Vale of York
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

22 November 2017, 9.30am to 11.30am

Snow Room (GO35), West Offices, Station Rise, York YO1 6GA

AGENDA

Prior to the commencement of the meeting a period of up to 10 minutes 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; this will start at 9.30am.

1. 9.40	Verbal	Welcome and Introductions		
2.	Verbal	Apologies		
3.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
4. 9.45	Pages 3 to 11	Minutes of the meeting held on 19 September 2017	To Approve	Keith Ramsay – Chairman
5.	Verbal	Matters Arising		All
6. 9.50	Pages 13 to 24	Primary Care Commissioning Committee Terms of Reference	To Approve	Phil Mettam – Accountable Officer
7. 9.55	Pages 25 to 29	Primary Care Commissioning Financial Report	To Receive	Tracey Preece – Chief Finance Officer
8. 10.10	Verbal	General Practice Visits and Engagement Update	To Note	Andrew Phillips – Joint Medical Director
9. 10.15	To Follow Sepatately	Primary Care Assurance Report	To Receive	Michelle Carrington – Executive Director of Quality and Nursing
10. 10.25	Pages 31 to 38	Prescribing Indicative Budgets	To Receive	Tracey Preece – Chief Finance Officer

11. 10.35	Pages 39 to 46	General Practice Forward View, Improving Access to General Practice Services	To Receive	Shaun Macey – Head of Transformation and Delivery
12. 10.45	Pages 47 to 57	Improving Access to General Practice Survey - Patient Engagement	To Agree	Heather Marsh – Head of Locality Programmes, NHS England (Yorkshire and the Humber)
13. 10.55	Verbal	Personal Medical Services Monies 2018/19	To Note	Shaun Macey – Head of Transformation and Delivery
14. 11.00	Pages 59 to 70	Presentation of the proposed primary care estates investment bids detailing the revenue impact for approval by the CCG *Stephanie Porter, Deputy Director – Estates and Capital Programmes, attending*	To Approve	Tracey Preece – Chief Finance Officer
15. 11.15	Pages 71 to 75	NHS England Primary Care Update	To Receive	Heather Marsh – Head of Locality Programmes, NHS England (Yorkshire and the Humber)
16. 11.25	Verbal	Key Messages to the Governing Body	To Agree	All
17. 11.30	Verbal	Next meeting: 9.30am, 24 January 2018 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.

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

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

Item 4

Minutes of the Primary Care Co-Commissioning Committee held on 19 September 2017 at West Offices, York

Present

Keith Ramsay (KR) - Chair	CCG Lay Chair
David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Heather Marsh (HM)	Head of Locality Programmes, NHS England (Yorkshire and the Humber)
Phil Mettam (PM)	Accountable Officer
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Tracey Preece (TP)	Chief Finance Officer

In Attendance (Non Voting)

Kathleen Briers (KB)	Healthwatch York Representative
Dr Aaron Brown (AB)	Local Medical Committee Liaison Officer, Selby and York
Dr Lorraine Boyd (LB)	GP, Council of Representatives Member
Shaun Macey (SM)	Head of Transformation and Delivery
Dr Andrew Phillips (AP)	Joint Medical Director
Michèle Saidman (MS)	Executive Assistant

Apologies

Dr Paula Evans (PE)	Chair, Council of Representatives
Dr Shaun O'Connell (SOC)	Joint Medical Director
Sharon Stolz (SS)	Director of Public Health, City of York Council.

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

There was one member of the public in attendance.

Question from Member of the Public

Bill McPate

Given the reported prospects of increased illness due to 'flu, what steps are being taken to mitigate its effect.

Response

MC explained that the 'flu plan would be presented to the Committee but was still being finalised. She noted that, where possible, the plan would be developed jointly

with councils and that the emergency outbreak plan was in addition to the annual Winter Plan. MC also noted that information about vaccine uptake by Practices was starting to be shared and added that through contracts the CCG held all providers to account for vaccination of staff.

AP highlighted that Practices had an annual 'flu campaign and were incentivised in this regard. KR added that the responsibilities of both commissioners and providers regarding vaccination had been emphasised at a national meeting the previous day.

AGENDA

1. Welcome and Introductions

KR welcomed everyone to the meeting He particularly welcomed AB to his first meeting since appointment as Local Medical Committee Liaison Officer.

2. Apologies

As noted above.

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

There were no declarations in relation to the business of the meeting. All declarations were as per the Register of Interests. KR reminded the Committee of the need to ensure declarations were updated if required.

4. Minutes of the meeting held on 25 July 2017

The minutes of the meeting held on 25 July were agreed.

The Committee

Approved the minutes of the meeting held on 25 July 2017.

5. Matters Arising

PCCC6 Primary Care Commissioning Committee Terms of Reference – Role of the Committee in the context of the Accountable Care Partnership Board: KR advised that these discussions were still ongoing.

SP joined the meeting

PCC23 Primary Care Dashboard Development: MC reported on a number of discussions, including with PE and Dr Emma Broughton, to develop operational indicators. She also noted that opportunities to learn from other areas were being sought and that work would take place across the Sustainability and Transformation Plan footprint but emphasised that this would not delay the CCG's dashboard. A prototype dashboard would be discussed at a meeting, to be attended by DB, on 27 September prior to presentation at the next Committee meeting. In response to AB enquiring about Local Medical Committee involvement in the discussions, MC agreed to include him in the next phase of development of the prototype.

In response to SP expressing concern that Primary Care as a provider was being treated differently to other providers in terms of consideration of quality information, MC explained the context of sharing available information in a public forum before it had been discussed with Practices. She also noted capacity concerns within the CCG and highlighted the need for clarity as to the purpose of the information, for example the CCG's position in the national average informing focus for work. KR proposed that initial discussion could take place at a Part II meeting immediately following the November Committee meeting prior to discussion at a future meeting in public.

Further discussion included the need for information sharing about activity and skill mix to progress collaborative working and also for clarity of the context of sharing information with recognition of the good quality General Practice in the CCG but emphasis on support for quality improvement.

PM requested a report to the November meeting of the Committee with a decision to be taken regarding whether this was initially in a Part II meeting.

Proposal for sponsorship of John Lethem annual essay competition: PM reported that in a joint letter of appreciation from himself, PE and KR to John Lethem they had proposed establishment of an annual essay competition for a medical school year group asking them to share their experiences of General Practice and how it might have influenced their development as doctors. PM advised that a response to this proposal had not yet been received.

The remaining matters were noted as agenda items or would be included in discussion of items.

The Committee:

1. Noted the updates.
2. Requested a report on development of the primary care dashboard at the next meeting.

6. Primary Care Commissioning Financial Report

TP presented the report which provided information on financial performance of primary care commissioning as at month 4 noting that the forecast outturn figure of £41,797k remained in line with the 2017/18 CCG financial plan for the capped expenditure process submitted on 12 June 2017. The £74k year to date slippage for CCG premium reinvestment, reported under primary care in the main CCG dashboard reported to the Governing Body, was being utilised to support locality structures as agreed at previous meetings of the Committee.

In respect of the £46k overspend on Other GP services, relating in the main to increased costs within administration for new retainers and ongoing sickness claims, TP advised that the latter had now been concluded. There was currently no foreseen recurrent expenditure pressures on this budget line.

In respect of the Quality and Outcomes Framework £47k accrual year to date adverse variance, TP noted that this would change as more information became available during the year.

TP explained that the two emerging legacy issues from 2016/17, £121k relating to Quality and Outcomes Framework accrual and £11k over accrual for Dispensing Doctors costs, would be reflected in the ledger when coding information had been received from NHS England.

Discussion ensued on the Quality and Outcomes Framework accrual process and potential for this to inform opportunities to consider Practice variation. Members noted that assessment of Quality and Outcomes Framework achievements was done annually but that the timing did not align with the CCG's planning processes; the annual review was part of contract negotiation with points varying from year to year due to areas being incorporated in core spend. Summary information of 2016/17 achievements was expected in October.

KB noted that Healthwatch was undertaking work on aspects of quality in General Practice and she would update the Committee accordingly.

PM referred to the recent establishment of capitated prescribing budgets and requested a report for the next meeting of the Committee on the associated principles, followed by a report to the January meeting of the data in view of the two month delay on availability of prescribing information.

In relation to national funding for extended access to General Practice, SM explained that the funding available was £3.34 per head on the basis of 50% population access in 2017/18 and £6 per head on condition of 100% population access in 2018/19, noting that if these figures were not achieved the money would not be available. SM reported that work was ongoing regarding operational implementation highlighting the NHS England expectation for this to be in the form of GP led services but detailed concerns about current levels of engagement, the need for establishment of a hub type approach and the complexity of accessing clinical records due to the fact that a number of systems were used locally. There were also liability and indemnity issues.

PM requested a report to the November Committee on proposals to address the issues above and noted that Dr Kevin Smith, Deputy Director Healthcare, Public Health England, Yorkshire and the Humber, was working with the CCG to progress engagement with GPs.

HM proposed including an update on the elements of the General Practice Forward View in the NHS England report standing agenda item.

SM described the work taking place in the three localities noting the expectation for the GP led services to be on a locality footprint. He also explained that discussion was taking place regarding the NHS England expectation for the CCG to undertake a procurement process for these services.

Further discussion included recognition of the ongoing work within localities, noting of the hub approach being established by York Medical Group, the intention that both extended access and urgent treatment centres would evolve from existing areas, and the need to ensure value for money and maximise resources.

Whilst recognising the CCG's challenging financial position PM requested development of a proposal for pilot initiatives for consideration at the November Committee with a view to requesting the Executive Committee agree release of resource and the required financial and governance arrangements to enable testing to be undertaken during the coming winter months. AP additionally referred to urgent and emergency care plans in 2018/19 for NHS 111 to have access to direct booking of Practice appointments.

With regard to estates members noted that the financial performance report reflected the current status and that notional rent reviews were presented to the Committee for approval. Strategic intent for out of hospital services and workforce was still being developed but should be on the basis of collective development of primary care resources as a whole.

The Committee:

1. Received the report on the financial position of the Primary Care Commissioning budgets as at month 4.
2. Requested a report on establishment of capitated prescribing budgets and the associated principles to the November meeting and a report to the January meeting on the data.
3. Requested a report on proposals for fulfilling the GP led extended access requirements for the next meeting.
4. Requested a proposal to the next meeting for pilot initiatives for testing GP led services in localities during the coming winter months.

7. General Practice Visits and Engagement: Briefing Summary

AP presented the report which included the aims, types of engagement and agendas for engagement with Practices, proposed a format and plan for Practice visits, identified potential risks, and described proposed actions to support this approach.

Members welcomed the comprehensive report. Discussion encompassed the need for clarity about the purpose of each visit from both the perspective of the CCG and Practices as providers to ensure appropriate attendance; recognition that Practice needs would vary; concern about the CCG's capacity to fulfil this approach; establishment of a baseline position to identify appropriate frequency of visits to each Practice, potentially through a framework with 'Red, Amber, Green' rating; engagement through Practice Patient Participation Groups; and the context of development of localities.

PM proposed that the specific actions relating to Practice visits and engagement be put on hold and that further consideration be given to the CCG supporting Practices as providers to develop innovation and collaborative working of a clinical delivery model for the best value for patients as quickly as possible. PM noted that Kevin

Smith had met with representatives from the CAVA Practices in this regard. He also referred to discussion with the Council of Representatives and agreed to bring a proposal to the next meeting.

The Committee:

1. Received and commended the briefing summary describing Practice visits and engagement.
2. Noted that PM would bring a proposal to the next meeting for CCG support to Practices for development of a clinical delivery model.

8. Nuffield Trust Primary Care Home Report

PM introduced this item which described a potential operating model to support General Practice as providers.

SM gave a presentation on aspects of the Nuffield Trust report *Primary Care Home: Evaluating a New Model of Primary Care,* noting availability of further detail: the full report at https://www.nuffieldtrust.org.uk/research/primary-care-home-evaluating-a-new-model-of-primary-care; case studies at http://www.napc.co.uk/primary-care-home; and NHS England https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/primary-care/

SM highlighted the four principles of the Primary Care Home programme: improving the patient experience of care (including quality and satisfaction); improving the health of populations; reducing the per capita cost of health care; and improving the experience of providing care. SM also noted the core characteristics of the Primary Care Home model and how rapid test sites began building and evaluating their Primary Care Home model.

'Enablers' to developing a Primary Care Home were identified as leadership, engagement, workforce training and culture, alignment of financial and clinical aims, organisational form, and monitoring and evaluation. Lessons for rapid test sites and future Primary Care Home sites were detailed in terms of implementing and evaluating the model.

Discussion ensued in the context of recognised high quality General Practice and transforming delivery so that General Practice was at the forefront but with recognition of the need to take account of sustainability of partner organisations. Relationships between Practices and the CCG, a shared vision and principles to reduce waste - including learning from other areas - were identified as key. A focus on improving the patient experience would ultimately achieve savings.

The Committee:

Received the presentation Nuffield Trust Primary Care Home Report *Primary Care Home: Evaluating a New Model of Primary Care.*

9. NHS England Primary Care Update

HM presented the report which provided updates in respect of Resilience Funding, Practice Based Pharmacist Scheme and the 2017/18 Directed Enhanced Service (Extended Access Element), noting with regard to the latter that Terrington Surgery had now confirmed their intention to continue closure of the Practice for half a day a week and would therefore not be eligible to access the funding. HM additionally referred to the earlier discussion and her intention to include updates on the General Practice Forward View in future reports.

Following discussion of the Practice Based Pharmacy Scheme HM agreed to include in her next report information about which Practices were included. Members also noted that this scheme was intend to enhance the skill mix in Practices and the expectation that NHS England would request information on expected outcomes to understand the impact of the scheme on Practices.

In response to KB enquiring about 'flu vaccination, HM explained that NHS England commissioned these from both General Practice and Pharmacists to enable patient choice.

The Committee:

Noted the updates.

10. Key Messages to the Governing Body

- The Committee discussed the ongoing development of the primary care dashboard.
- The Committee noted the Nuffield Trust Primary Care Home report.
- The Committee highlighted the financial lever to improve patient access to primary care as discussed under the Financial Performance Report.

The Committee:

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

11. Next meeting

9.30am on 22 November 2017 at West Offices.

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE

SCHEDULE OF MATTERS ARISING FROM THE MEETING HELD ON 19 SEPTEMBER 2017 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCCC6	28 February 2017 28 March 2017	Primary Care Commissioning Committee Terms of Reference	• Discussion to take place of the role of the Committee in the context of the Accountable Care Partnership Board with the Executive Director of Planning and Governance • KR to discuss with PM	SM KR/PM	 Ongoing
PCCC25	19 September 2017	Matters arising from previous minutes	• Report on development of the Primary Care Dashboard	MC	22 November 2017
PCCC26	19 September 2017	Primary Care Commissioning Financial Report	• Report on establishment of capitated prescribing budgets and the associated principles to the November meeting and a report to the January meeting on the data. • Proposals for fulfilling the GP led extended access requirements • Proposal for pilot initiatives for testing GP led services in localities during the coming winter months	SOC SM AP/SM	22 November 2017/ 24 January 2018 22 November 2017 22 November 2017

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCCC27	19 September 2017	General Practice Visits and Engagement: Briefing Summary	• Proposal for CCG support to Practices for development of a clinical delivery model	PM	22 November 2017

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Item Number: 6

Name of Presenter: Phil Mettam

Meeting of the Primary Care Commissioning Committee

Date of meeting:
22 November 2017

NHS
Vale of York
Clinical Commissioning Group

Report Title – Primary Care Commissioning Committee Terms of Reference

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

Reason for Report

The terms of reference are presented for review with particular reference to the Committee's membership.

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

To agree terms of reference.

Responsible Executive Director and Title	Report Author and Title
Phil Mettam Accountable Officer	Helena Nowell Planning and Assurance Manager

NHS
Vale of York
Clinical Commissioning Group

Primary Care Commissioning Committee terms of reference

Terms of reference – NHS Vale of York CCG Primary Care Commissioning Committee

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

2. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended) (the "NHS Act"), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Vale of York CCG. The delegation is set out in Schedule 1.

3. The CCG has established the NHS Vale of York CCG Primary Care Commissioning Committee (the "Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

4. It is a committee comprising representatives of the following organisations:
   - NHS Vale of York CCG
   - NHS England
   - Healthwatch
   - Health and Wellbeing Board(s)
   - Director of Public Health

Statutory Framework

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

6. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

   a) Management of conflicts of interest (section 14O);

   b) Duty to promote the NHS Constitution (section 14P);

   c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

   d) Duty as to improvement in quality of services (section 14R);

   e) Duty in relation to quality of primary medical services (section 14S);

   f) Duties as to reducing inequalities (section 14T);

   g) Duty to promote the involvement of each patient (section 14U);

   h) Duty as to patient choice (section 14V);

   i) Duty as to promoting integration (section 14Z1);

   j) Public involvement and consultation (section 14Z2).

8. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act

   - Duty to have regard to impact on services in certain areas (section 13O);
   - Duty as respects variation in provision of health services (section 13P).

9. The Committee is established as a committee of the Governing Body of NHS Vale of York CCG in accordance with Schedule 1A of the NHS Act.

10. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the Committee

11. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in the Vale of York area, under delegated authority from NHS England.

12. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Vale of York CCG, which will sit alongside the delegation and terms of reference.

13. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

14. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

15. This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);

- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);

- Decision making on whether to establish new GP practices in an area;

- Approving practice mergers; and

- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

16. The CCG will also carry out the following activities:

    a) To plan, including needs assessment, primary care services in the Vale of York CCG area;

    b) To undertake reviews of primary care services in Vale of York CCG area;

    c) To co-ordinate a common approach to the commissioning of primary care services generally;

    d) To manage the budget for commissioning of primary care services in Vale of York CCG area.

Geographical Coverage

17. The Committee will comprise the NHS Vale of York CCG area.

Membership

18. The Committee shall consist of:

    Lay Chair of Governing Body (Chair)
    Lay Chair of Audit Committee
    Lay Chair of Finance and Performance Committee
    Accountable Officer
    Chief Finance Officer
    Chief Nurse
    Representative of NHS England
    (voting members)

19. The Chair of the Committee shall be the Lay Chair of the Governing Body**.**

20. The Vice Chair of the Committee shall be the Lay Chair of the Audit Committee.

21. The following standing attendees (non-voting) will be invited:
    - Up to two GPs from each locality
    - Chair of Clinical Executive

- LMC representative
- Director of Public Health
- Healthwatch Representative
- Health and Wellbeing Board Representative
- Practice Manager

Meetings and Voting

22. The Committee will operate in accordance with the CCG's Standing Orders. The Executive Support to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 5 working days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

23. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

Quorum

24. The committee shall be quorate with the following attendance:

    At least four members, one of which shall be a Lay Member and one a Chief Officer.

Frequency of meetings

25. The committee will meet six times a year with dates circulated to committee members in advance. Additional meetings may be convened at short notice if the Chair deems it necessary in accordance with paragraph 22 above.

26. Meetings of the Committee shall:
    a) be held in public, subject to the application of 26(b);

b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

27. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

28. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest. A Primary Care Commissioning Delivery Group will be established to ensure the delivery of arrangements agreed by the Committee.

29. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

30. Members of the Committee shall respect confidentiality requirements as set out in the CCG's Constitution.

31. The Committee will present its minutes to the North (Yorkshire and Humber) area team of NHS England and the governing body of NHS Vale of York CCG each quarter for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 28 above.

32. The CCG will also comply with any reporting requirements set out in its constitution.

33. The Committee shall review its terms of reference at least annually. The Committee shall undertake a review of its effectiveness at least annually.

Links to other Committees and Groups

34. Due to the nature of integrated governance, the work of the Committee dovetails with some functions of the Audit Committee. Both Chairs will work collaboratively to ensure that where objectives align, their work will complement rather than duplicate effort, bringing their own perspectives to agenda items.

Accountability of the Committee

35. The Primary Care Commissioning Committee is a delegated committee of the Clinical Commissioning Group Governing Body, and its powers are set out in the CCG's Constitution, including revised Standing Financial Instructions and Standing Orders.

36. For the avoidance of doubt, in the event of any conflict between the provisions of these Terms of Reference and the CCG's Standing Orders or Standing Financial Instructions, the latter will prevail.

Procurement of Agreed Services

37. The detailed arrangements for procurement of agreed services will follow the Standing Financial Instructions and Standing Orders of the Clinical Commissioning Group. These reflect the arrangements within the CCG's constitution and the delegation agreement with NHS England. The Committee will adhere to these arrangements.

Decisions

38. The Committee will make decisions within the bounds of its remit.

39. The decisions of the Committee shall be binding on NHS England and NHS Vale of York CCG.

40. The Committee will produce an executive summary report which will be presented to the North (Yorkshire and Humber) area team of NHS England and the governing body of NHS Vale of York CCG each quarter for information.

Conflicts of Interest

41. Conflicts of interest shall be managed in line with NHS Vale of York CCG Conflicts of Interest policy.

[Signature provisions]

Schedule 1 – Delegation

[Delegation from NHS England attached separately]

Schedule 2: Delegated Commissioning Functions

Delegated commissioning functions are as follows:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);

- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

Delegated commissioning arrangements exclude individual GP performance management (medical performers’ list for GPs, appraisal and revalidation).

Item Number: 7

Name of Presenter: Tracey Preece

Meeting of the Primary Care Commissioning Committee

22 November 2017

NHS
Vale of York
Clinical Commissioning Group

Primary Care Commissioning Financial Report

Purpose of Report
For Information

Reason for Report

To brief members on the financial performance of Primary Care Commissioning as at the end of October 2017.

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

Responsible Executive Director and Title	Report Author and Title
Tracey Preece, Chief Finance Officer	Caroline Goldsmith, Deputy Head of Finance

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

Report produced: November 2017

Financial Period: April 2017 to October 2017

Introduction

This report details the financial position of the CCG's Primary Care Commissioning areas at year to date and at forecast outturn (FOT) level.

Financial position – Month 7

The table below sets out the year to date and outturn position as at Month 7.

Area	Cumulative To Date				Forecast Outturn		
	Budget £000	Actual £000	Variance £000		Budget £000	Actual £000	Variance £000
Primary Care - GMS	12,109	12,052	56		20,758	20,758	0
Primary Care - PMS	5,013	4,874	139		8,594	8,371	223
Primary Care - Enhanced Services	648	657	(9)		1,110	1,042	68
Primary Care - Other GP services	1,764	1,820	(56)		2,988	3,142	(164)
Primary Care - Premises Costs	2,478	2,516	(38)		4,248	4,353	(105)
Primary Care - QOF	2,391	2,473	(82)		4,099	4,361	(262)
Sub Total	**24,402**	**24,393**	**10**		**41,797**	**42,037**	**(240)**

- The overall year to date position is a £10k under spend.
- The total FOT figure has been revised to £42,037k, which reflects a £240k over spend against budget. This is the FOT provided by NHS England, based upon month 5 figures, updated for subsequent changes the CCG has been made aware of. NHS England is expecting to provide a revised FOT based upon month 8 figures.
- GMS is based upon current list size and is showing a year to date underspend of £56k.
- The PMS contract assumes Scott Road sign up to the contract as calculated by NHS England. This has been formally agreed and sign-up is in progress. The budget for CCG premium reinvestment funding is showing as slippage (£130k YTD and £223k FOT), however this has been accrued and forecast within Other Primary Care in the main CCG dashboard. The list size adjustment and Out of Hours deduction are £9k under YTD as per the current list size.
- The year to date position on Other GP services is an overspend of £56k, due in the main part to increased seniority payments of £37k (additional payments made to reward experience based upon a GPs number of years reckonable service). The FOT provided by NHS England worsened the position by £123k which included £40k for seniority payments and £20k for late maternity claims. The FOT has subsequently been adjusted by the CCG following conversations with NHS England for the following:

  - an additional £95k for maternity claims submitted late (total now known);
  - a reduction of £54k for dispensing doctors as a result of a reduction in tariff.

- Premises Costs are based on current expected costs with assumptions on the rent revaluations due. Business rates are currently forecast to overspend by £70k in 17/18 (assuming that those who haven't claimed yet will be over budget by the same proportion as those who have already claimed) and were under accrued by £35k in 16/17.

- QOF has been accrued based upon 2016/17 points and prevalence at 2017/18 prices with an increase of 0.7% for estimated demographic growth. This has resulted in an adverse variance of £82k YTD. The FOT includes £141k as a result of the finalisation of 2016/17 points and prevalence and £121k which was under accrued in 16/17.

- Prior year variances to budget have currently been accrued out pending finalisation of all 2016/17 costs.

Primary Care

It was requested at the last committee meeting that expenditure on Primary Care within the core CCG budget was included to ensure the Committee has awareness of the wider spend in primary care. Please note that this is for information only.

Primary Care	Cumulative To Date				Forecast Outturn		
	Budget	Actual	Variance		Budget	Actual	Variance
	£000	£000	£000		£000	£000	£000
Primary Care Prescribing	29,317	29,121	197		50,196	49,470	726
Other Prescribing	393	809	(416)		673	1,517	(844)
Local Enhanced Services	990	937	53		1,918	1,920	(2)
Oxygen	154	172	(18)		263	291	(28)
Primary Care IT	588	645	(58)		1,147	1,178	(31)
Out of Hours	1,848	1,867	(19)		3,167	3,226	(58)
Other Primary Care	350	34	316		856	777	79
Sub Total	**33,639**	**33,584**	**54**		**58,221**	**58,378**	**(158)**

The £223k of PMS premium monies is included in the Other Primary Care forecast above.

PMS premium monies

At the committee meeting in July 2017, it was agreed that PMS premium monies would be allocated across the three localities for three areas of expenditure as follows:

1) Costs to support GP attendance at Locality meetings, Unplanned Care Steering Group meetings and Accountable Care System Partnership Board.
2) Funding to support a GP lead in each of the localities who will work across their locality to develop the programme of work and secure engagement with each locality's constituent Practices to develop their sustainability and manage demand.
3) Any remaining funding should be offered through localities to support constituent Practices in the management of demand.

The cost of part 1 of this split was calculated based upon reimbursement of meetings from 1st April 2017 onwards, however GP Practices have subsequently requested that meetings prior to this date also be reimbursed. A re-costing exercise has been undertaken and the impact of reimbursing meetings prior to this date is expected to be minimal. Therefore it has been agreed by the Accountable Officer and Chief Finance Officer that these meetings will be funded. This decision was also supported by the Chair of the Council of Representatives. A clear financial procedure has been implemented for processing these claims and GP Practices have been notified. Expenditure on meetings will be monitored as claims are received.

Recommendation

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

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Item Number: 10

Name of Presenter: Laura Angus/Rachel Cooke

Meeting of the Primary Care Commissioning Committee

Date of meeting:
22 November 2017

NHS
Vale of York
Clinical Commissioning Group

Prescribing Indicative Budgets

Purpose of Report
For Information

Reason for Report

CCG Executive approved the case for prescribing indicative budgets at their meeting in June and this is now live. The purpose of the scheme is to better enable the CCG to manage GP practice prescribing costs. The financial model works on a gain share basis and savings have to be invested to support the delivery of primary care services.

The Primary Care Commissioning Committee requested a brief update on the purpose, governance and progress of the initiative to ensure it has a fully rounded view of activity in primary care.

Strategic Priority Links

- ☒Primary Care/ Integrated Care
- ☐Urgent Care
- ☐Effective Organisation
- ☐Mental Health/Vulnerable People
- ☐Planned Care/ Cancer
- ☒Prescribing
- ☐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

Recommendations

The Committee is asked to receive the update report for information.

Responsible Executive Director and Title	**Report Author and Title**
Dr Shaun O'Connell Joint Medical Director	Laura Angus Lead Pharmacist & Rachel Cooke Head of Finance

NHS
Vale of York
Clinical Commissioning Group

Prescribing Indicative Budgets
Primary Care Commissioning Committee
Wednesday 22nd November 2017

Executive Summary

Background & Governance

- The CCG is working with local GP alliances to optimise the efficiency of GP practice prescribing.
- We have agreed a gain share model on the terms of a Memorandum of Understanding (MoU) which will enable the CCG to manage GP practice prescribing costs. The CCG has set an indicative budget for each alliance, for each contract year, based on historic spend, uplifted for planned growth assumptions, and will share any savings made by the alliance against such indicative budget.
- The CCG will pay a proportion of the anticipated savings upfront to allow resources to be put in place by the alliance to facilitate schemes that will generate these savings. The alliance will be required to comply with its obligations under the MoU in order to receive a proportion of any savings. Alliance savings must be used to support delivery of primary care services.
- The CCG will continue to hold and retain statutory responsibility for the prescribing budget including accountability for overspends and underspends and ensuring the most clinically appropriate, cost-effective and safe use of medicines across the locality.
- DAC-Beachcroft (Legal) have supported the CCG with writing the MoU – signed by CCG CFO and equivalent for each GP Federation. The MoU has been shared with CCG Lay Members for information.
- The introduction of PIB, along with its principles and implications has undergone an ethical review by Dr Stuart Calder, Training Programme Director for York GP Training Scheme, Lecturer/Resource in Applied Medical Ethics, NHS GP Appraiser and Deputy Chair of the Council of Representatives for the VoYCCG.
- Prescribing Indicative Budgets was approved for implementation by CCG Executive Committee June 2017 and is now live.
- The MoU includes a clause that allows the CCG to fully comply with any national direction from NHS England or other eligible body.

Finances

The financial model is based on the Dermatology Indicative Budgets model, but adapted for the Prescribing budgets, and retains the trigger points to determine the basis for sharing the savings.

See 'Financial Detail' for full details.

Activity

Alliances are expected to outline their preferred activity per quarter and report monthly on activity occurring in GP Practices. Monthly they will be expected to report on specific switches or stopping prescribing per drug and per GP Practice to demonstrate required activity OR if changing a system, for example managed repeats, they must provide an action plan to demonstrate how they will achieve change.

Measures

CCG will evaluate the success of PIB through a number of measures:

- Reduction in prescribing spend via ePACT data
- Reduction in number of items prescribed via ePACT data
- Reduction in spend in specific key areas, for example red and black drugs prescribing
- Alliance Quarterly Reports
- Completion of quality indicators
- Patient experience – for example via patient complaints

Use of Advance Sum and Proportion of Savings

CCG savings will be used to achieve QIPP

Alliance savings must be used to support delivery of primary care services – MoU provides specific wording:

> ***USE OF ADVANCE SUM AND PROPORTION OF SAVINGS***
>
> 1.1 *The GP Federation must seek prior approval from each of the CCG's Joint Medical Director, Lead Pharmacist and Head of Finance in writing or at the quarterly review meetings described further in clause 8.1 for any proposed use of the Initial Payment and the Proportion of Savings. Such proposed use may include:*
>
> *1.1.1 investment in additional staff time, equipment or services to undertake quality prescribing review and to enhance the Member Practices [and Associate Practices]' ability to provide services commissioned by the CCG in the community that reduces the need for patients to attend hospital; and*
>
> *1.1.2 reimbursement of spend incurred to achieve the Proportion of Savings.*
>
> 1.2 *The GP Federation shall provide evidence to the reasonable satisfaction of the CCG showing how it has spent the Advance Sum and the Proportion of Savings, such evidence may include, at the CCG's request, invoices, staff payslips, work rotas, attendance records and minutes from meetings to justify the time spent by staff and the seniority of staff used.*

Risks

PIB covers: cost-effective medicine choices, branded generics, brand to generics, therapeutic switches, waste meds/managed repeats, ONS (sip feeds). A number of risks were recognised and managed through the development of PIB:

a) Delayed start in financial year. PIB went live July- September 2017. Mitigated by 'usual' MMT led activity still occurring.
b) Risk that PIB model overspends on the prescribing budget – mitigated by contract with alliances, break clause included in contract. Schedule added to contract - alliances must report on activity on a monthly basis, in a method specified by CCG, CCG to ratify activity and say if satisfactory. If a cumulative overspend develops, the CCG can choose to end PIB. Mitigation also that alliance has incentive to make savings and hence will not want to overspend as they will lose their proportion of gain share.
c) Risk that seen by public in negative light – may be perceived that 'practices limit prescribing in order to make money'. Mitigated by Ethical Analysis completed by Dr Stuart Calder and after a discussion with Engagement Lead and Communications Lead – a positive message was pro-actively given to the media on commencement of the scheme i.e. ethically GP required to prescribe most appropriate medicine, should continue to follow local formulary choices; and any savings will be reinvested into primary care services. No negative feedback received to date from public.
d) Currently very limited resource/capacity to support delivery of PIB. Exec agreed to invest a sum for PIB (alliances to determine how to spend) but also requires CCG level staff to coordinate and support delivery. MMT has vacancies – 1 FTE band 5 technician vacancy; 1 FTE band 8a has just started and 1 band 8a senior pharmacist due to start at end of November. Utilisation of National QIPP Support Programme resource provided locally by NECS to support this.

Other considerations

- Ensuring we maintain high quality prescribing – included in MoU
- CCG Policies – alliance expected to adhere to CCG Prescribing Policies
- Medicines Commissioning Committee decisions – MCC will still make decisions about which drugs are suitable for inclusion on York Scarborough joint formulary and alliance expected to adhere to formulary.
- To ensure high quality prescribing alliance expected to achieve quality indicators. CCG will retain 10% of any proportion of savings each quarter and will release at end of contract year, 5% of the retained sums on completion of the 5 core quality indicators and 1% for each optional quality indicator.
- What should be removed from PIB – covered in finance section
- Unaligned practices – still require support with prescribing which will continue to be provided.

- Dispensing practices – alliance responsible for impact on dispensing practice income.

- Optimise Rx – CCG currently fund Optimise Rx as a schedule in MoU regarding CCG expectations of ensuring Optimise Rx provides return on investment.

Financial Detail

Setting the budget

- Indicative budgets for 2017-18 are based on historic spend. The baseline used for the model is 2016-17 spend.
- This covers all GP prescribing except for continence, stoma care, dressings, flu vaccinations, gluten free prescribing and items recharged to local authorities - which have been removed from the spend data. The CCG will therefore keep aside a 'top sliced' budget to cover spend on these items. Most of these areas have been excluded because the CCG has already been carrying out various projects to address spend in these areas and including these would not give a level playing field for alliances. An uplift of 5.47% in line with the prescribing uplift in the CCG's financial plan for 2017-18 has been applied to alliance indicative budgets.
- 1% of the indicative budget has also been removed, to cover the spend on expensive drugs, which can vary disproportionately.

The gain share model and trigger points

- Savings are split between the alliance and CCG at different rates, based on two trigger points – average spend per weighted head across the CCG, and lowest alliance spend per weighted head across the CCG (with unaligned practices treated as one separate alliance).
- Alliances will receive 25% of any savings where their spend is higher than the CCG overall average spend per weighted head.
- Where the alliances' spend is lower than the CCG average, the alliance will attract 50% of any saving below that level. *(i.e. not on the whole saving)*
- A benchmark spend per weighted head will be based on the lowest alliance. Any alliance whose spend is lower than this benchmark level will receive 75% of the relevant saving below that level. *(i.e. not on the whole saving)*
- Spend per head is based on weighted population. The chosen method of deriving this is the weighted population used for the prescribing element of the CCG's allocation formula. This is based on ASTRO PU weightings but also takes into account a range of other factors, e.g. standardised mortality rate, fertility rate and deprivation. This is also directly related to the method used to determine the CCG's overall allocation and therefore the amount that the CCG has overall to spend on prescribing.

- The table below shows the two trigger points and illustrates how the savings are split between alliance and CCG. The trigger points are uplifted in line with the 2017-18 plan.

Table 1: Gainshare trigger points:

Gainshare trigger points		
	Alliance	CCG
Savings to CCG average	25%	75%
Savings to CCG benchmark	50%	50%
Further savings	75%	25%

Upfront investment

- The CCG will pay an upfront sum to each alliance on commencement of the scheme to allow resource to be put in place to facilitate schemes that will generate savings. Repayment of this will be split 50/50 between the alliance and the CCG. The alliance share of this will be deducted from their share of the savings, equally over the first 3 quarters, before the quarterly payment is made.
- A clause has been included within the Memorandum of Understanding to allow claw back of the alliances' share of this investment if savings against the indicative budget are not delivered.

Monitoring and payment

- Savings are calculated quarterly in arrears once prescribing information for that quarter is available.
- Indicative budgets are profiled across the 12 months of the financial year, using the CCGs prescribing profile. This is based on historic spend patterns over the last 4 years.
- Savings are calculated on a cumulative year to date basis. Payment would be made each quarter based on the year to date cumulative savings less any payments already made.
- If at the end of any quarter share of cumulative savings was less than payment already made to the alliance (i.e. if alliance prescribing was higher than indicative budget in one quarter) no payment will be made until cumulative savings exceed payment already made. A clause has been included in the Memorandum of Understanding to allow clawback of any overpayment made when the scheme ends.
- The Memorandum of Understanding includes a set of remedial actions in the event that an alliance's spend does exceed their indicative budget. This includes the requirement to meet with the CCG to discuss reason behind the over spend and progress against planned savings schemes, with a requirement to provide an action plan to the CCG. An option for termination of the scheme will also be included.

Alliance involvement

- By setting budgets at alliance level this reduces variability in under and over spends against indicative budgets. Unaligned practices <20,000 will therefore not be able to take part in the scheme as individual practices, however there is an offer to unaligned practices an ‘affiliate membership’ for this scheme only.
- Any affiliate practices would therefore have their spend added into the alliance budget. However the gain share trigger points will not be recalculated.

Timescale

- The scheme will run for the 2017-18 and 2018-19 financial year i.e. until 31 March 2019. The Memorandum of Understanding includes a break clause should the CCG’s circumstances change and make the scheme unviable at any point before then.
- 2018-19 indicative budgets will be based on 2017-18 budgets, uplifted for growth in line with the 2018-19 plan. An indication of this will be provided to alliances based on the CCG’s current financial plan but this uplift will be confirmed following the 2018-19 planning round.

Ends

Item Number: 11

Name of Presenter: Shaun Macey

Meeting of the Primary Care Commissioning Committee **Date of meeting:** **22 November 2017**	NHS Vale of York Clinical Commissioning Group

General Practice Forward View, Improving Access to General Practice Services - Update November 2017

Purpose of Report
For Information

Reason for Report

To update the Primary Care Commissioning Committee on national guidance and local progress on the General Practice Forward View requirement to provide improved access to General Practice services during evenings (to 8pm) and weekends.

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	**Covalent Risk Reference and Covalent Description**
☐Financial ☐Legal ☒Primary Care ☐Equalities	

Emerging Risks (not yet on Covalent)

Recommendations

For information only at this stage.

Responsible Executive Director and Title	Report Author and Title
Phil Mettam Accountable Officer	Shaun Macey Head of Transformation and Delivery

General Practice Forward View, Improving Access to General Practice Services

1. Background and Guidance

The NHS England Operational Planning and Contracting Guidance 2017-2019[1] (p53) outlines the planning requirements of CCGs to support implementation of the General Practice Forward View (GPFV), and specifically how access to General Practice will be improved.

From the guidance:

> NHS England will provide additional funding, on top of existing primary medical care allocations to enable CCGs to commission and fund extra capacity to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other Primary Care and General Practice services such as urgent care services.

Timing of appointments:

> Commission weekday provision of access to pre-bookable and same day appointments to General Practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day (i.e. to 8:00pm)
>
> Commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs
>
> Provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week
>
> Appointments can be provided on a hub basis with Practices working at scale.

Funding:

> Recurrent funding to commission additional capacity and improve patient access will increase over time. CCGs will be required to start access improvement in 2018/19, with funding at £3.34 per head of population for the year (based on 50% of the population having access to these additional appointments), and achieve 100% coverage from April 2019, when funding will reach at least £6 per head of population in 2019/20.

[1] https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

2. Progress to Date

To date the CCG has engaged with Vale of York Practices re. the Improving Access agenda via the following:

Council of Representatives workshop on 20 July 2017 – describing the NHS England guidance, and working with locality groups to consider the potential footprint of services to ensure coverage across the population.

All Practices have been provided with details of a series of NHS England webex sessions[2] during October and November that focus on the next steps for improving access to General Practice, aimed at General Practice staff and Commissioners. These will cover the seven core requirements and what this means for those working in General Practice, key messages and frequently asked questions, and will provide an update on the range of resources that have been made available nationally to support rollout.

South Locality - meeting held on 13 September 2017. Agreement reached that initial work would focus on redesigning services around Selby Hospital with a view to providing additional evening and weekend access out of this setting (and potentially some in-hours access to GP-led minor illness/ailments services). There was also an acknowledgement that a Selby located service would not meet the needs of Tadcaster, Sherburn and South Milford patients, and that ultimately a mix of additional consultation capacity across these Practices and Selby Hospital would be the preferred solution.

Work around Selby Hospital opportunities/options is currently being led by Beech Tree Surgery who submitted a successful bid for GPFV resilience funding (£6k) to work on an improved same day / urgent access model for the Selby area Practices.

Heather Marsh supporting South locality Practices with this work.

Central Locality – meeting held on 26 September 2017. Agreement reached that Practices will work up a model that delivers the required additional consultation capacity for 2018/19. A request that this is initially contracted on an individual Practice basis – but with Practices working collaboratively to deliver the required service capacity, and to ensure that the patients of Practices who may not wish to participate are covered under the contractual arrangements – i.e. some Practices may sub-contract with others to provide cover for their patients.

Further details are currently being worked up by Central locality Practices – Shaun Macey supporting Practices with this work.

[2] https://www.england.nhs.uk/gp/gpfv/redesign/improving-access/

North Locality – meeting held on 28 September 2017. Not all North locality Practices attended (Millfield, Stillington, Kirkbymoorside, Pickering were present) but agreement was reached to look into options for providing the required service capacity.

Potential solutions for the North are constrained/complicated by the lack of scale to be able to develop efficiencies through greater skill-mix, and the geographical split between the Easingwold area Practices (Millfield/Tollerton/Stillington) and the Ryedale Practices (Pickering, Kirkbymoorside, Helmsley, Terrington).

There are potential options for North locality Practices to deliver additional capacity on a rota basis around the member Practices - or the Ryedale Practices to consider a collaborative approach with adjacent Scarborough Ryedale CCG Practices (initial conversations have taken place), and Easingwold Practices to collaborate with the Central locality to provide access to services for their patients.

Further details are currently being worked up by North locality Practices – Becky Case supporting Practices with this work.

3. Additional Guidance and Information from NHS England Webex Sessions

- We understand that the CCG will receive an allocation in May 2018 (of £3.34 per weighted population) that it can deploy throughout the year to meet the requirements. The NHSE suggestion is that we could therefore establish either a part (access to 50% of the population) service at the start of the financial year - or wait until later in the year (e.g. September) and deliver access to 100% of the population for 6 months. Plus we can use some of the annual budget to meet enabling/setup costs. The 34p 'extra' in year 1 is intended to help with some of the non-recurrent start-up costs. In view of the fact that it's difficult to restrict a service to 50% of the population, our thinking is that it might be best to aim for 100% coverage from September 2018.

- Appointment length is not nationally defined, so this can be any mix of short telephone appointments, 10,15 30 min face to face appointments, and online consultations. It's only the total required hours (or additional Clinical Capacity as NHSE calls it) that are defined in the guidance.

- The increase in consultation capacity from 30 to 45 mins per 1,000 population has no real time scale attributed to it, and should be needs driven - i.e. in the event that we find that 30 mins additional capacity per 1,000 patients is being outstripped. So we think for the foreseeable future, we work on delivering the 30 min per 1,000 patients requirement. This will still attract the same funding - there will be no further funding for any required increase to 45 mins per 1,000 patients. The following table shows the expected finding on a locality basis.

Locality	Locality Weighted List Size	Locality Weighted % of Total	Additional Consultation Capacity (hours) Required per week at 30 mins per 1,000 patients	Annual Funding at £3.34 per Weighted (2018/19 financial year)	Annual Funding at £6.00 per Weighted (from April 2019, recurrently)
Central	225,802	65.81%	112.90	£754,177.54	£1,354,809.96
North	38,339	11.17%	19.17	£128,052.43	£230,034.30
South	78,985	23.02%	39.49	£ 263,811.14	£473,912.22
Totals	*343,126*	*100.00%*	*171.56*	*£1,146,041.11*	*£2,058,756.48*

- The offer initially has to include some provision on both Saturdays and Sundays. We won't be able to move away from Sunday opening until it has at least been trialled - there has also then been a suggestion that if this capacity isn't utilised well by routine requests, then we may wish to look at other ways in which this capacity can support improved access. Practices may want to give consideration to what type of Sunday service may help support Practices on a Monday - e.g. is there an increase in nursing/residential home requests on a Monday that could be pre-empted by a service on a Sunday? We don't have to utilise all additional consultation capacity as a reactive service, we could have some proactive services.

- As long as the service provides some access from 6:30 to 8:00pm, and something on Saturday and Sunday in terms of the core service requirements, then some of the additional consultation capacity (to meet the total required number of additional hours) could be provided at other times, e.g. before 8:00am or even during core GMS hours (but note that this **additional capacity** would have to be **open to all patients** with evidence that appointments were being well-utilised). This blend of access times should be based on need – but potentially gives more flexibility in terms of how the additional consultation capacity could be spread across the day.

- There must be a GP available somewhere on the patch that patients can access throughout the whole of the 6:30 to 8:00pm and weekend hours – so this will at least define our minimum GP requirement in terms of staffing.

- Any clinical staff count towards our required additional consultation capacity and can be accessible via any means (access to physio/nurses, face to face, telephone triage, online consultations, Skype consultations all count) but care navigators and signposters don't count.

- The national team are quoting costs from Vanguards to deliver evenings and weekend access of an average of between £3.84 and £4.84 per head with running costs included - and £5.60 per head from wave one pilots, hence them agreeing £6.00 per head as a national figure.

- The 'access to 50% of the population for 2018' is a national target, not a local one - so how we want to utilise the funding in 2018/19 is flexible. But we do need to be at 100% by April 2019.

- 6:00-6:30pm services - there is no contractual change to this period and there is no current plan to alter the out of hours service, so Practices could continue to sub-contract this - however Practices may wish to look at how this time is covered as they develop plans for additional evening appointments.

- There is no specification regarding locations of services. Provision could be provided at GP surgeries in order to launch the service, or within another suitable clinical setting. The only stipulation is that the service can be accessed by patients from any of the Practices within the surrounding localities. There is no guidance on suitable travel distances etc. Some areas are rotating service provision around their localities – i.e. out of different Practices on different evenings.

- How this service is commissioned and contracted is not nationally defined, however we have to ensure that we comply with procurement regulations. This does not mean that all services have to be openly procured, but if they are not, we have to have justification for not doing so. There's an NHSE webex on this on 21st November that we will feed back on.

- There is no individual Practice requirement to participate in the provision of this service. It is a CCG commissioning responsibility. We could therefore, in year one, commission a service for only a part of the population from Practices who wish to participate. However, by year 2 we have to commission for 100% of our population regardless of our Practices' appetite to participate. The issue for the CCG would be our need for 100 % coverage, so if we opt for a Practice delivered service, then either all Practices need to sign up, or we have to agree a way through which a Practice or group can be contracted to provide the service on behalf of any others not willing to take it on. We can't be left with a requirement to Procure separately for a section of the population that isn't covered by our Practices.

- Technically we believe this is only a service for registered patients, but we may want to consider how it supports temporary residents. In areas where there is significant tourism it may be a very useful service to use for temporary residents, and could work well for Practices. These patients already have the issues of loss of continuity of clinician and may be more willing to travel to access a service. Unregistered patients could be excluded.

- Non-staffing costs - we would need to work through the different cost lines associated with service provision. Budgets for prescribing and vaccines are already in the system and therefore we may just need to work out how we

direct them appropriately rather than using core service funds. Other infrastructure costs, however, may be new costs and need to be supported through the £3.34/£6.00 funding. There is no additional budget for premises costs etc.

- Funding streams - how the CCG would pay the service provider would depend on how we contract for this service. It is highly likely that we would contract using a per capita payment agreement against a service specification, but there may be other ways.

- We have identified a number of areas that have already established this type of service, however, whilst these give some useful examples of how some of the issues may be overcome (IT access, centralised booking, site rotation to try and address equity of access, etc) there are none that realistically provide a directly transferable model. Once a locality has a clearer view on preferred options/models we will look in more detail at how we support these solutions. The transformation team in NHSE is also looking at the wider enabling systems such as IT.

4. Next Steps

The CCG will continue to work with localities and their constituent Practices to develop plans for the delivery of this service.

Taking the guidance from the recent Webex sessions into account, it is anticipated that we will work with Practices with a projected go-live for access to evening and weekend services from September/October 2018.

The CCG will start a patient consultation exercise (start date to be confirmed) to give the Vale of York population the opportunity to shape these services and influence what they look like in terms of access times, and services offered (within the required national service specification parameters).

It will be important that the CCG also acknowledges and exploits the links between this programme of work and other national schemes around the development of GP-led Urgent Treatment Centres[3], wider reconfiguration of the urgent and emergency care system[4], 111 direct booking arrangements, and the Clinical Assessment Service (CAS).

NHS England is also continuing to host subject specific webinars, which CCG staff will engage in. These will initially focus on procurement and communications in relation to improving access. The dates for these webinars are as below.

•Procurement: Tuesday 21 November at 12.00 – 1.00pm

•Procurement: Friday 1 December at 12.00 – 1.00pm

•Communications: Wednesday 29 November at 9.30am – 10.30am

[3] https://www.england.nhs.uk/wp-content/uploads/2017/11/urgent-treatment-centres-faqs-1.pdf
[4] https://www.england.nhs.uk/urgent-emergency-care/nhs-111/urgent-care-workforce-development/

Item Number: 12

Name of Presenter: Heather Marsh

Meeting of the Primary Care Commissioning Committee

Date of meeting:
22 November 2017

NHS
Vale of York
Clinical Commissioning Group

Report Title – Improving Access to General Practice Survey - Patient Engagement

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

Reason for Report
For the Committee to have sight of the Improving Access in General Practice Patient Engagement Survey. For the committee to approve the wording and content of the survey in order to enable the survey to go ahead within timescales identified in the Communications Plan.

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 requested to ratify and decide the following in order for patients to have the opportunity to have input into the Improved Service Provision within their locality

- Agree The Improving Access in General Practice survey - Annexe 1
- Survey 'Go Live' date

Responsible Executive Director and Title	Report Author and Title Jane Wild NHS England Supporting Vale of York CCG Primary Care

Annexes (please list)

Annexe 1 - Improving Access Survey
Annexe 2 - Improving Access Communications Plan

Vale of York Primary Care Commissioning Committee: Improving Access in General Practice Survey – Patient Engagement Summary

1 Background

The General Practice Forward View published in April 2016 set out plans to enable clinical commissioning groups (CCGs) to commission and fund additional capacity across England to ensure that, by 2020 everyone has improved access to GP services including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out of hours and urgent care services.

The NHS Operational Planning and Contracting Guidance 2017 – 2019 sets out the funding trajectory for this work, supporting CCGs to deliver extended access as part of delivering the General Practice Forward View.

NHS England has committed to achieving 50% national coverage by March 2018 and 100% of the population by March 2019.

Public satisfaction with general practice remains high, but in recent years patients have increasingly reported, through the GP Patient Survey, more difficulty in accessing services including a decline in good overall experience of making an appointment in general practice.

However, good access is not just about getting an appointment when patients need it. It is also about access to the right person, providing the right care, in the right place at the right time.

2 Improving Access Survey

The CCG has commenced work within the three Localities (North, Central & South) in order to plan delivery of this service. In order to plan, patient engagement is crucial to assessing service provision

National research took place to assess how CCG's (Bassetlaw, Harrogate & London boroughs) had tackled patient engagement in respect to Improving Access. All CCG's researched, utilised the online 'Survey Monkey' tool, in which the CCG and practices placed links to the survey on their websites. This would be the recommended communications tool that Vale of York utilise as this would provide analysis of the results.

3 Consultation

Extensive consultation has taken place with both Healthwatch readability panel and Practices, amendments have been made to the survey in order to reflect the majority of comments from both parties.

4 Communications Plan

In order to achieve the best out of the eight week survey period, the communications team, recommend the survey being launched first week of January 2018.

It is felt that should the survey be launched after this Primary Care Commissioning Committee meeting there would be the potential to lose momentum of the message and miss an opportunity of engaging the whole audience, due to the 2-3 week Christmas period. Therefore the Communications Plan (Annexe 2) does not have dates inputted.

NHS
Vale of York
Clinical Commissioning Group

NHS GP Services

Improving Access Survey

Please help us to help you

The Vale of York Clinical Commissioning Group (CCG) plans and funds healthcare services for the York area.

There is a National requirement to increase access to GP services across England and Wales by funding evening (6:30-8:00) and weekend appointments from March 2018. Some surgeries in our area already provide a limited evening and weekend service and the CCG wants to ensure everyone is served equally. The expanded service would allow an increase of same day and routine appointments in the evening and/or on weekends, provided by a mix of clinicians such as Doctors, nurses and pharmacists appropriate to your need.

The purpose of this survey is to give you the opportunity to tell us how you would like the service to be delivered.

It will take about 5 minutes to complete.

Question 1 - Were you aware that the Government has committed to provide seven day access to GP services by making extra appointments available in the evenings (6.30pm – 8.00pm) and at weekends (Saturday & Sunday) from March 2018?

Yes ☐

No ☐

Question 2 - For ongoing care i.e. for an existing condition for which you are already receiving advice/treatment from your own practice, would you be prepared to see another clinician (not from your own practice) during these evening and weekend appointments?

Yes ☐

No ☐

Question 3 - For any urgent or 'one off' care needs, would you be prepared to see a clinician (possibly from another practice) during these evening and weekend appointments?

Yes ☐

No ☐

Question 4 - In order to make sure that potential weekday evening appointments are available at the times that best suit your needs at which of the following times would you be willing to make an appointment? Please select all that apply.

6pm – 6.30pm ☐

6.30pm – 7pm ☐

7pm – 8pm ☐

I wouldn't want an appointment on a weekday evening ☐

Question 5 - If it was possible to access GP Services at the weekend, on which of the following days would you be willing to make an appointment? Please select all that apply.

Either Saturday or Sunday ☐

Saturday Only ☐

Sunday Only ☐

I wouldn't want an appointment at the weekend ☐

Question 6 - Would you be happy for a doctor or nurse to call you by telephone to assess your needs, in order to understand whether you need a face to face appointment, or simply to give advice?

Yes ☐

No ☐

Not sure ☐

Question 7 - If other appointment types were available, such as Skype consultations (Face to Face appointment held virtually by use of the internet) or e-mail consultations, would you be interested in using these?

- Yes ☐
- No ☐
- Not sure ☐

Question 8 - How do you normally get to your usual practice? Please select the most frequently used.

- Walk ☐
- Drive ☐
- Bus Journey ☐
- Taxi ☐
- Cycle ☐
- Get a lift from a friend/relative ☐
- Other……..

Question 9 - How long would you be willing to travel to get to an appointment?

- Less than 15 minutes ☐
- 15 - 30 minutes ☐
- 30 – 45 minutes ☐
- 45 – 60 minutes ☐
- Travel would not be an issue for me ☐
- I would not be willing to travel to get to an appointment ☐

Question 10 - Which General practice are you registered with?

Old School Medical Practice	☐	Tollerton Surgery	☐
Elvington Medical Practice	☐	Stillington Surgery	☐
York Medical Group	☐	Pickering Medical Practice	☐
Front Street Surgery	☐	Helmsley Medical Centre	☐
Priory Medical Group	☐	Terrington Surgery	☐
Haxby Group Practice	☐	The Kirkbymoorside Surgery	☐
Unity Health	☐	Beech Tree Surgery	☐
My Health	☐	Posterngate Surgery	☐
Pocklington Group Practice	☐	Scott Road Medical Centre	☐
Dalton Terrace Surgery	☐	Escrick Surgery	☐
Jorvik Gillygate Medical Practice	☐	Sherburn Group Practice	☐
East Parade Medical Practice	☐	South Millford Surgery	☐
Millfield Surgery	☐	Tadcaster Medical Centre	☐

Other ☐

Question 11 - Please specify your age from the groupings below

16-24	☐
25-34	☐
35-44	☐
45-54	☐
55-64	☐
65-74	☐
75-84	☐
85+	☐
	☐

Prefer not to say

Question 12 – What is your gender?

Male ☐

Female ☐

Other ☐

Prefer not to say ☐

Question 13 – What is the first part of your post code?

☐

Question 14 – What is your ethnicity?

White British ☐ White Irish ☐

White – Any other white background ☐ Mixed – White and Black Caribbean ☐

Mixed – White and Black African ☐ Mixed – Any other Mixed Background ☐

Asian or Asian British, Pakistani ☐ Asian or Asian British, Bangladeshi ☐

Asian or Asian British, Any other Asian Background ☐

Black or Black British, Caribbean ☐ Black or Black British, African ☐

Prefer not to say ☐

Question 15 – What is your sexual orientation?

Heterosexual/Straight ☐

Gay/Lesbian ☐

Bisexual ☐

Other (Please specify) ☐

Prefer not to say ☐

Question 16 – What is your religion or belief?

- Christian ☐
- Muslim ☐
- Jewish ☐
- Hindu ☐
- Sikh ☐
- Buddhist ☐
- Non-Religious ☐
- Other (Please state) ☐

Question 17 – Do you consider yourself to have a disability? Please tick most appropriate.

- No Disability ☐
- Physical disability such as difficulty moving your arms or mobility issues wheelchair user ☐
- Sensory impairment such as being blind or visually impaired ☐
- Mental Health condition such as depression, dementia or schizophrenia ☐
- Long standing condition such as cancer, HIV, diabetes, chronic heart disease or epilepsy ☐
- Learning difficulty or disability (such as Down's syndrome or dyslexia) or cognitive impairment (such as autistic spectrum disorder) ☐
- Prefer not to say ☐
- Other (please specify) ☐

Many thanks for taking the time to complete this survey information is key in helping us to deliver successful services based around the needs of our population

NHS
Vale of York
Clinical Commissioning Group

Annexe 2 Improving Access survey field work: Communications plan and actions

NB It is recommended that resource is assigned to visit practices and encourage survey takeup via iPad/tablet	Dates tba	Dates tba	Dates tba	Dates tba	Dates tba	Dates tba	Dates tba	Dates tba	Dates tba	Dates tba
Important activities prior to launch (sequential order)										
Paper required for Primary Care Commissioning Committee (to seek approval)	x									
Launch survey (following PCCC approval)	x									
Survey duration (eight weeks)										
Highlight work that will take place through Council of Representatives		x								
Highlight work that will take place through Locality meetings										
Courtesy note to all Health and Wellbeing Boards (CYC, NYCC, ERYC)										
Courtesy note to all Overview and Scrutiny Boards (CYC, NYCC, ERYC)										
Courtesy note to Healthwatch partners (York, NY and ERY)										
Survey close and evaluation										x
Awareness raising and call to action										
Article in Practice Communication to ensure all practices are aware		x								
Media release with Medical Director quote			x							
Information and link to survey on the CCG's website		x								
CCG tweets		x	x	x	x	x	x	x	x	x
Produce article for inclusion in local partner publications		x								
Healthwatch newsletters (York, NY and ERY areas)			x							
Unitary council publications (York, NY, and ERY areas)						x				
Town and district council publications (Selby, Easingwold, Helmsley, etc.)				x						
Parish council newsletters x 400							x			
Request to member practices to support awareness raising										

ongoing

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Item Number: 14

Name of Presenter: Tracey Preece

Meeting of the Primary Care Commissioning Committee

Date of meeting:
22 November 2017

NHS
Vale of York
Clinical Commissioning Group

Report Title
Presentation of the proposed primary care estates investment bids detailing the revenue impact for approval by the CCG

Purpose of Report
For Approval

Reason for Report
There are a number of General Practice bids seeking approval by the CCG in relation to estates investment. The majority of these requests are also seeking support for submission to NHS England requesting capital grants from the Estates and Technology Transformation Fund (ETTF) to abate some of the revenue increase resulting from the investment. NHS England (NHSE) require all bids to be approved by the CCG asking the Chief Finance Office to confirm that they are satisfied the investment of capital is necessary expenditure and offers value for money. In addition the CCG sign off is intended to confirm that any commitments made to the covering of revenue will be honoured by the CCG and/or its relevant stakeholders – confirming that the CCG understand how any revenue increase is going to be funded.

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 review and approve each individual scheme recommendations for Primary Care estates investment as detailed in the overview paper attached.

Responsible Executive Director and Title	**Report Author and Title**
Tracey Preece Chief Finance Officer	Stephanie Porter Deputy Director of Estates and Capital Programmes

1. Context

The CCG has been working with general practices over the last 24 months to understand the primary care estate. This work commenced with an estates strategy, underpinned by a six facet survey of all primary care property. This work has helped assess and prioritise bids for either capital grants or revenue support resulting from estates investment by general practice.

Practices were asked to consider how they would support the service transformation agenda captured in the Five Yea Forward View and in support of this NHS England (NHSE) launched the Estates and Technology Transformation Fund (ETTF). In June 2016 the CCG supported 15 bids to go forward to NHS E for capital grant support for a range of estates and technology investment on the understanding that any revenue impact was mitigated by an ETTF grant for major transformational schemes and for minor schemes there was nil impact to the CCG. Only two of the schemes, both very minor in cost have progressed and concluded via an ETTF capital grant and a third scheme was approved outside of any ETTF grant because the existing tenancy for the premises was at risk compromising service continuity.

More recently NHS E confirmed that they would not be in a position to fund all schemes submitted against ETTF and asked all CCGs to review their bids and to focus on a smaller number of transformational schemes and to confirm through more detailed work, that the revenue impact of all proposals was affordable.

In March 2017 the Primary Care Commissioning Committee and then in April 2017 the CCG Executive Committee supported a reduced number of bids, for further detailed development for consideration and it is in this context that we now submit an updated position for the bids to be considered.

The exercise to consolidate and reprioritised the ETTF bids was undertaken against the following principles:

- Proposals should align with plans around localities, making best use of other system ‘assets’, and support the General Practice Forward View requirements around improving patient access, and extending service hours to offer greater numbers of appointments.
- Proposal must support wider system plans to move to more integrated population health management service models, and the development of an Accountable Care System (ACS).
- Proposals must support national and Sustainable Transformation Partnerships (STP) wide plans to shift work and resource out of specialist Acute Hospital settings and into Community settings where appropriate. Specifically, in the context of the Five Year Forward View refresh, the General Practice premises strategy needs to support better management of urgent demand, and improve system flow to reduce the burden on Acute Hospital A&E departments.
- Proposals need to acknowledge constraints around affordability in terms of both capital investment and ongoing revenue costs in the context of the CCG’s funding allocation from NHS E, and also need to strike a balance between affordability and accessibility to services for the CCG’s population,

with particular reference to the future physical placement of services in localities to deliver effective access.

- Proposals needs to link closely to Local Authority planning initiatives to ensure that the local system is sighted on population increases around specific Practices and localities with a view to meeting future demand.
- Proposals must be deliverable, and strike a balance around maintaining the quality and safety of existing buildings versus developing greater collaborative and integrated working across Provider organisations – with the development of facilities that support future working 'at scale' in order to deliver improved out-of-hospital services.

2. Reprioritised Bids supported by the CCG to the next stage of bid development

As a result of the instruction from NHS E, likely affordability constraints against benefits to deliver service transformation from an estates investment the CCG concluded that the following schemes would be prioritised to be worked up to assess scope, scale and affordability.

- Easingwold Scheme which would see general practice co-located with York Hospital Foundation Trust Services. New Build scheme
- Sherburn/South Milford Surgery's co located on a new site. New Build Scheme
- Burneholme Scheme which would see primary care services co located with social services/extra care. New Build Scheme
- Carlton Branch Surgery – expansion of existing property. Improvement grant to an existing building
- Pickering Surgery - extension to existing premises through acquisition of neighboring property. Improvement grant once the practice purchased the property
- Priory Medical Group – reconfiguration of existing property to create patient lounge and associated facilities. Improvement grant

The CCG have yet to receive any further information to consider for either the Pickering Surgery or the Priory Medical Group bids.

All the bids are at different stages of development – but this summary is intended to show all the bids and cost impacts to the CCG at a point in time so a decision can be made about which scheme progress to NHS England.

The CCG have been asked to consider a development proposal for Tollerton Surgery, which was approved in principle in year 1 of the ETTF, but was deprioritised when the CCG were asked to reduce the number of bids being put forward to ETTF. The practice have worked with their developer to arrive at a deliverable scheme without a capital injection and the scheme details are include in the next section.

3. ETTF Scheme Details

Scheme Easingwold Integrated Care Centre
Overview The CCG have been working with York Foundation Trust, NHS Property Services and the GP surgeries of Millfield Surgery, Tollerton Surgery and Stillington Surgery to assess the current and future impact of housing growth on service delivery. An estates strategy has been produced at the request of Hambleton District Council which confirms the impact and works through a range of site options for co-location of services in Easingwold in a phased way. This work commences with phase 1 the co-location of existing Renal Services, Millfield Surgery and the services currently at Easingwold Health centre. Both Tollerton and Stillington Surgeries declined to be involved in the development in phase 1.
Summary Details Millfield Surgery is in the top 5 premises undersized for the current patient list size, in the CCG and is identified as such in the estates strategy. This proposal will see the GP, co locate with community services and Renal services, in Easingwold. This will allow three properties which are in poor condition to be rationalised, enabling costs to be shared and reduced and a single fit for purpose property to be created to enable services to develop and expand to meet future patient needs. Future phases of the scheme (on the preferred site) could see St Monica's Hospital co locate. The practice over the next 5 – 10 years expects to see the list size grow from circa 7,300 patients to over 10,000 patients as a result of planned housing growth. Subject to approval routes, its anticipated that the scheme in 24 months.
Capital The GP element of the scheme totals 985m^2 and represents 37.25% of the total phase one scheme. Total GP capital costs at this budget stage are £6.482m. a 40% capital grant therefore would be £3,068,060 of which we estimate Reimbursable fees of £50k via ETTF GP Information Technology (GPIT) bid of £40k via a separate bid
Revenue The practice currently has 415m^2 of reimbursable space plus car parking spaces. The District Valuer (DV) currently reimburses the space at £135 per m^2. Assuming an enhanced cost per m^2 on a new build, the estimate below uses a reimbursable rate of £170m^2. The proposed new build will have 985m^2 of clinical space. Its estimated that the new reimbursable rental value will be £111,485 (excluding VAT and car parking)

This represents a revenue increase of £55,964 abated for 15 years (for an additional 570m^2)

After the abatement period the rent will increase to £167,450 per annum

Risk The proposal is led by York Foundation Trust – if they do not secure full funding for the scheme, this may create a delay. The CCG and practice can mitigate against this risk by ensuring that the preferred developer will deliver a GP only scheme on the site. If this is the case then there will need to be a reworking of the proposal and associated costs.

Recommendation
The recommendation is to approve this scheme to progress to the next decision stage, which is to submit a fully worked up PID to NHS England and progress to the development of the Outline Business Case.

In communications with the Practice, the CCG is to make clear that reimbursement of fees incurred by the Practice will only be undertaken if there is a successful ETTF bid.

Scheme Sherburn and South Milford Surgery New Build

Overview The proposal is for a new build on a new site, equidistant between to two existing properties. The practices are working with a third party provider, Apollo to deliver the scheme.

Summary Details The new two storey building would be 1,961m^2 (GMS 1,811m^2 plus a pharmacy of 150m^2) and would be serviced by 100 car parking spaces on a 1.5 acre site located equidistant between the existing surgery premises at South Milford and Sherburn. The proposed site is highly accessible and prominent and able to service the current and proposed new housing developments within the immediate area.

Capital
The total build scheme is in the region of £5.5m which will be funded by Apollo the third party developer. In order to mitigate the full revenue impact to the CCG – the proposal seeks to secure capital grants via a number of sources including planning contributions by Selby District Council and a Capital Grant via the ETTF.

If all the funding applied for is secured, the proposal by the developer would keep current reimbursement budget already in place for the properties going into the new development for the abatement period of 15 years.

The Practices will also have one off transaction costs which are estimated at present and expected to be reimbursable via ETTF in the region of £100,000 inclusive of stamp duty.

Revenue
Summary of Funding proposal

The proposed revenue position of the CCG would be:

- Commitment to the existing level of rent reimbursement for both practices - £148,080 per annum

Risk This scheme is dependent on a significant capital grant from two sources of funding. Both sources need to be secured at the requested levels to make the scheme revenue neutral to the CCG for the proposed abatement period of 15years. There is a significant risk that this level of funding is not made available.
If that happens then the project group would look to minimise any additional revenue by

- Reducing the space and capital costs
- Reducing the abatement period
- Increasing the lease length

Recommendation
The recommendation is to approve this scheme to progress to the next decision stage, which is to submit a fully worked up PID to NHS England and conclude the discussions to understand the likely capital grant contribution to the scheme. If the scheme has to be reworked and cannot arrive at a revenue neutral positon to the CCG then the proposal needs to be resubmitted to the Executive Management Committee for review and an additional approval stage before Outline Business Case.

In communications with the Practice, the CCG is to make clear that reimbursement of fees incurred by the Practice will only be undertaken if there is a successful ETTF bid.

Scheme Burnholme Scheme

Overview The CCG initially supported the proposed new build Burnholme Health Centre as part of the Council's Burnholme Health and Wellbeing Village Scheme on the old Burnholme Community College site, which will rehouse GP Practices in the locality, provide an Urgent Care Centre, and offer a range of integrated community services.

Details The proposal will see a new build co located with social care services on the Burnholme site. A focus on integrated care spanning Primary, Secondary, Community and Mental Health provision in Partnership with Social Care and the Voluntary Sector is essential to the delivery of cost effective, safe and efficient care to patients. This care should be delivered from Premises that are easy to access, in high footfall areas, and provide "one-stop shop" convenience. The development of the proposed Burnholme Health Centre is central to achieving this goal.

Capital
Health costs including Professional fees and Contingencies £5,448,530
Request a 40% capital grant from NHS England of £2,179,412

Revenue

Health income has been based upon an net internal area of 1,855m^2.

The revenue impact for the health element of the scheme in addition to the existing reimbursable rent of £133,000 is assessed as:

Rental increase on existing required is £190,154 per annum

The CCG and practice have been working together to determine how the revenue gap can be funded through service transformation and will work up the following:

Funding options:
The revenue gap is proposed to be funding through the Out of Hospital Programme's reinvestment of money back into the community through relocation of services out of the acute and reducing emergency admissions and avoidable and reduced lengths of stay.

The CCG is confident that a revenue gap of this scale can be met through this reinvestment money with the proposed service usage, and will be happy to support the ETTF at that level.

Risk

- City of York Council approval to purchase land and purchase price
- Appropriate planning consents being granted to proceed with scheme
- Disposal of Tang Hall Lane, Parkview and Heworth Green surgeries to offset capital
- 40% of only GP operations m^2 being achieved which will have a negative impact on revenue costs.

Recommendation

The recommendation is to approve this scheme to progress to the next decision stage, which is to submit a fully worked up Project Initial Document to NHS England and conclude the discussions to understand the likely capital grant contribution to the scheme.

In communications with the Practice, the CCG is to make clear that reimbursement of fees incurred by the Practice will only be undertaken if there is a successful ETTF bid.

Scheme Carlton Branch Surgery development

Overview Practice proposes to undertake a major extension at the branch surgery to manage patient list size growth. This will be on the basis of on Improvement grant.

Details The existing surgery is a small single storey building purpose built in 1978. It has 1 x GP room, 1 x practice nurse room, 1 x small office, 1 x examination room, 1 x dispensary, 1 x reception, 1 x waiting room & 1 x w/c. It has a number of significant issues resulting in it falling well below the standard required of a modern GP surgery. Last year the lease came to an end and the practice purchased the building to secure a venue to continue to deliver services too.

This bid will see the site double in area, but more importantly be reconfigured to allow for compliant rooms and better configuration for the delivery of services.

- The practice have worked with an architect on designing the proposals
- A planning application has been submitted
- The capital works are out to tender

The practice has yet to prepare an updated NHS England compliant Project Initiation Document – but will do so when the tender exercise has been completed at the end of November 2017.

Capital

Current best estimates £450,000 total capital project costs plus VAT

66% grant requested from ETTF £297,000 plus VAT

The capital grant on 2/3rd of the new scheme will be abated for 15 years
So
Practice will be seeking a reimbursement of fees from the ETTF in the region of £40,000

All costs will be confirmed following the tender exercise and all rents will be reviewed and recommended by the District Valuer.

Revenue

Current notional rent £11,000 estimated to increase for 15 years to £14,000 then after the abatement period to increase to £35,000 (or the market equivalent in 2032)

Also increase in Rates and Water estimated to be an additional £1,600 annually.

Risk

The practice has done a great deal to mitigate risks, with the work going out to tender and in for planning. However the conclusion of that work is after this approval meeting. As such there are risks

- ETTF does not allocate 66% of the total costs so the impact on revenue is greater.
- Planning permission yields greater construction costs and that also impacts on the revenue.

Recommendation

The recommendation is to approve this scheme to progress to the next decision stage, which is to submit a fully worked up Project Initiation Document to NHS England and progress to the development of the Business Case.

In communications with the Practice, the CCG is to make clear that reimbursement of fees incurred by the Practice will only be undertaken if there is a successful ETTF bid.

4. Non ETTF estates bid

The Tollerton bid is not now one of the proposals being put forward for a capital grant via the ETTF, as the bid is an estate driven solution to replace very small accommodation with new modern facilities rather than a significant service transformational scheme. As a result of this, the move from a GP owned property to a leased property via a third party developer means that the full revenue impact of a market rent will be incurred via reimbursement from year 1 of occupation.

Scheme Tollerton Surgery
Overview Tollerton Surgery, together with their development partner Daniel Garth Homes, submitted a year 1 bid to ETTF and received approval in principle to progress. Initially the scheme was a 66% improvement grant but when further discussions took place with NHS England, and they confirmed a maximum 40% grant. Coinciding with this bid development – the CCG, together with York Foundation Trust began to respond to the housing growth projections for Easingwold and surrounding areas and together with Millfield Surgery began to develop a much bigger scheme for Easingwold and asked for the feasibility work to engage Tollerton and Stillington practices. This work has developed, but both Stillington and Tollerton have declined to be part of the wider proposals for Easingwold at this stage. Stillington concluding that their existing practice premises would cope with growth in the medium term (up to 10 years) and Tollerton, whilst experiencing significant space constraint, felt the wider scheme would not deliver in time and that they wanted to pursue the more developed option to replace their existing premises via Daniel Garth Homes. Tollerton specifically wish the CCG to consider their proposal for the following reasons - The scheme is developed and could deliver an interim or long term solution for the practice much quicker that the larger scheme in Easingwold. This scheme is likely to be delivered in 12-16 months. - The proposal addresses the significant space constraints for the practice as identified in the CCG estates strategy - The proposal represents value of money
Details The property would be built and owned by Daniel Garth Homes. The proposal is to design and build a purpose build GP Surgery of 300m^2 together with 23 parking spaces and sufficient land to extend to 450m^2 if required. The build specification is to be NHS compliant. This initial build will address the under sizing of the existing property and allow for patient growth due to planned housing developments in the locale. The practice have a list size currently of circa 3,300 patients anticipated to grow to 4,000 – 5,000 over the next 5-10 years subject to housing developments in line with the Local Development Plan. The likely distance between Tollerton Surgery and the patient population and that of Easingwold and any new surgery is circa 5 miles.

Capital – the build costs will be covered by the owner/landlord This scheme is not seeking an ETTF grant, having acknowledged that NHS England asked the CCG to prioritise major service transformation scheme. Practice would seek reimbursement from the CCG of one off costs in the region of £62,000 which includes stamp duty.
Revenue Based on a Full Repairing and Insuring 15 year lease rent of £54,850.00 per annum (plus vat) with 5 yearly rent reviews would be required. The practice currently has rents reimbursed at £17,542 so the rent increase is £37,308 for an additional 120m^2 of space – without a capital grant there is no abatement period.
Risk The strategic risk sits with the decision to approve Tollerton without reference to the service resilience and transformation objectives in the Easingwold proposals. If at a point in the future services from Tollerton move in part or whole to Easingwold, there would be the risk of the residual costs of the 15 year lease to understand. The risk to Tollerton practice is that the Easingwold scheme doesn't get approval and is not delivered, or is delayed and practice have to wait a further 24 months beyond which their smaller, more deliverable scheme could have been operational.
Recommendation The PCCC is asked to consider the Value for Money of this proposal given a capital grant to abate the revenue impact will not be available. The Committee is asked to assess this bid alongside the broader strategic objectives for service transformation for primary care in the CCG.

5. Summary of proposals

The CCG is reviewing these estates proposals at a point in time and the schemes are at different stages, so costs are estimates. For those schemes which are seeking an ETTF capital grant, there is a requirement to understand from NHS England the likely level of grant so that the CCG together with the practices can assess affordability. In approving the schemes, there will be further opportunities to review and assess continued approval if significant financial variances emerge from those presented here.

In presenting the financial information, rent only is used as an indicator of likely revenue increase, but other reimbursable items are also applicable, such as rates, water and car parking and these, along with the rents are determined and signed off by the District Valuers office, for new build scheme, rates in particular can be significant and could double the reimbursable values shown here. Schemes which

are further progressed will be able to determine those figures and they will be better understood at the next CCG approval stage.

Scheme	Capital grant request	**Estimated Rent** reimbursement increase if capital grant received	**Estimated Fees** reimbursement request	notes
Easingwold	£3,068,060	£55,964	£30,000	ETTF bid. Foundation Trust do not attract stamp duty on new development.
Sherburn/South Milford	£900,000 £500,000	-	£100,000	ETTF bid and District Council
Burnholme	£2,179,412	£190,000	£100,000	Increase in revenue off set by service and contract changes
Carlton branch Surgery	£297,000	£3,000	£10,000	ETTF improvement
Tollerton	-	£37,308	£62,000	No capital grants to abate the revenue impact. Fees include Stamp duty projected at £31,600
Total CCG rent increase annually		£286,272		

Item Number: 15

Name of Presenter: Heather Marsh

Meeting of the Primary Care Commissioning Committee **22 November 2017**	NHS Vale of York Clinical Commissioning Group

Primary Care Update

Purpose of Report
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

- ☒Primary Care/ Integrated Care
- ☐Urgent Care
- ☐Effective Organisation
- ☐Mental Health/Vulnerable People
- ☐Planned Care/ Cancer
- ☐Prescribing
- ☐Financial Sustainability

Local Authority Area

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

Impacts/ Key Risks	**Covalent Risk Reference and Covalent Description**
☐Financial ☐Legal ☐Primary Care ☐Equalities	

Recommendations

N/A

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

Vale of York
Delegated Commissioning
NHS England Update
November 2017

Prepared by David Iley

Primary Care Assistant Contracts Manager

NHS ENGLAND – North (Yorkshire and The Humber)

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13 November 2017

1. Contractual Issues

1.A Quality and Outcomes Framework (QOF)

The QOF annual report for 2016/17 was published on 26th October and as agreed we will now establish a small team to review the QOF outcomes. This will include contractual, clinical and LMC representation.

2. GP Forward View (GPFV)

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 of the elements of the programme on a monthly basis.

The details of the programme are contained in appendix 1.

The Committee are asked to note the NHSE update

						Progress		
GPFV	**High Impact Action (HIA)**	**Summary**	**Year**	**Funding**	**Deadline**	**North Locality**	**Central Locality**	**South Locality**
Improving Access in General Practice	5 Productive Workflows	Plan delivery of extended access as per the requirements in the 2017-19 Planning Guidance - access to General Practice services in evenings to 8pm, plus some weekend provision. Agree plan for NHSE (needed to attract funding) - with CCG sign off. Reinforce links into locality programmes - and the wider agenda around the development of Urgent Treatment Centres. Planning guidance states procurement required.	2018/19	£3.34 per head	Mar-19	Initial Meeting held 28/09/2017 Discussions underway around a possible joint approach with Scarborough Ryedale CCG for North Locality. Becky Case supporting Practices.	Initial Meeting held 26/09/2017 Further information sent to Practices after NHSE Webex sessions. Initial discussions suggest that not all Practices wish to participate, so working on a solution where Practices can collabotate to cover each others patients. Shaun Macey supporting Practices.	Initial Meeting held 26/09/2017 Established a project team with a wide representation of the practices to take forward their proposals for extended access. Aim to provide a hub and spoke solution based around Selby Hospital plus some provision rotated around non-Selby Practices. Heather Marsh supporting Practices.
	7 Partnership Working		2019/20	£6.00 per head	Mar-20			
Reception & Clerical Training	1 Active Signposting	Funding for training of reception and clerical staff to undertake enhanced roles in active signposting and management of clinical correspondence. This innovation frees up GP time, releasing about 5 per cent of demand for GP consultations in most Practices.	2016/17		Mar-19	Have written out to alliance groupings to request feedback on 2016/17 spend - and to ask for plans on a page for 2017/18 funding. Response received from CAVA Awaiting response from other Nimbus, Shield and non-aligned. Chased		
	4 Develop The Team		2017/18	£ 61,000				
	6 Personal Productivity		2018/19	£ 61,000				
Clinical Pharmacists	4 Develop The Team	NHS England is inviting GP practices and other providers of general practice medical services to apply for funding to help recruit, train and develop more clinical pharmacists. Clinical pharmacists work as part of the general practice team to resolve day-to-day medicine issues and consult with and treat patients directly. This includes providing extra help to manage long-term conditions, advice for those on multiple medications and better access to health checks. The role is pivotal to improving the quality of care and ensuring patient safety.	2017/2018	£ -	Mar-20	A number of Practices have withdrawn their interest since the original application was submitted. Work with 'reserve' Practices was undertaken to keep overall numbers the same, however this was unsuccessful. Communication has been ongoing with NHSE, regarding a recalculated bid (1 SCP, 4 CP) Original Bid (1 SCP, 6 CP) and the process the CCG has to go through, this has now been defined. A Telephone conference will take place 8th November with the practices identified in the revised bid, to agree revised groupings, recruitment process and payment. Sign off Enhanced Service document and template to be completed after this meeting. Funding to be over 3 years 1st - 60%, 2nd 40%, 3rd 20% funding towards the Clinical Pharmacists Meeting taken place, awaiting agreement from practices on employing practices. Revised recruitment timeline and bid to be submitted to NHSE,		
ETTF	5 Productive Workflows	The Estates and Technology Transformation Fund (ETTF) is a multi-million pound programme to accelerate the development of GP premises and make greater use of technology. The aim is to improve facilities, increase flexibility to accommodate multi-disciplinary teams and develop the right infrastructure to enable better services for patients as well as increasing staff training facilities.	2017-2019	£ -	Mar-19	Sherburn and South Milford - Potential new build, 3PD project revenue neutral. PID to be developed. Beech Tree Surgery, Carlton branch - Improvement Grant - scheme cost approx £350k - PID being developed. Priory Medical Group Burnholme Health & Wellbeing Campus - Potential New Build - £10k feasibility study being undertaken by NHSE to look at local options Easingwold Health and Wellbeing Hub - New Build - Developing options paper for locality in partnership with York Foundation Trust. May not progress through ETTF. CCG would need to identify revenue if to progress.		
Resillience Funding	5 Productive Workflows	Funding to support Practices to develop resilience in the following areas: Support for Practices having difficulties with recruitment Support for support Practice mergers Support for organisational development Support for the costs of a prescribing course for Practice nurses Support for an ANP to undertake a review / implement changes within the Practice that support the longer term plan / resilience of the Practice Organisational Development via a recognised programme following a CQC review that identifies improvements that need to be made	2016/17	£ 29,000		Slippage to be utilised in addressing 2017/18 unsuccessful bids.		
	10 Develop of QI Expertise		2017/18	£ 15,000	Mar-18	Manage delivery of the 2 successful VoY schemes for Selby urgent access, and Sherburn/SMilford collaborative working towards potential merger. Review remaining bids after 5th December when NHSE panel meet to discuss underspends and reallocation of funds.		
Patient Online	2 New Consultation Types	Work on uptake across Practices to meet national contractual targets. Most VoY Practices are achieving the targets, but there are a couple of outliers @ under 10% and 8 practices under 20%. 20% to be achieved by March 2018		£ -		Communication with the practices offering support, to achieve 20% target. Attending Priory meeting November 23rd to discuss opportunities. Next step is to pull together Working Group with the 8 outlier practices and engage with Patient Online representative to understand the barriers and work through solutions.		

Time For Care	4 Develop The Team 5 Productive Workflows	The programme focusses on spreading best practice, implementation support, and building improvement capability for the future. Support training and development opportunities are available for practice managers, reception and clerical staff, GPs and managers throughout the programme.		£ -	2020	Working groups to be formed with NHSE Time For Care Programme and Practices to drive forward two of the GPFV Ten High Impact Actions. The CCG will concentrate on Reception and Back Office training, including signposting, clinical coding and Care Navigation, to attempt to engage with Practices.
Wi-Fi Public Access	9 Support Selfcare	Patient access to Wifi from Practices https://digital.nhs.uk/nhs-wi-fi Funded by us and delivered by NHS Digital, NHS Wi-Fi is a response to patient feedback asking for free Wi-Fi services to be introduced in NHS locations. It provides an efficient, reliable and secure platform that enables GPs to offer and utilise the latest digital health and care services.	2017/18	£ 169,000	Dec-17	Working with Embed to ensure delivery is both on time and communicated with practices. Clarified number of practces/branches, contact and property details relayed back to Embed. Communication sent to practices There is potential for delivery slipping to March 2018, but currently still working towards December completion date
Online Consultation	2 New Consultation Types	Funding from NHSE allocated from 2017/18 to CCG's on a weighted capitation basis, once a plan for delivery by the CCG has been signed off by NHSE. With rapid development of a number of online consultation systems for patients to connect with their general practice. Using a mobile app or online portal, patients can tell the practice about their query or problem, and receive a reply, call back or other kind of appointment. They can also access information about symptoms and treatment, supporting greater use of self care.	2017/18	£ 88,962	Mar-20	Practices emailed with information relating to online consultation, access to Webinars and funding. Voting Buttons used to assess initial interest within practices. Procurement webinar 17th November 2018 with a framework to be available January 2018, Indicative costs per patient are 0.65 without collaboration and 0.25 with a collaborated population.
	9 Support Selfcare		2018/19	£ 118,616		
	3 Reduce DNA's		2019/20	£ 59,308		
Practice Management	4 Develop The Team	Practice Management Development monies to upskill workforce	2016/17	£ 7,800	Mar-20	Full programme content finalised - running through Oct/Nov 2017. Includes: Leadership Workshops Employment Law Update Internal Appraisal Training Effective Meetings, Strategic Planning, Time Management
			2017/18	£ 17,302		CCG to mail out practices, providing different options for the practices to vote on, to enable the CCG to provide the practices with the most value.
Edenbridge Workforce Tool	5 Productive Workflows 10 Develop QI Expertise	Opportunity to become part of an early access programme to Edenbridge Apex - Business Intelligence tool that plugs into the Clinical System to enable Practices to better understand capacity and demand, and extract/report a range of operational/workforce/clinical data. Currently EMIS only - but SystmOne functionality in the pipeline.	2017/2018	£ -	Oct-17	There are 13 EMIS Practices within the Vale of York, 11 have recently shown interest in this opportunity to utilise the tool to assist with planning, match resources to demand and process alignment. To date the tool has been installed in 6 Practices (Pickeing, Pocklington, My Health, Sherburn, Tollerton, Stillington)