nhs.uk/pcn or email england.pcn@nhs.net.

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Item Number : 11

Name of Presenter : Dr Andrew Lee

Meeting of the Primary Care Commissioning Committee **Date of meeting : 11 July 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 :

- 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	Rachael Simmons Corporate Services Manager

Annex 1 – events / risks management by the Primary Care Commissioning Committee

PRIMARY CARE COMMISSIONING COMMITTEE : 11 JULY 2019

Risk Update Report

There are currently three risks on the Committee's risk report.

Two new risks have been identified since the last meeting :

Reference	Description	Rating
PRC.12	Commissioning of evening and weekend access to General Practice for 100% of population	Likelihood 4; impact 2 – RAG 8
PRC.13	Primary Care Team resource to deliver the CCG statutory functions	Likelihood 3; impact 4 – RAG 12

The rating for the third risk has not changed :

Reference	Description	Rating
PRC.11	Estates and Technology Transformation Fund Strategy	Likelihood 4; impact 4 – RAG 16

NHS
Vale of York
Clinical Commissioning Group

COMPLETE

CORPORATE ON-GOING EVENTS MANAGED BY PRIMARY CARE COMMISSIONING COMMITTEE – JULY 2019

Risk Ref & Title	Description	Impact on Care, Potential for Harm	Mitigating Actions	Latest Note	Operational Lead	Lead Director	L'hood	Impact	Current Risk Rating	Movement this Month	Last Review

NHS
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CORPORATE RISKS MANAGED BY PRIMARY CARE COMMISSIONING COMMITTEE

Risk Ref & Title	Description	Impact on Care, Potential for Harm	Mitigating Actions	Latest Note	Operational Lead	Lead Director	L'hood	Impact	Current Risk Rating	Movement this Month	Last Reviewed
PRC.11 Estates and Technology Transformation Fund Strategy	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.	All bids have been developed to the point where they need to be approved by Region to progress to Outline Business Case. NHS England North Region have put all new build requests on hold, pending amendments to Premises Costs Directions. These changes have been awaited for three years. Regular update discussions with local team to keep the schemes 'alive'.	The national NHS England team responsible for ETTF have written to the regional finance lead to indicate that there has been agreement as to how the current Premises Costs Directions can be used to support grants for new builds. This has been the main issue with our bids not progressing. The local team are now in the process of reassessing and scoring all new builds. We await the outcome of that assessment and an indication as to whether the regional team will support the funds required to underwrite business case costs. 18.04.2019 No update – still awaiting NHS England confirmation of next steps to fund business cases.	Stephanie Porter	Accountable Officer	4	4	16		18 April 2019
PRC.12 Commissioning of evening and weekend access to General Practice for 100% of population.	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.		Paper to Primary Care Commissioning Committee on 09.05.2019 to request approval to develop a contract with Vocare to deliver this service across the registered populations of South locality Practices (x6).	SM working with both emerging Primary Care Networks in the South locality to re-start conversations around developing the Improving Access service in the context of PCNs being responsible for providing this service by 2021 through their Network Contract. Conversations in progress with the Clinical Directors of both PCNs to explore options to use the available funding to recruit additional staff to deliver evening and weekend appointments in General Practice. No current challenge from NHS England,	Shaun Macey	Executive Director of Primary Care and Population Health	4	2	8	NEW	30 April 2019

Risk Ref & Title	Description	Impact on Care, Potential for Harm	Mitigating Actions	Latest Note	Operational Lead	Lead Director	L'hood	Impact	Current Risk Rating	Movement this Month	Last Reviewed
				but there is an on-going risk that the CCG will be challenged to commission this service in line with current national requirements. Other CCG staff also involved with related discussions around Selby Urgent Treatment Centre and Selby Hospital bed cover.							
PRC.13 – Primary Care Team resource to deliver the CCG statutory functions	NHSE/I will commence its next phase of organisational review in Sept 2019. In addition to a new Director being appointed who has already begun looking at the various ways in which NHSE/I offer support to CCGs and the inconsistency in the offer to the different CCGs in the STP. VoY CCG currently has a number of staff supporting the CCG effectively delivering the statutory functions for Primary Care. We have a significant reliance of these external resources in the new proposed staffing structure.	This is a CCG statutory function relating to the contracting of primary care.	The core skills and functions of the NHSE team need to shared and transferred into CCG teams. This will require staff to be trained and operational procedures to be prepared. The mitigation actions/staff align with those functions within the Finance and Contracting team with support and oversight from the Assistant Director Primary Care.	June 2019 – new risk	Stephanie Porter	Executive Director of Primary Care and Population Health	**3**	**4**	**12**	**NEW**	05 June 2019