NHS
Vale of York
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

30 January 2020, 9.30am to 11.30am

Snow Room, West Offices, Station Rise, York YO1 6GA

AGENDA

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

1. 9.40am	Verbal	Welcome and Introductions		
2.	Verbal	Apologies		
3.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
4.	Pages 3-28	Minutes of the meeting held on 21 November 2019	To Approve	Julie Hastings Committee Chair
5.	Verbal	Matters Arising		All
6. 9.55am	Pages 29-35	Primary Care Commissioning Financial Report Month 9	To Receive	Simon Bell Chief Finance Officer
7. 10.05am	Pages 37-48	Primary Care Networks Update	To Receive	Fiona Bell, Lead Officer Primary Care (Vale) Gary Young, Lead Officer Primary Care (Central)
8. 10.20am	Pages 49-67	Care Quality Commission Ready Programme	To Receive	Dr Andrew Lee Executive Director of Director of Primary Care and Population Health
9. 10.40am	Presentation	Primary Care Quality	To Receive	Dr Andrew Lee Executive Director of Director of Primary Care and Population Health

10. 11.00am	Pages 69-76	Updates on Improving Access to General Practice at Evenings and Weekends, and Selby Urgent Treatment Centre	To Receive	Dr Andrew Lee Executive Director of Director of Primary Care and Population Health
11. 11.10am	Pages 77-85	NHS England Primary Care Update	To Receive	David Iley Primary Care Assistant Contracts Manager NHS England and NHS Improvement (North East and Yorkshire)
12. 11.25am	Verbal	Key Messages to the Governing Body	To Agree	All
13.	Verbal	Next meeting: 9.30am, 19 March 2020 at West Offices	To Note	All

EXCLUSION OF PRESS AND PUBLIC

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

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

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

NHS
Vale of York
Clinical Commissioning Group

Minutes of the Primary Care Commissioning Committee held on 21 November 2019 at West Offices, York

Present

Julie Hastings (JH)(Chair)	Lay Member and Chair of the Quality and Patient Experience Committee and Remuneration Committee in addition to the Primary Care Commissioning Committee
Simon Bell (SB	Chief Finance Officer
Chris Clarke (CC)	Senior Commissioning Manager, NHS England and NHS Improvement (North East and Yorkshire)
Dr Andrew Lee (AL)	Executive Director of Director of Primary Care and Population Health

In attendance (Non Voting)

Laura Angus (LA) – item 11	Head of Prescribing - Strategic Lead Pharmacist
Lisa Billingham (LB) – item 3	Training Manager, Haxby Group Training
Dr Paula Evans (PE)	GP at Millfield Surgery, Easingwold, representing South Hambleton and Ryedale Primary Care Network
Sarah Goode (SG) – item 3	Lead Clinician for Quality and Compliance, Haxby Group Training
David Iley (DI)	Primary Care Assistant Contracts Manager, NHS England and NHS Improvement North Region (Yorkshire and the Humber)
Alex Kilbride (AK) – item 11	Commissioning and Transformation Manager
Shaun Macey (SM)	Head of Transformation and Delivery
Dr Tim Maycock (TM)	GP at Pocklington Group Practice representing the central York Primary Care Networks
Dr Andrew Moriarty (AM)	YOR Local Medical Committee Vale of York Locality
Fiona Phillips (FP)	Deputy Director of Public Health, City of York Council
Lesley Pratt (LP)	Healthwatch York Representative
Michèle Saidman (MS)	Executive Assistant

Apologies

David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Dr Aaron Brown (AB)	Liaison Officer, YOR Local Medical Committee Vale of York Locality
Phil Goatley (PG)	Lay Member and Audit Committee Chair
Phil Mettam (PM)	Accountable Officer
Stephanie Porter (SP)	Assistant Director of Primary Care
Sharon Stoltz (SS)	Director of Public Health, City of York Council

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

There were no members of the public in attendance and no public questions had been received.

Agenda

The agenda was discussed in the following order.

1. Welcome and Introductions

JH welcomed everyone to the meeting.

2. Apologies

As noted above.

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

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

5. Minutes of the meeting held on 19 September 2019

The minutes of the last meeting were agreed.

The Committee:

Approved the minutes of the meeting held on 19 September 2019.

6. Matters Arising

PCCC35 Local Enhanced Services Review 2019/20: In addition to agenda item 10, AL reported that discussions were taking place with the Local Medical Committee regarding Local Enhanced Services. The Committee would continue to be kept informed of progress.

PCCC39 Committee Terms of Reference - Primary Care Networks representation on the Committee: This was noted as completed with the exception of the South Locality.

PCCC40 Primary Care Estates Strategy - Consideration to be given to engagement with City of York Council and North Yorkshire County Council: AL reported that discussions were taking place regarding the establishment of a “care in the community” programme board at a strategic, regional level with the aim of progressing development of collaborative working. CC and DI additionally confirmed that all potential opportunities for capital investment were being explored and they were working closely with SP in this regard. They also confirmed that it would be helpful if Primary Care Networks began to articulate gaps in their estate requirements.

PCCC41 Primary Care Resilience: This was partially completed as described in agenda item 8.

PCCC42 £3 per head Locality Updates: AL advised that the CCG was working with the Local Medical Committee to move forward from the associated issues, also noting that the Local Medical Committee had written to all GPs in this regard. TM highlighted the need to learn lessons in the context of future joint CCG and primary care initiatives.

PC43 Risk Update Report - Development of a system estates strategy and Primary care resilience to be added to the risk register: AL confirmed this had been completed.

Other matters were noted as agenda items or were carried forward.

The Committee:

Noted the updates.

LB and SG joined the meeting

4. Update from the Humber, Coast and Vale Primary Care Workforce and Training Hub Hosted by Haxby Training and Freshney Green

LB gave the attached presentation. She noted that in the national context Humber, Coast and Vale compared very favourably in terms of training and highlighted the highest number of student nurses on schemes in this regard.

PE and TM advised that their practices were benefitting from the training schemes.

Detailed discussion included:

- Confirmation that the training schemes were available to all 26 practices and that the information was circulated via the regular CCG practice communications.
- Aspects of funding, including noting the context of “invest to save”.
- Recognition of the different roles of the workforce in the context of Right Person and Right Place to meet the need of the patient.
- Noting that Advanced Clinical Practitioners required a GP mentor and therefore the associated time commitment.
- The need for a flexible workforce.
- Impact of market forces and associated resilience issues for practices.
- The welcome consistency from standardised training.
- Emphasis on the need for communication with patients to ensure understanding of the various roles within practices highlighting the fact that other than a GP appointment may be appropriate.
- The context of increasing capacity in General Practice.

With regard to communication with patients AL advised that discussions were already taking place with the CCG Communications Team. He proposed, and members agreed, that Haxby Group Training and LP work with the CCG to develop an approach to provide clarity about the various roles in primary care and remove the expectation that a GP appointment was always necessary.

The Committee:

1. Welcomed the presentation and commended the training opportunities provided.
2. Noted that AL would arrange for Haxby Group Training, LP and the CCG's Communication and Engagement Team to develop communication with patients on the various roles in primary care removing the expectation that a GP appointment was always necessary.

LB and SG left the meeting

7. Primary Care Commissioning Financial Report Month 7

In presenting this report SB noted a £302k forecast underspend against the £45.3m delegated commissioning budget, due mainly to technical adjustments relating to practice list size adjustments as well as the dispensing drugs tariff.

Other primary care budgets were forecast to overspend by £2.1m, mainly around primary care prescribing. This was a combination of unplanned price increases in category M drugs alongside an under-delivery of prescribing savings. Although the CCG was still forecasting that the 2019/20 £18.8million deficit plan would be achieved, further actions would be required than those described in the QIPP (Quality, Innovation, Productivity and Prevention) plan at the start of the year.

With regard to primary care QIPP SB reported that the second Prescribing Indicative Budgets scheme, PIB2, had been launched in September. Also that the primary care savings programme had been increased from £600k to £700k by the Executive Team as part of a number of mitigations intended to ensure the delivery of the CCG's overall plan

AL referred to the managing repeat prescriptions initiative and, whilst recognising its impact on General Practice and pharmacists, explained its potential to achieve £2m savings if fully realised. TM observed that impact assessment for such initiatives should take wider account of the system and patients' response.

With regard to the reported areas of underspend on additional roles AL assured members that this related to the timescales and challenges around recruitment. SB noted limited flexibility to recruit other posts than nationally specified. CC advised that greater flexibility was expected in 2021/22 regarding workforce roles.

TM expressed concern that the CCG was forecasting full spend of the budget associated with the Primary Care Networks given the likelihood that some posts would not be recruited to, noting the context of lessons learnt from the £3 per head issues as referred to earlier. Whilst recognising the CCG's intention he advised that this was not realistic at the present time due to factors such as market forces and the existing skill mix in primary care. SB welcomed TM's advice in the context of the CCG's overall financial position. He confirmed that the allocation was recurrent but that the underspend was non recurrent.

AL reported on a positive meeting with NHS England and NHS Improvement regarding aspects of the Primary Care Networks contract. He also highlighted the £3.3m uplift for primary care budgets in 2019/20, alongside the £1.4m allocation for clinical negligence

schemes nationally. JH emphasised the importance of timely and appropriate communication, relationships built on trust and the recognition of the complexity of the local system. In conclusion SB referred to the context of the CCG's determination to set a realistic financial plan which had been agreed at £18.8m deficit instead of the £14m deficit proposed by NHS England and NHS Improvement for 2019/20.

The Committee:

Received the Primary Care Commissioning Financial Report as at Month 7.

8. Primary Care Networks Update

AL referred to the report which provided an update on progress in the Central York Primary Care Network and Vale Primary Care Networks. He commended all the Primary Care Networks for their timely completion of the NHS England Development Needs/Maturity Matrix. In this regard DI reported that the Humber, Coast and Vale Primary Care Programme Board had approved organisational development monies for all Primary Care Networks on a fair share capitation basis. He noted there was a 20% backfill limit and £3.5k for Clinical Director development; the balance had been sent direct to the Primary Care Networks.

With regard to the primary care resilience update relating to Central York Primary Care Networks, AL explained the change in the Yorkshire Ambulance Service Urgent Care Practitioner hours to 7am to 7pm in response to times of highest need. PE noted that the Urgent Care Practitioners were also responding positively in areas other than the City. AL also described progress in development of an innovative, collaborative model to deliver extra urgent care capacity for 10-weeks (end of November to early February) to ease winter pressures expressing appreciation to Nimbuscare in this regard. TM advised that this initiative would test the concept of the model and provide additional capacity for the City practices but emphasised that GPs had concerns, particularly in the context of the existing difficulties in filling out of hours rotas.

AL reported that all the Vale Primary Care Networks were progressing well and commended South Hambleton and Ryedale Primary Care Network in being runner up in the Primary Care Network of the Year awards.

Discussion ensued in the context of the Primary Care Network contract, including such as complexities of VAT and impact from market forces with particular reference to clinical pharmacists. AM agreed to raise with the Local Medical Committee the concerns expressed by PE and TM about this at scale working in terms of both funding and also terms and conditions to try and facilitate a solution.

The Committee:

1. Received the Primary Care Networks update.
2. Noted that AM would raise with the Local Medical Committee the concerns expressed by PE and TM about this at scale working in terms of both funding and also terms and conditions to try and facilitate a solution.

9. Care Quality Commission Ready Programme

This was covered under item 6 Matters Arising.

10. Update on Local Enhanced Services

SM referred to previous presentations to the Committee noting the aspiration to simplify Local Enhanced Services, ensure value for money from the commissioning perspective, consider quality of service provision and understand variation of uptake of these services across the CCG. He explained that the process for practice claims for Local Enhanced Services had been simplified and was now on a quarterly basis noting that no issues had been raised in this regard.

SM highlighted the information in the report relating to the PSA Local Enhanced Service which included notification of aspects of clarification being sought prior to the specification being amended. He also noted the Neonatal Checks Local Enhanced Service had been withdrawn in accordance with the Committee's approval at the previous meeting.

In terms of future proposals SM referred to the proposed establishment of a project group in December to review the CCG's overall approach to Local Enhanced Services with a view to simplifying and reducing the number from 16. He highlighted the example of Leeds CCG where there were only two Local Enhanced Services, phlebotomy and shared care drugs. SM advised that work was taking place with practices and the Local Medical Committee in this regard and the ambition was for new contracts, which would have simplified reporting and monitoring requirements, to be in place from April 2020. It was hoped that all practices would take up the Local Enhanced Services noting the potential for them to be aligned with Primary Care Network contracts.

PE and TM expressed a number of concerns, including: the proposed 1 April 2020 timescale as practices required at least three months' notice for such initiatives; the context of practice resilience; the fact that staff had been employed to deliver the Local Enhanced Services; the historic issue whereby some Local Enhanced Services had not been open to all practices; and the potential for any resources resulting from this work to be reinvested to provide additional support to primary care, such as through an uplift at least in line with inflation.

AL emphasised that this work was not a QIPP. The intention was to consider potential alternative ways of delivering services with simplified governance and equity across the CCG, noting that the Local Medical Committee was involved in the review.

The Committee:

Noted the ongoing work to review the CCG's approach to Local Enhanced Services, which was expected to be reported in full to the March 2020 meeting.

LA and AK joined the meeting

11. Statin Optimisation Pilot Evaluation

AK presented the report which detailed the findings of the Statin Optimisation Pilot at Haxby Group Practice from February 2019 noting that an evaluation had been completed to capture the mobilisation process, uptake of optimisation, improved cholesterol management, financial impact and lesson learnt. The overarching assumptions based on pilot findings were:

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

Members sought clarification on aspects of the report and commended the pilot as evidence of positive clinical change. Detailed discussion ensued including: the need for patient education and reassurance about the switch to atorvastatin, which would become routine care; the context of the current pressures on GPs; potential for implementation to be progressed via the Primary Care Networks, in particular the clinical pharmacists; the context of patients with multi morbidity and opportunities to incorporate additional aspects of care through learning from work in other areas; and suggestion of a session at a future Protected Learning Time. In respect of the latter AK advised that she had a session booked at the April event.

FP referred to the opportunity for partnership working through Public Health Trainers as a resource to identify eligible patients and AL highlighted the aspects of prevention and population health. He proposed establishing a Population Health Working Group, including Public Health and Healthwatch representation, to implement a targeted approach to statin optimisation across the whole CCG.

The Committee

1. Commended the clinical change achieved through the statin optimisation pilot at Haxby Group Practice.
2. Supported establishment of a Population Health Working Group.
3. Noted that a session on statin optimisation would be included in the 30 April 2020 Protected Learning Time.

LA and AK left the meeting

12. NHS England Primary Care Update

DI presented the report which provided updates under the headings of NHS Vale of York CCG Delegated Commissioning Primary Care Commissioning Committee Annual Chair's Report, GP Forward View / Transformation, and the Community Pharmacist Consultation Service launched on 29 October. In relation to the GP Forward View / Transformation DI highlighted the Estates and Technology Transformation Fund Improvement Grants information and noted with regard to the GP Retention Scheme that the CCG had applied to be part of a national pilot to test video consultations.

The Committee:

Received the NHS England Primary Care Update, including the Committee Chair's Annual Report 1 April 2018 to 31 March 2019.

13. Risk Update Report

AL referred to the report that comprised risks relating to the Estates and Technology Transformation Strategy, Commissioning of evening and weekend access to General Practice for 100% of the population and Primary Care Team resource to deliver the CCG's statutory functions.

SM reported in respect of evening and weekend access that this was in place for the North and Central Localities. Work was taking place in the South Locality with Sherburn Group Practice and South Milford Surgery with a view to a contract being in place in December 2019. There would then be 100% coverage across the CCG as required. SM expressed appreciation to the practices in this regard.

AL advised that one of the secondees from NHS England and NHS Improvement to the CCG's Primary Care Team was no longer based within the CCG but would still be available to assist. He expressed appreciation to NHS England and NHS Improvement colleagues for their support.

The Committee:

Reviewed all risks and risk mitigation plans for the cohort of risk under the management of the Committee.

14. Key Messages to the Governing Body

The Committee:

- Commended the clinical change achieved by the statin optimisation pilot and supported its extension through partnership working across the CCG.

- Welcomed the presentation from the Primary Care Workforce and Training Hub and the opportunities offered.

The Committee:

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

15. Next meeting

9.30am, 30 January 2020 at West Offices.

Exclusion of Press and Public

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

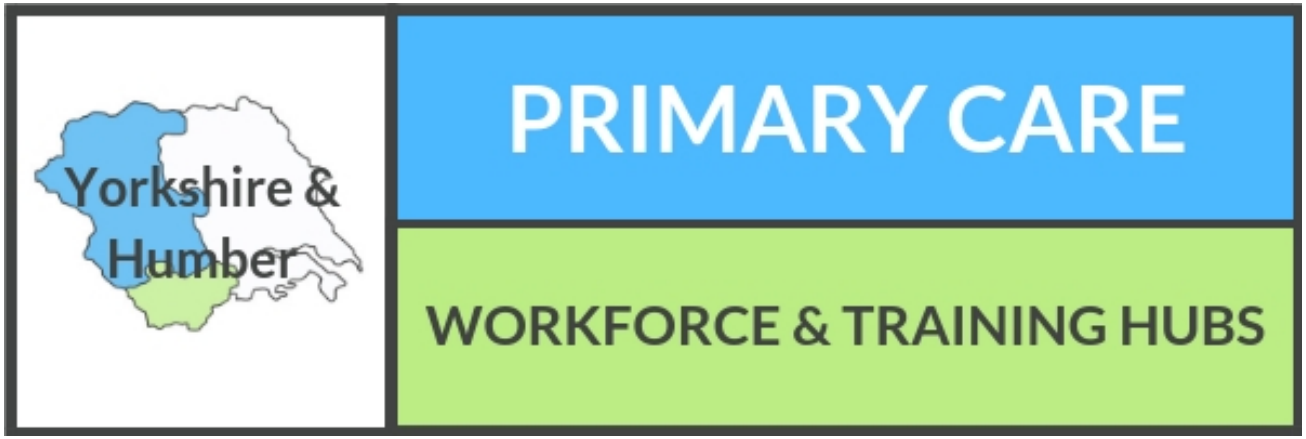
NHS VALE OF YORK CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE

SCHEDULE OF MATTERS ARISING FROM THE MEETING HELD ON 21 NOVEMBER 2019 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCCC35	24 January 2019 9 May 2019 21 November 2019	Local Enhanced Services Review 2019/20	• Report on PSA review as part of the LES report to the November meeting • Full LES report to March meeting	SP	9 May 2019 11 July 2019 21 November 2019 19 March 2020
PCCC37	11 July 2019 21 November 2019	Care Quality Commission Ready Programme	• Full review report to November meeting • Deferred to next meeting	AL	21 November 2019 30 January 2020
PCCC38	11 July 2019 19 September 2019 21 November 2019	Estates Capital Investment Proposals – Progress Report	• SS to facilitate engagement with City of York councillors through Members Briefings	SS	19 September 2019 21 November 2019 30 January 2020

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCCC41	19 September 2019	Primary Care Resilience	• DB to discuss with AL and GY opportunities to learn from Rochdale Health Alliance Limited.	DB, AL, GY	
PCCC44	21 November 2019	Update from the Primary Care Workforce and Training Hub	• Communication with patients to be developed on the various roles in primary care removing the expectation that a GP appointment was always necessary.	AL:	
PCCC45	21 November 2019	Primary Care Networks Update	• AM to raise with the Local Medical Committee concerns about this at scale working in terms of both funding and also terms and conditions to try and facilitate a solution. •	AM	

Haxby GROUP TRAINING



Humber, Coast & Vale

Primary Care Workforce & Training Hub

Hosted by:

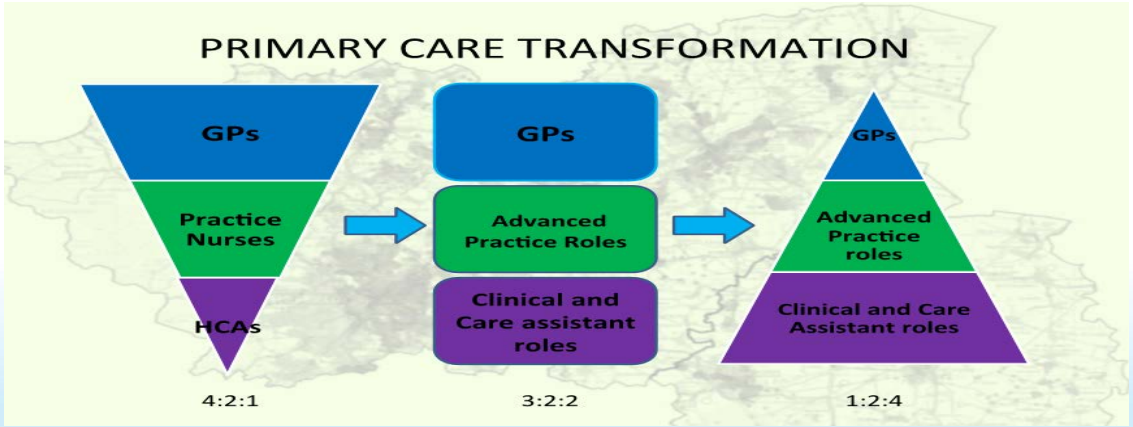
- Haxby Group Training

- Freshney Green

'Major primary care supply challenge'

- 90% of patient contact in primary care
- Demand for consultations to double in next 10 years
- Circa 22% of GPs over 55
- Circa 20% of nurses over 55

- **Growing the workforce**
- **Reshaping the workforce**
- **'Inverting the Toblerone' ➔Evolved Toblerone!**



Background

- ATP - Yorkshire-wide initiative lead by HEE, started 2009
- Develop training infrastructure in primary care
- Increase placements for undergraduate student nurses in general practice to promote practice nursing as a career pathway
- Increasing involvement and support from key stakeholders
- Workforce 'Ready' schemes introduced

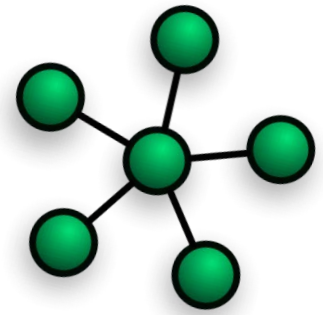
- Hub & Spoke model

- Future – linking with Primary Care Networks

PCWTH Model

- **Hub & Spoke**
  - 3 Y&H Hubs aligned within each of the 3 STP footprints - 7 ‘hosts’

- **Hubs/Hosts:**
  - Recruit and support spoke practices, support mentors, host meetings etc.
  - Claim and distribute funding to spokes
  - Undertake admin responsibilities for HEE
  - Link with Universities & maintain mentor register
  - Promotion of general practice at career fairs etc.
  - Host a larger amount of student activity
  - Coordinate workforce schemes



- **Spokes:**
  - Provide a minimum of 2-3 undergraduate student nurse placements per year
  - Report activity to their Hub practice
  - Links to other schemes

Workforce & Training Schemes

- **Student Nurse Placements in General Practice**
- **HCA Ready** – supporting apprentice HCAs
- **GPN Ready** – supporting newly qualified nurses
- **ACP Ready** – supporting trainee Advanced Clinical Practitioners
- **PA Ready** – supporting new Physician Associates
- **TNA Ready** – supporting trainee Nursing Associates

PRIMARY CARE

WORKFORCE & TRAINING HUB

Humber, Coast & Vale

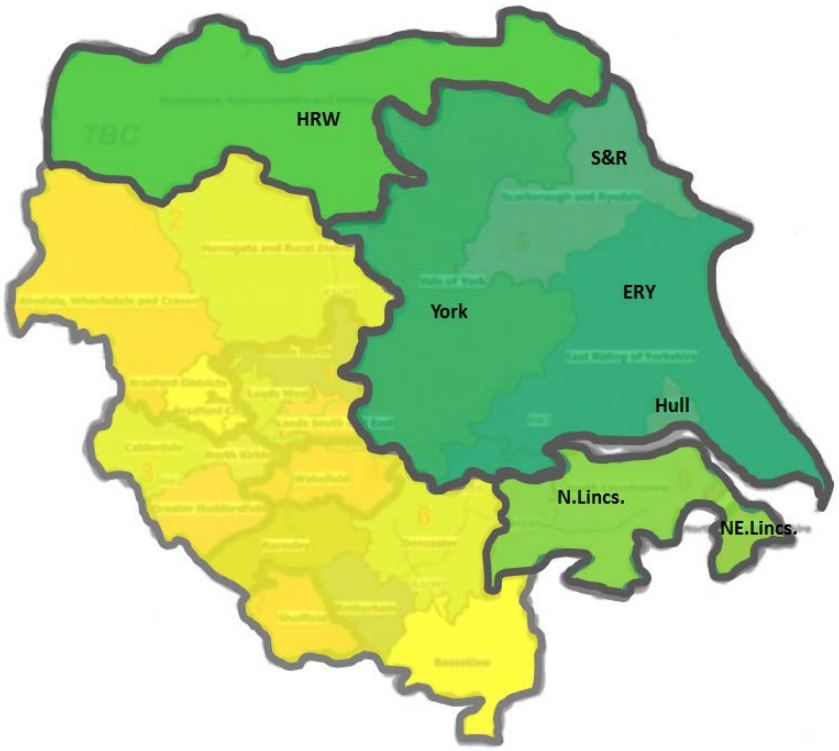
Primary Care Workforce & Training Hub

72 SPOKES taking student nurses

- 8 HULL
- 8 YORK
- 14 ERY
- 12 S&R
- 6 HRW
- 24 N/NE L

120 Practices across all schemes

Circa **55%** of practices in HCV



596 Student Nurse Placements

194 Nurse Mentors

84 Newly Qualified Nurses Employed

86 HCA Ready Apprentices (since 2015)

56 GPN Ready Nurses (since 2016)

88 ACP Ready Trainees (since 2017)

14 PA Ready Physician Associates (since 2018)

Student Nurses

- Great recruitment tool
- Professional development opportunity for staff
- Help secure the primary care workforce of the future
- Bring enthusiasm and two-way learning into the practice
- Provide quality placements
- Receive **£120 per student per week** (pro rata **£24 per day**)
- Funding currently available for mentor training

GPN Ready Scheme

- Funded initiative to support practices to employ & train newly qualified nurses or return-to-practice nurses
- *'The next step in converting enthusiastic students into practice nurses'*

- Access up to £8,000 in funding;
  - £3,000 bursary over two years to support recruitment and employment
  - up to £5,000 to cover education and training course fees
- Support network and guidance

HCA Apprenticeship Scheme

- Funded initiative to support practices to employ and train an Apprentice HCA

- Receive a bursary of £6,800 to support in recruiting and employing an apprentice HCA, and to cover the apprenticeship levy.
- Includes a fully funded programme of study days and 'bolt-on' clinical training modules.
- HCAs completing the apprenticeship gain a Level 3 Diploma in Healthcare Support, Level 2 English and Maths and the Care Certificate.
- Coordinated on a cohort basis starting around September.

ACP Ready Scheme

- Supporting practices to employ and train an Advanced Clinical Practitioner, working towards completing the MSc in Advanced Clinical Practice
  - Training Grant - £18,000 per annum per post for 2 years
  - MSc course fees - Paid directly to the chosen University so the trainee can complete their full MSc award (3 years)
- - Support network, workshops and guidance

- Open to a full variety of roles who may develop into an ACP, e.g:
  - Registered nurses
  - Paramedics
  - Physiotherapists
  - Pharmacists

- *Developing new roles in Primary Care to increase the workforce*
- *ACPs can address acute demand to free GPs for more complex patient management*

PA Ready Scheme

- Provides funding and support for practices to recruit and develop a new Physician Associate over an initial two year preceptorship period.
- Support network, workshops and guidance

- Funding consists of:
  - £5,000 in year one under a national HEE programme for General Practice
  - £10,000 per year for two years local preceptorship grant within HCV
- Practices must agree to providing the support outlined in the preceptorship programme criteria

TNA Ready Scheme

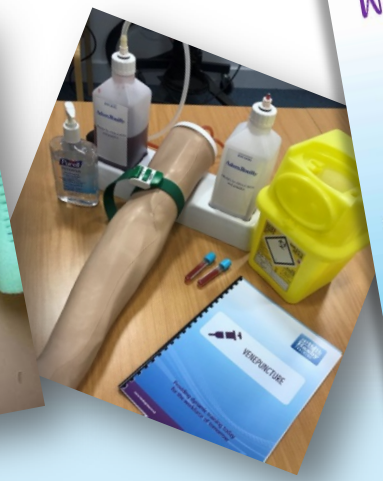
- Support for practices to develop a Nursing Associate undertaking the TNA Apprenticeship Programme.
- Partnership working with local HEIs and healthcare employers
- Help to access a levy transfer

- Funding:
  - £7,200 available from HEE nationally (currently until 31st March 2020)

Other Projects and Offers

- Cervical Screening Training Coordination
- Next Generation GP
- Leadership & Management Training

- HGT Ltd Short Courses



Key contacts

HC & V PRIMARY CARE WORKFORCE & TRAINING HUB

- Haxby Group Training Team
- haxbygroup@training.co.uk

Freshney Green PCWTH Training Hub

- Freshney Green (N/NE Lincs)
- FreshneyGreen.PCWTH@nhs.net

PRIMARY CARE

WORKFORCE & TRAINING HUB

Any Questions?

Item Number: 6

Name of Presenter: Simon Bell

Meeting of the Primary Care Commissioning Committee **Date of Meeting: 30 January 2020**	NHS Vale of York Clinical Commissioning Group

Primary Care Commissioning Financial Report Month 9

Purpose of Report
To Receive

Reason for Report

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

Strategic Priority Links

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

Local Authority Area

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

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

Emerging Risks

Impact Assessments

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

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

Risks/Issues identified from impact assessments:

Recommendations

The Primary Care Commissioning Committee is asked to note the financial position of Primary Care Commissioning as at Month 9.

Decision Requested (for Decision Log)

The Committee is asked to note the report.

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

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

Report produced: January 2020

Financial Period: April 2019 to December 2019

Introduction

This report details the year to date financial position as at Month 9 and the forecast outturn position of the CCG's Primary Care Commissioning areas for 2019/20.

Delegated Commissioning Financial Position – Month 9

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

Delegated Primary Care	Month 9 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Primary Care - GMS	16,502	16,351	151	22,003	21,837	166
Primary Care - PMS	6,725	6,671	54	8,966	8,916	50
Primary Care - Enhanced Services	837	873	(36)	1,106	1,149	(43)
Primary Care - Other GP services	3,262	3,097	165	4,387	4,208	179
Primary Care - Premises Costs	3,326	3,304	23	4,436	4,406	30
Primary Care - QOF	3,275	3,338	(63)	4,367	4,442	(75)
Sub Total	**33,927**	**33,634**	**293**	**45,265**	**44,957**	**308**

- The draft plan included total expenditure for delegated primary care of £45.8m including contingency of £229k (0.5%) as per the planning requirements which is recorded within the CCG core budget. PMS premium monies of £313k were transferred into CCG core budget in Month 4, reducing the total delegated primary care budget to £45.3m.
- The **forecast outturn** is £45.0m with an underspend of £308k against budget.
- **GMS** is based upon the current contract and list sizes to date and is showing a year to date underspend of £151k due to smaller list size movements than expected. MPIG is as per current contract, which has reduced by 50% compared to 2018/19.
- **PMS** contracts has a year to date underspend which is due primarily to list size adjustments of £54k.
- A more detailed breakdown of **Enhanced Services** is shown in the table overleaf.

Enhanced Services	Month 9 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Extended Access	427	425	2	559	557	1
Learning Disability	62	77	(15)	83	102	(19)
Minor Surgery	332	352	(20)	443	465	(22)
Violent Patients	16	19	(3)	22	25	(3)
Sub Total	837	873	(36)	1,106	1,149	(43)

- **Other GP services** is shown in more detail in the table below.

Other GP Services	Month 9 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Dispensing/Prescribing Doctors	1,679	1,527	153	2,201	1,927	274
PCO Administrator	795	903	(108)	1,060	1,241	(181)
GP Framework:						
Network Participation	462	462	(0)	616	616	0
Clinical Director	123	123	0	184	184	0
Additional Roles	288	62	226	432	213	219
Needle, Syringes & Occupational Health	14	20	(6)	19	27	(8)
Reserves	(98)	0	(98)	(124)	0	(124)
Sub Total	3,262	3,097	165	4,387	4,208	179

Dispensing Doctors are paid two months in arrears and has a year to date underspend of £153k due to a tariff reduction from October of 19.5%. This has been reflected in the year to date and forecast position.

PCO Administrator has a year to date overspend of £108k. This is primarily due to a number of late maternity claims which have resulted in a year to date overspend of £258k. Practices have been reminded of the requirement to submit claims promptly in line with guidance. The maternity overspend is partly offset by an underspend on seniority of £76k which is being phased out and an underspend on sickness claims of £61k.

Additional Roles has a year to date underspend of £226k. This is due to slippage in PCNs recruiting to the clinical pharmacist and social prescriber roles. The forecast has been updated to reflect the latest information provided by PCNs and is showing an underspend of £219k. A breakdown of the forecast underspend by PCN is shown on the table overleaf.

PCN	Budget £000	Forecast Outturn £000	Variance £000
York City Centre PCN	54	52	2
YMG PCN	54	30	24
Nimbuscare PCN	162	34	128
South Hambleton & Ryedale PCN	54	38	16
Selby Town PCN	54	30	24
Tadcaster & Selby PCN	54	29	25
	432	213	219

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

- **Premises** are based on current costs including any revaluations due this financial year. Business rates accruals are as per actual rate bills submitted by practices and verified by GL Hearn. Premises water costs have been accrued based on claims submitted pro rata or to budget.

- **QOF** has a year to date overspend of £63k which includes a prior year overspend of £27k. The accrual for 2019/20 is based on 2018/19 points and prevalence at 2019/20 price with a 1.2% demographic growth assumption. A 0.46% growth adjustment has been applied to the points, which reflects the increase in points between 2017/18 and 2018/19.

Other Primary Care

The table below sets out the core primary care financial position as at Month 9.

Primary Care	Month 9 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Primary Care Prescribing	36,266	37,868	(1,602)	47,365	49,337	(1,972)
Other Prescribing	1,633	1,523	110	1,978	2,026	(48)
Local Enhanced Services	1,724	1,632	92	2,242	2,144	98
Oxygen	279	283	(5)	371	378	(6)
Primary Care IT	688	610	78	917	800	117
Out of Hours	2,435	2,508	(72)	3,247	3,372	(125)
Other Primary Care	2,035	2,112	(77)	2,713	2,946	(233)
Sub Total	**45,060**	**46,535**	**(1,475)**	**58,833**	**61,003**	**(2,170)**

The year to date **Prescribing** position is overspent by £1.6m as at Month 9. This position is based upon 7 months of prescribing data and includes two months of estimated QIPP (totalling £249k). PIB 2 started in September, however prescribing data is only available up to October and so it the impact of PIB2 is not yet fully reflected. The forecast position of an

overspend of £2.0m assumes achievement of £1.0m of the total QIPP target of £2.0m and includes a £665k pressure in relation to Category M price increases from August onwards.

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

Local Enhanced Services have been accrued and forecast based upon Q1 and Q2 claims. The biggest underspend within this category is anti-coagulation which is forecast to underspend by £98k.

The **Primary Care IT** budget is forecast to be underspent by £117k. This is due in the main part to budget for HSCN of £60k which is no longer required and slippage on enhanced GPIT infrastructure and resilience.

The **Out of Hours** contract with Northern Doctors is currently overtrading and based upon activity to Month 6 is forecast to overspend by £125k.

Other Primary Care is forecast to overspend by £233k. This is due to the other primary care QIPP target being included in full in this budget line however some of the savings have been achieved in other prescribing and other GP services. This is shown in more detail in the QIPP table below.

Allocations

The CCG received the following allocations for Primary Care in Months 8 and 9.

Description	Month	Recurrent / Non-recurrent	Category	Value £000
GPFV – Practice Resilience – STP Funding	8	Non-recurrent	Core	5
GPFV – Primary Care Networks – STP Funding	8	Non-recurrent	Core	242
Q2 Flash Glucose sensor reimbursement	9	Non-recurrent	Core	44
Primary Care allocations in Months 8 and 9				**291**

QIPP

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

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

The primary care QIPP target of £700k has now been achieved as follows:

Description	Category	Value £000
Primary Care QIPP target	**Other Primary Care**	**700**
Limited Improving Access service in the South locality	Other Primary Care	(246)
18/19 PIB underspend compared to year-end forecast and budget	Other Prescribing	(113)
Underspend on £3/head schemes	Other Primary Care	(47)

Slippage on additional roles	Primary Care - Other GP Services	(219)
DIB funding	Other Primary Care	(70)
Underspend on SMI Physical Health Checks	Other Primary Care	(5)
Remaining QIPP target		**0**

Recommendation

The Primary Care Commissioning Committee is asked note the financial position of the Primary Care Commissioning budgets as at Month 9.

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Item Number: 7

Name of Presenter: Gary Young

Meeting of the Primary Care Commissioning Committee

Date of meeting: 30 January 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Primary Care Resilience and Capacity: Central York (Update)

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

Reason for Report

To update the committee on the report presented in September 2019.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

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

Risk Rating

Emerging Risks

Impact Assessments

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

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

Risks/Issues identified from impact assessments:

Recommendations

Decision Requested (for Decision Log)

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

Responsible Executive Director and Title	**Report Author and Title**
Dr Andrew Lee Director of Primary Care and Population Health	Gary Young Lead Officer Primary Care

Primary Care Resilience and Capacity: Central York (Update)

In September 2019 our report to PCCC surmised "*not all practices in the City are at crisis point, but some are. The risk is that if one practice fails, General Practice in York does not have sufficient capacity to absorb the fall out and the impact will be felt across the whole health and care system*". At the same time, analysis by Venn Group for BCF concluded that, on an average day, the York system has capacity to function effectively but, on a bad day, the system is so stretched that when one part of the system comes under pressure the whole system becomes pressured.

With support from VOYCCG, previous issues at one practice had largely been resolved and the practice cleared a CQC inspection. Another practice had been open and transparent about their capacity problems arising from difficulties recruiting medical and clinical staff and most practices reported operating at, or near, maximum capacity most days with some reflecting they feel they are, on some days, possibly operating beyond maximum capacity.

Since September these practices have coped but report that the pressures and causes of pressure remain. In addition, a large central practice reported Opel 4 three times in Dec 2019/Jan 2020 citing a lack of medical and clinical staff as the root cause.

The resilience and capacity report made several recommendations and, in addition, we visited Rochdale Health Alliance to look at the work they were doing to support practices.

The four recommendations of the report were:

1. GP Workforce

As part of the workforce review and strategy refresh, VOYCCG to work with GPs to establish the viability of establishing (1) Locum Bank, (2) Urgent Care Practitioners for Home Visits, and (3) review the 'Scarborough model. Within this, support/facilitate all practices in the central locality to jointly review the Improving Access service with a view to improving equitability of access and efficiency of the service.

- A bid for GPFV funding (Retention or Resilience) for a Vale of York Locum Bank was made to HCV Partnership (awaiting decision). Appendix 1.
- Liaison with YAS has taken place to focus more manpower into fewer hours in order to provide greater support to primary care and review how the service can work with GP home visits (ongoing).
- A desktop review of the Scarborough model resulted in a collaborative BCF funded bid (YFT/Vocare/Nimbuscare) to provide additional sessions in ED and GP Improving Access Hubs Dec 2019 – February 2020.
- As a result of this collaborative bid, a wide review of urgent care contracts (defined as 24/7 same/next day primary care) has led to the Urgent Care Transformation workstream. With meetings scheduled throughout January

and February this is being led by frontline clinicians across all current urgent care providers, looking at reducing the number of inappropriate ED attenders while improving primary care resilience.
- Opel. Take up by practices has been piecemeal and, with a system review of Opel underway, there is an opportunity to review how primary care becomes an integral part of Opel (aligns with urgent care transformation). As one CD recently remarked, when one practice reports through Opel you get a snapshot view, if all practices report through Opel you get a full primary care picture.
- Data analysis by the Improving Access team at NimbusCare has reduced DNAs so improving access and equitability of access to the service.
- The visit to Rochdale Health Alliance was insightful: their work is focused supporting recruitment across the whole practice team along with education and development. Tameside 'urgent care village' was cited as a successful urgent care transformation.

2. Changes in Services, Specifications and Waiting Times

As local 'partnership boards' are created through the PCN contract, Commissioners and providers should find a mechanism to jointly consult with General Practice to establish workload impact before finalising changes to existing services, including a review of hospital waiting times. Where GPs are experiencing a clear increase in appointments and administration, they should, together with consultants, establish pathway specific working parties to review waiting list and follow-up management.

- Local partnership boards are embryonic: after urgent care pressure across the system, the impact on routine appointments due to hospital waiting times is cited by GPs as the next greatest cause of unnecessary workload pressure.

VOYCCG should review the feasibility of allowing the MSK Triage service to directly book patients for onward referral without referring back to the GP first.

- Now fully rolled out

A rapid review of resource available to the York Integrated Care Team (YICT) would establish if further investment would be a cost-effective intervention to help reduce GP workload and support more patients to navigate effectively through the system.

- This is outstanding and aligns with Ageing Well. In central York, Primary Care Home (provider collaborative steering group) is resetting to take on this piece of work with a population health perspective.

3. IT & Estates

A dedicated group, led by General Practice, should be created to refocus attention on the risk to patients and practitioners arising from the multiple and complex issues around IT and Estates. For example, any practice looking to reduce the number of surgery sites it operates from faces a huge amount of scrutiny and resistance. This is right and proper but presents a major barrier to practices looking for solutions to the complex pressures they face. A wide stakeholder group including public and patient

representatives, other providers (including neighbouring practices), Shared Agenda (estates strategy), councillors, and commissioners would be a positive step forward.

- A report by CYC Public Health team analysed the demographic and health workload impact of York's increasing population and a focused piece of work with practices and CYC on the 'teardrop' development is ongoing with the four practices impacted working collaboratively agreeing to share a new GP surgery premise. Follow up is a HWB workshop on 5th March 2020.

- All city practices are fully engaged with the estates strategic review.

- VOYCCG have sharpened focus and resource supporting practices with the digital agenda and system interoperability

4. Individual Practice Support

The resilience funding offered to General Practice last year (December to January) was warmly welcomed as a solution that supported overstretched practices to add additional short-term capacity to their teams. This should be repeated this winter.

- The winter resilience bid, along with Improving Access service, fulfilled this aim.

VOYCCG to recognise increasing workload on practices close to surgeries that are themselves under pressure - working with groups of practices on a 'neighbourhood' basis should be part of the remit of the local estates stakeholder group/s.

- VOYCCG have offered support to practices under pressure including public engagement and liaising with councillors.

A review of specific needs identified should be carried out with the individual practices and GPs identified to create bespoke packages of support.

- Support for a practice to identify frequent ED attenders and clinical supervision for GPs managing a high mental health workload is in progress (multi-agency)

- VOYCCG is jointly funding a YORLMC project 'Practice Manager Resilience' to strengthen effective working relationships with key stakeholders who directly impact on the workload and resilience of Practice Managers.

Discussion

Welcomed by GPs, the findings of the resilience report have sharpened the focus on the needs of our primary care teams, not just in York but across the Vale. As GP workforce is the main cause of pressure (locally and nationally) this is where the main effort has been concentrated. The urgent care transformation workstream is an opportunity to relieve pressure across urgent care and create space for General Practice to focus on routine appointments, improve continuity of care, and successfully progress the PCN DES contract.

Appendix 1: Application for GPFV funding (Retention or Resilience) – Vale of York Locum Bank

Background

As being found nationally Vale of York is experiencing workforce recruitment and retention difficulties. There are a high number of GP vacancies across the locality particularly in the city. The knock-on effect of this and the impact it is having on primary care resilience is highlighted in the attached paper which was tabled at the Primary Care Commissioning Committee earlier this year. It demonstrates significant pressure across primary care leading to staff absences through sickness and difficulties retaining staff. Due to the number of vacancies being carried Practices are reporting back it's extremely difficult to secure a locum at short notice to provide cover due to sickness absence as the majority of locums are booked up in advance to essentially work as salaried GPs. The knock-on effect of this is that appointments are having to be cancelled at short notice which results in patient care and access being compromised as well as a reduction in patient satisfaction. Alternatively, the sessions are being covered by Partners or salaried GPs on their days off in addition to their regular workload which can attribute to work related stress and further absences.

Proposal

The Practices across Vale of York would like to trial the use of a locum bank over a 3-month period to provide primary care resilience. The locum(s) would be employed through a host Practice or Federation and be available for call off by any Practice who is notified of a staff absence at short notice ie, with less than 24 hours of the session starting. If on any day the locum is not required within GP Practices they would add capacity at ED front door or the urgent care centre. If successful, the Practices would be committed to funding this service ongoing. The overall proposal is for the locum bank to consist of a GP, an Advanced Nurse Practitioner and an Urgent Care Practitioner.

If funding is not available for all 3 clinicians, then please could a request for the locum GP to be funded*.

If the proposal is considered against the resilience programme it would meet the following criteria – 'Coordinated support to help practices struggling with workforce issues'

Costs

GP - 8 sessions of locum costs per week @£360 per session - £34,560 over a 12-week period*.

ANP - 8 sessions of locum costs per week @£160 per session - £15,360 over a 12-week period.

UCP - 8 sessions of locum costs per week @£160 per session - £15,360 over a 12-week period.

Total cost - £65,280

Benefits

The funding would provide short term resilience to primary care across the Vale of York whilst also trialling a system that could be deployed longer terms of found to be successful. It would also have the following benefits;

- Reduce the number of cancelled appointments
- Support the continuity of care, maintain access levels and reduce waiting times for appointments
- Reduce unnecessary demand on urgent and A&E services
- Increase patient satisfaction
- Increase workforce satisfaction
- Improve retention rates
- Provide flexibility within the primary care workforce
- Collaborative working between Practices

Item Number: 7

Name of Presenter: Fiona Bell-Morritt

Meeting of the Primary Care Commissioning Committee

Date of meeting: 30 January 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Primary Care Networks Update (Vale PCNs)

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

Reason for Report

To update PCCC on current progress with the Vale PCNs.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

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

Risk Rating

Emerging Risks

Impact Assessments

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

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

Risks/Issues identified from impact assessments:

Recommendations

Decision Requested (for Decision Log)

To note progress.

Responsible Executive Director and Title	**Report Author and Title**
Dr Andrew Lee, Director of Primary Care and Population Health	Fiona Bell-Morritt: Lead Officer Primary Care

PRIMARY CARE COMMISSIONING COMMITTEE: 30 JANUARY 2020

Primary Care Network (PCN) Update (Vale)

1. PCN Development

The three Vale PCNs in South Hambleton and Ryedale, Selby Town and Tadcaster and Rural District continue to meet monthly within their localities. Focus over the last couple of months has been on securing the workforce attached to the Additional Roles Funding and establishing core services in each locality. (See individual updates below).

All PCNs are now working hard to invite partners into PCN discussions to develop closer working relationships for their populations. A workshop was held before Christmas between Vale Clinical Directors and lead GPs and colleagues from North Yorkshire County Council to explore shared objectives and develop links. This is being followed by more focused locality discussions in each of the three areas. Since the last update, all PCNs across Vale of York have received development funding attached to their completion of outline plans in the initial maturity matrix submission. Work is now ongoing to develop more detailed plans which will support the PCNs delivering services together with their wider partners, and developing system leadership skills.

All three Vale PCNs have submitted expressions of interest to participate in the national 'Time To Care' programme which focusses on supporting practices to make sustainable changes that release time in practice. It is hoped that all 14 practices will secure places on the programme in the next few months. In addition, the Lead Officer and Clinical Directors are meeting with the Regional Time to Care lead to discuss additional PCN level support from the national team which will focus on developing relationships and implementing large scale change with system partners. This complements the workshops already outlined with social care partners.

In early January, the national service specifications to support deliver of Primary Care Network Direct Enhanced Service (PCN DES) were published in draft. Whilst the broad outlines have been well received, the level of detail contained in the specifications has caused concern in primary care about capacity to deliver these. Extensive feedback received nationally is expected to see at least two of the five service specifications (Anticipatory Care and Personalised Care) being put back into later years. Final outlines are expected in the coming weeks.

All PCNs are now offering additional appointments under the improving access service and support is being given through the CCG to optimise this offer.

2. South Hambleton and Ryedale PCN (SHaR)

Partnership meetings continue in SHaR with a key focus on the priority areas of dementia and anticipatory care. Recent staffing challenges in community services have significantly impacted the ability of front-line community staff to attend multidisciplinary case meetings to support anticipatory care. This highlights the significant challenge that workforce pressures across the system have in delivering integrated care and the need for a system workforce plan.

The PCN is strongly engaged in recent workshops looking at same day and urgent primary care demand and is keen to influence how the system supports patients across rural populations.

A pilot scheme exploring the impact of First Contact Practitioner Physiotherapists ahead of the national funding for these posts in 2020/21 is progressing in Pickering and is already proving to be of benefit to releasing GP time at practice level.

3. Selby Town PCN

Partnership working in Selby Town is progressing at pace. Four part time social prescribing link workers have been appointed through the North Yorkshire Living Well Service, with the first two workers starting w/c 20 January. The service based within each of the four practices will be fully operational by end of February 2020. A clinical pharmacist is now in post through the additional roles funding providing support for those practices who have not previously had this function. The four practices have also made a significant commitment to their wider workforce by using practice funds to employ a care home nurse focusing specifically on supporting advance care planning and review of patients in care homes. This is part of a new care home team which includes some input from a Care of the Elderly consultant from York Trust to develop practice wide support for these patients.

A Dementia Care Co-ordinator has also been appointed with some non recurrent support funding from Tees, Esk and Wear Valleys NHS Foundation Trust. Funding has been topped up by the practices to make this a full time post with the intention of mainstreaming this beyond next year if it proves successful.

Selby Town PCN has also recently been confirmed as one of six PCNs in the STP who will participate in an intensive population health management programme which commences in February 2020. The learning from this will be shared with all PCNs across the Vale and will significantly support partnership working at a locality level across the wider Selby District to focus improvement efforts on the specific needs of its population.

Work continues with colleagues from Health and Social Care to progress a joint working and integration strategy for the wider locality.

4. Tadcaster and Rural PCN

The recently appointed Clinical Pharmacist and Social Prescribing Link Worker roles are becoming established and working successfully across the three practices in the locality. The PCN is now exploring appointing project management support to help oversee and deliver projects identified as part of the Tadcaster and Rural PCN workplan and has also registered to participate in the time to care programme with a focus on optimising appointments with GP's and the wider clinical workforce. A workshop with District and County Council colleagues, including West Yorkshire representation is planned for 24 January to progress identification of shared priorities and workplans.

Item Number: 8

Name of Presenter: Dr Andrew Lee

Meeting of the Primary Care Commissioning Committee **Date of meeting: 30 January 2020**	NHS Vale of York Clinical Commissioning Group

Report Title – Care Quality Commission Ready Programme

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

Reason for Report

To inform the Committee of

- progress made by Practices to meet the core essential standards for registration with the Care Quality Commission (CQC)
- the discontinuation of the CCG led 'CQC ready program'
- the offer by the CCG to support practices with an increased focus upon incident, complaint investigation, management and shared learning

Strategic Priority Links

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

Local Authority Area

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

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

Emerging Risks

N/A

Impact Assessments

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

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

Risks/Issues identified from impact assessments: N/A

Recommendations

N/A

Decision Requested (for Decision Log)

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

Responsible Executive Director and Title	**Report Author and Title**
Dr Andrew Lee Executive Director of Primary Care and Population Health	Paula Middlebrook Deputy Chief Nurse Including previous report as appendix by • Lynn Lewendon, Senior Manager Practitioner Performance (NHS England) • Sarah Goode, CCG Quality Lead for Primary Care

1. Purpose of this Report

The purpose of this report is to provide Primary Care Commissioning Committee (PCCC) with an update regarding the 'CQC Ready Program' for Primary Care which was a time limited program in 2018/19.

The report will share the outcomes of the program including the outcome of CQC reviews in 2019 as the key 'output' from the program.

Methodology of the program and the previous report submitted to PCCC in July 2019 are included within Appendix A for reference and access to the self assessment tool

Whilst the CCG led CQC Ready Program is now stepped down, the CCG is committed to supporting practices either at an individual level (upon request) or as a thematic work approach to a specific area of priority. This area of priority for 2020 will be identified within this report.

The report will identify general recommendations for primary care in order to ensure their statutory responsibilities for CQC compliance.

2. Introduction and Background

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

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

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

All practices in the Vale of York had been inspected by CQC between March 2015 and June 2017. All had received a rating of good with 14 practices being given a rating of outstanding in a specific domain.

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

The aim of special measures is to

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

Practices that are given a rating of inadequate for a single key question or for a population group will not be paced in special measures but are re-inspected within six months. However, if there is still a rating of inadequate for any key question or population group after six months, the practice will then be placed into special measures.

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

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

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

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

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

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

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

As demonstrated above, the consequences of an inadequate finding on inspection by the CQC are significant.

The CCG therefore implemented a time limited 'CQC Getting Ready programme' to identify and support those practices that may be in a similar position to the one identified by CQC.

Please see Appendix A for methodology and outcomes of the CQC Ready program.

3. Outcome of 2019 CQC reviews / ratings

All practices throughout 2019 have now completed their round of CQC reviews. This has resulted in the following CQC ratings (Please note ratings are only changed following inspection and not an annual desk top review)

GP Name	O	S	E	C	R	W
Beech Tree Surgery						
Dalton Terrace Surgery						
Dr Andrew Christopher Murray						
Drs Jones, Dr McPherson & Dr Metcalfe						
Drs T Hughes, J Lodge, R Hodgson, D Powell trading as The Kirkbymoorside S						
Drs Wilson and Matthews						
Elvington Medical Practice						
Escrick Surgery						
Front Street Surgery						
Haxby Group Practice						
Jorvik Gillygate Practice						
Kimberlow Hill Surgery						
Millfield Surgery						
MyHealth						
Pickering Medical Practice						
Posterngate Surgery						
Priory Medical Centre						
Scott Road Medical Centre						
Sherburn Group Practice						
South Milford Surgery						
Tadcaster Medical Centre						
Terrington Surgery						
The Beckside Centre						
The Old School Medical Practice						
Tollerton Surgery						
Wenlock Terrace Surgery						
York Medical Group						

1	Outstanding
26	Good
0	Requirements improvement
0	Inadequate
0	Not formally rated as yet

Key Questions:
O = Overall
S = Safe
E = Effective
C = Caring
R = Reponsive
W = Well-led

(Source of information – NHSE/I, December 2019)

4. Learning from the CQC team

The CCG has received the following 'informal' feedback of areas where improvement has been needed within primary care. Please note these are not necessarily from our CCG area, however valuable for our practices to consider any areas of learning and focus for their own improvement.

Safe domain –

- HR and recruitment practices including DBS checks, professional registration checks, induction programs etc.
- Medication management including safety, medication reviews from a safety perspective, incident identification and taking appropriate actions.
- tracking results on the same day and what practices do with them if abnormal, policies and procedures in place.
- Serious incidents / complaints –practices not identifying, investigating and reporting incidents and serious Incidents. Thus leading to failure to learn from incidents and take appropriate action to prevent recurrence. Trends of incidents and complaints are not routinely captured and reviewed in appropriate governance forums. (Having robust processes in place for this area can potentially move a 'good' rating to 'outstanding'
- Use of cryotherapy – leakage issues and transporting inappropriately (similar issues also for blood transportation)

5. Future of the CQC Ready Program and CCG support

The ‘CQC Ready program’ has now formally stepped down as it achieved its objectives to increase understanding by practices in the requirements and evidence provision for attaining the required CQC standards.

Whilst the program has stepped down, the Quality and Nursing team within the CCG retain the offer of support for any practice who requests it. In recognition of CQC feedback regarding incidents and complaint, the team will focus support in 2020 upon effective incidence and complaints management processes to include ensuring effective shared learning across the CCG footprint.

The methodology and self-assessment remains available for practices to self assess or utilise to develop a ‘peer’ approach

6. Next Steps

The new CQC annual regulatory reviews (ARR) will commence 1 April 2020.

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

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

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

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

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

CQC will send a provider information request before the inspection. This is to help CQC gain information that is not available through national data collections, which

will inform the inspection. CQC will not send an annual provider information request or carry out a formal annual review of the information they hold about each practice.

7. Recommendations

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

- The CCG should explore how they can support practices to improve incident and complaint investigation processes to ensure there is shared learning across the whole locality – this should include the learning from reviews of unexpected deaths

- Practices should review the lessons learnt from other CQC visits to consider any areas of learning / potential for improvement within their own areas.

- Practices to consider how the development of Primary Care Networks can provide an opportunity for a process of peer support and acting as ‘critical friends’

- Practices to consider how the CCG can best support them to meet these recommendations

8. Conclusion

The CQC Ready program was an effective time limited program to assist primary care in its knowledge, processes and evidence preparation for compliance with and attaining the required CQC standards.

Whilst the program has now formally stepped down to allow primary care to progress with its own responsibilities, the CCG remains committed to supporting primary care with key areas for continued improvement. This is outwith the CCG commissioning responsibilities to ensure we have effective assurance mechanisms in place regarding quality and safety within primary care.

Appendix A

1. Methodology & Outcomes of the CQC Ready program in 2018/19

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

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

All practices were offered a table top review of the evidence they proposed to use to demonstrate compliance with the standards; but to assure validity of the submissions a 20% validation exercise was proposed, whereby visits to practices chosen at random would be undertaken by a member of the quality team with NHS England support to review the evidence.

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

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

Percentage compliance rates were analysed as follows:

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

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

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

2. Findings

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

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

a. Self-assessments

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

As the CCG was aware of imminent visits for some practices it was felt important that they had the benefit of a table-top review if they wished this. However, without being able to disclose a visit was imminent there was a need for some persuasion by the quality team that the review took place sooner than later.

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

b. Table top reviews

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

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

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

3. Compliance across the domains

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

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

example of this is the question about managing children at risk, with the three elements being

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

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

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

Recommendations from the Program

The following recommendations were made to practices following the consolidation of the desk top reviews.

Recommendations

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

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

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

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

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

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

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

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

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

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

Outcomes of the Program

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

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

We heard at the table top reviews that this was something that would change and practices would structure their clinical governance meetings to include a review of compliance with the CQC essential standards. One practice we spoke to had taken the approach of having one domain discussed at each clinical governance meeting,

which allowed all staff to review where the gaps in compliance may be and put these items on their work plan to ensure they are addressed and not forgotten.

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

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

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

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

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

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

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

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

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Item Number: 10

Name of Presenter: Shaun Macey

Meeting of the Primary Care Commissioning Committee

Date of meeting: 30 January 2020

NHS
Vale of York
Clinical Commissioning Group

South Locality – Updates on Improving Access to General Practice at Evenings and Weekends, and Selby Urgent Treatment Centre

Purpose of Report
For Information

Reason for Report

This report provides an update to the May 2019 paper that was presented in the private section of the Primary Care Commissioning Committee regarding the CCG's requirement to commission improved access to General Practice services at evenings and weekends for the South locality.

This report also updates the committee on a related piece of work around commissioning a formally-designated Urgent Treatment Centre in the New Selby War Memorial Hospital.

Strategic Priority Links

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

Local Authority Area

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

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

Emerging Risks

None to note.

Impact Assessments

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

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

Risks/Issues identified from impact assessments:

None to note.

Recommendations

Report is provided for information.

Decision Requested (for Decision Log)

N/A

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

1. Improving access to General Practice services at evenings and weekends

1.1 Background

From the NHS Operational Planning and Contracting Guidance 2017-2019 and the NHS England Refreshing NHS Plans for 2018/19 documents:

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. This must include ensuring access is available during peak times of demand, including Bank Holidays and across the Easter, Christmas and New Year periods.

This service is intended to benefit patients by providing additional appointments and access to General Practice services, at times which may be more convenient, through extended opening hours – and is also intended to benefit local Practices through the commissioning of additional capacity into the Primary Care system that helps to manage the demand that is increasing in core GMS services.

CCG's currently have the responsibility to commission this service for 100% of their registered populations.

1.2 Improving access in the South locality

In accordance with NHS England's requirements, NHS Vale of York CCG undertook a full procurement exercise during 2018 in order to commission Improving Access services across each of the North, Central and South localities (as 3 procurement 'lots'). Unfortunately, the CCG was unable to award a contract through this procurement exercise for the delivery of services in the South locality.

In May 2019, the Primary Care Commissioning Committee received a paper that outlined the challenges that the CCG had experienced in working to commission this service in the South locality (this was presented in the private section of the meeting due to potential commercial sensitivities). At that point in time, a proposal was available to contract through a third party Provider, but this presented concerns around availability of workforce, the delivery of face-to-face appointments, and robust integration with core hours General Practice services. Ultimately the Committee agreed that this proposal, although helpful, did not present the required value to patients and Practices that should be achieved via this funding.

The publication of 'A five-year framework for GP contract reform to implement The NHS Long Term Plan' in January 2019 also signalled that responsibility for Improving Access services would shift to Primary Care networks (PCN's) from April 2021, and in that context, the Committee recommended that the CCG re-engaged with local Practices and the emerging PCN's in the South locality in order to explore how this service could be delivered.

After a number of meetings with local Practices, explaining the available funding, potential delivery models and skill-mix, and potential benefits to both patients and Practices, the CCG has successfully formalised two contracts for delivery of Improving Access services in the South locality.

1. From 2 September 2019, Beech Tree Surgery as lead Provider has contracted with the CCG to provide Improving Access services for patients registered with Beech Tree Surgery, Posterngate Surgery, Scott Road Surgery and Escrick Surgery. Beech Tree Surgery is working in partnership with the Practices in Selby Town PCN to provide workforce and premises for the delivery of this service.

2. From 2 December 2019, South Milford Surgery as lead Provider has contracted with the CCG to provide Improving Access services for patients registered with South Milford Surgery and Sherburn Group Practice. Both Practices are working in partnership to provide workforce and premises for the delivery of this service.

Note that in the South locality, Tadcaster Medical Centre is still working in the Nimbuscare Ltd contract to provide Improving Access services to its registered patients.

The award of the above contracts to Beech Tree Surgery and South Milford Surgery now means that 100% of the CCG's registered population is covered for Improving Access services and can access evening and weekend appointments in accordance with NHS England's requirements.

For Practices in the South locality, there are still practical challenges around delivery of this service – particularly around workforce and staffing – meaning that there are occasional days when services cannot be offered. The CCG will continue to engage with Practices to develop these services to meet contractual requirements – with a potential for wider integration with services based in the Urgent Treatment Centre in the New Selby War Memorial Hospital.

2. Selby Urgent Treatment Centre

2.1 Background

Over recent months, NHS Vale of York CCG has been working with NHS England/Improvement and NHS Harrogate and District Foundation Trust to redesign Selby Minor Injuries Unit to become an Urgent Treatment Centre (UTC).

The Selby Minor Injury Unit (MIU) was previously based in the New Selby War Memorial Hospital, commissioned by NHS Harrogate and Rural District CCG (as a legacy of Transforming Community Services arrangements), and provided by NHS Harrogate and District Foundation Trust.

NHS Vale of York CCG held an associate contract with NHS Harrogate and Rural District CCG (who acted as lead commissioner) for the provision of this service to Vale of York patients.

The MIU accepted both referrals and walk-in attendances for a range of common injuries that do not require extensive testing or hospital admission – with the aim of providing an accessible service that could provide patients with effective treatment without needing to attend an A&E Department. In its MIU form, this service did not provide facilities for the treatment of minor illness.

2.2 Urgent Treatment Centres

Urgent Treatment Centres are GP-led, open at least 12 hours a day, every day (including public holidays), offer appointments that can be pre-booked through NHS 111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments that people attend A&E with. A key advantage of the UTC compared with the MIU model is that it can see and treat a wider range of presentations – including both minor injury and minor illness.

From a system perspective, UTC's are designed to reduce pressure on hospital A&E Departments, enabling them to focus on treating the most serious cases. Also, bringing a wider range of services together under the UTC name will help to simplify the urgent care system so patients know where to go and have clarity of which services are on offer wherever they are in the country. UTCs will work alongside other parts of the urgent care network including primary care, community pharmacists, ambulance and other community-based services to provide a locally accessible and convenient alternative to A&E for patients who do not need to attend hospital.

CCG's, supported by NHS England/Improvement regions, have been tasked with redesigning urgent care services outside of A&E, aiming to designate all remaining type 3&4 services as UTC's or to change their function to become other primary health care services by December 2019. This means UTCs will be embedded as part of a consistent 'out-of-hospital urgent care' offer in all localities with the option of appointments booked through a call to NHS 111.

2.3 Urgent Treatment Centre standards and designation

The ‘Urgent Treatment Centres – Principles and Standards’ document which was published in July 2017 presents 27 minimum standards that UTC’s must comply with in order to be formally designated as UTC’s.

See the following document, page 7 onwards for further details:

https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres–principles-standards.pdf

The following document includes details of the formal designation process:

https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres-faqs-v2.0.pdf

Specifically, the formal sign-off process to designate a UTC requires the following:

- Designation of UTCs is intended to be ‘light-touch’, reliant on regional assurance that localities have met or have agreed plans in place to meet the key standards for UTCs.

- A&E Delivery Board Chairs, or a representative as agreed with the NHS England / NHS Improvement regional teams, should provide assurance that the standards have been met.

- The regional director, or delegated signatory, should countersign the designation document. Confirmation from the region should be given that the service meets the standards of a UTC. National sign off is not required, but a record of all decisions should be shared with the national team.

2.4 Selby Urgent Treatment Centre – sign off and formal designation

NHS Vale of York CCG, working in partnership with NHS Harrogate and Rural District CCG, NHS Harrogate and District Foundation Trust, and Beech Tree Surgery in Selby has now secured a GP-led Urgent Treatment Centre service in the New Selby War Memorial Hospital which is compliant with the 27 minimum national standards.

The UTC's compliance was signed off at the 21 November 2019 Health and Care Resilience Board, and the service has started to offer both minor injuries and minor illness appointments from January 2020. This local sign-off has been communicated to NHS England/Improvement, and the Selby Urgent Treatment Centre has now been formally designated.

2.5 Further work and opportunities

Further work will take place to develop reporting to support contract management of this service, and understand how this service integrates with the wider system to help manage patient demand and drive service improvement.

Support is in place from local GP's through Beech Tree Surgery with a view to developing competencies and skills within the service, and ensuring that pathways are developed to best meet the needs of patients.

There is a requirement to change local road signage now that the UTC is designated. Preliminary conversations have already taken place with North Yorkshire County Council Highways Department and arrangements for the installation of signage are progressing.

There are real opportunities to integrate the Selby UTC into the local urgent care system to provide support across other services, including local GP Practices, NHS 111, GP improving access services, local pharmacy, and social prescribing / signposting – with a potential to co-locate some of these services to improve patient access and to use clinical resource more effectively.

It is hoped that, with GP leadership already in place within this service, local clinicians will be able to work through the two Primary Care Networks in the surrounding area to further develop the UTC to best meet the needs of the local population as part of an integrated urgent care system. The CCG will actively support this process with a view to integrating and improving services for local patients, and has plans to meet with stakeholders in January 2020.

Item Number: 11

Name of Presenter: David Iley

Meeting of the Primary Care Commissioning Committee **Date of meeting: 30 January 2020**	NHS Vale of York Clinical Commissioning Group

Report Title – Primary Care Update

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

Reason for Report

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

Strategic Priority Links

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

Local Authority Area

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

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

Emerging Risks

Impact Assessments

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

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

Risks/Issues identified from impact assessments:

N/A

Recommendations

For the Committee to receive the report

Decision Requested (for Decision Log)

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

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

Annexes (please list)

- **Appendix 1 – Protocol in respect of locum cover or GP performer payments for parental and sickness leave**
- **Appendix 2 – GPFV Update**

Vale of York CCG
Delegated Commissioning
Primary Care Update
January 2020

Prepared by David Iley

Primary Care Assistant Contracts Manager

NHS England and NHS Improvement – (NE and Yorkshire)

21st January 2020

1. **Items for Approval**
   No items for approval

2. **Items for Noting**

2.1 Contractual

2.1.1 General Practice Electronic Declaration (eDEC)

The General Practice Electronic Declaration (eDEC) is an annual contractual requirement in which GP Practices complete a return to NHS England and NHS Improvement to provide assurance regarding contractual compliance. The CCG have been advised all 26 Practices submitted a return. The responses will be fed back to the CCG later in the year and a further update brought to a future Committee meeting.

2.1.2 Protocol in respect of locum cover or GP performer payments for parental and sickness leave

The paper attached as appendix 1 is being discussed amongst CCGs with APMS contracts, as Vale of York don't commission any APMS agreements the paper is just for information.

2.2 Estates

No items

2.3 GP Forward View / Transformation

2.3.1 General Practice Forward View

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

2.3.2 GP Retention Scheme

The scheme is aimed at doctors who are seriously considering leaving or have left general practice due to personal reasons (caring responsibilities or personal illness), approaching retirement or requiring greater flexibility. The scheme supports both the retained GP (RGP) and the practice employing them by offering financial support in recognition of the fact that this role is different to a 'regular' part-time, salaried GP post, offering greater flexibility and educational support.

There are currently 2 Retained GPs working at Practices in the Vale of York, one based at Sherburn Group Practice and one based at Priory Medical Group both doing 4 sessions a week.

2.4 Other

No items

The Committee is asked to note the updates in the paper

Protocol in respect of locum cover or GP performer payments for parental and sickness leave

1. Issue

Eligibility for the payment of the locum allowance for GPs attached to practices with APMS contracts.

2. Background

The General Medical Services Contracts Statement of Financial Entitlement Directions 2013 (SFE) as amended in the SFE (amendment) Directions 2017, 2018 and 2019 set out the provisions, conditions and payments relating to reimbursement to GP practices for GP performers covering parental leave and sickness leave.

The Primary Medical Care Policy and Guidance Manual included a protocol for the management of the scheme and payments.

The protocol is applied only to GMS practices but with the expectation that commissioners should ensure they treat Primary Medical Services (PMS) practices equitably.

The Protocol does include reference APMS practices. The assumption would then be that the GPs engaged and employed by APMS contractors are not eligible to claim the allowances under the Scheme.

The APMS contracts for primary medical care services for the North Yorks. and Humber area are listed below:

CCG	Practices
ERY	Fieldhouse, Bridlington – Humber FT Wolds View , Bridlington - CHCP
Hull	Northpoint, Hull – Humber FT Haxby Kingswood, Hull - Haxby Haxby Newington, Hull - Haxby Kingston Medical Group, Hull - CHCP East Park Practice, Hull - CHCP
North East Lincolnshire	Humberview, Grimsby – Pelham Group Open Door, Grimsby – Care Plus Quayside, Grimsby – Care Plus Ashwood, Grimsby – Roxton@Weelsby
North Lincolnshire	Market Hill , Scunthorpe – Core Care FP
Scarborough and Ryedale	Castle Health – Scarborough – Intrahealth Ltd
Vale of York	None
Hambleton, Richmond and Whitby	None

3. Documents

The Protocol and GMS SFE 2013 are embedded below for reference:

Protocol in respect of locum cover or GI

Protocol in respect of locum cover or GP performer payments for parental and sickness leave


SFE April 2013.pdf

Please note the SFE is amended annually.

4. Summary of Context and Issues

The claims form GPs in Humber Coast and Vale are processed through our local Business Office. The Team referencing the Protocol, have rejected applications from all GPs attached to or working in APMS Practices based on the extract from the protocol below:

2.1.2 This protocol applies only to GMS practices, but commissioners should ensure they treat Primary Medical Services (PMS) practices equitably.

There has been an assumption that the Scheme was applied and covered all GPs regardless of the contractor. This doesn't appear to have been the case and in turn, has raised concerns that application of this policy could raise the risk of indirectly discriminating against those GPs engaged within an APMS contract.

Within the context of the local position and pressure on the clinical workforce capacity, this may not be helpful. Equally as the value for core services provided under local APMS contracts have been aligned with the GMS equivalent values over the last 5 years with the result that the commercial need or expediency to exclude APMS contracts from accessing the Scheme shouldn't be necessary. A revised offer may prove helpful in supporting and increasing the resilience of these contracts.

5. Proposal and Action

To apply local discretion and:

- agree to extend the scheme to cover GPs attached to and working in practices or providers with APMS contracts.
- issue CVs to existing APMS contracts to include equivalent terms to the SFE specifically for this Scheme and align the management of applications with the broad principles of the approach set out in the Protocol as appropriate to include GPs working with GMS , PMS and APMS Contractors.

6. Recommendation.

To support the issue of a CV and implementation of equivalent terms to ensure equivalent terms for APMS GPs

Date 12.12.2019.

GPFV	High Impact Action (HIA)	Summary	Year	Funding	Deadline	Position November 2019
Improving Access in General Practice	5 Productive Workflows 7 Partnership Working	Plan delivery of extended access as per the requirements in the refreshed Planning Guidance - access to General Practice services in evenings to 8pm, plus some weekend provision to 100% of the population by October 2018. Commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1,000 population. Reinforce links into locality programmes - and the wider agenda around the development of Urgent Treatment Centres.	2019/20	£6.00 per head	Mar-20	Four contracts are now in place covering 100% of the Population - Providers working to secure more consistent coverage from the available workforce to cover the required clinical hours. Additional services are being brought on stream from Physiotherapists, Nurses, HCA's – with some testing of Skype type consultations. Utilisation rates are currently good, and Providers are working to increase the number of available appointments, whilst maintaining good utilisation rates.
Reception & Clerical Training	1 Active Signposting 4 Develop The Team 6 Personal Productivity	Funding for training of reception and clerical staff to undertake enhanced roles in active signposting and management of clinical correspondence. This innovation frees up GP time, releasing about 5 per cent of demand for GP consultations in most Practices. In previous years the Vale of York CCG has offered this funding through GP Alliance groupings to help train reception staff in signposting and to develop improved processes around clinical correspondence management.	2019/20	£239,682	Mar-20	NHSE have confirmed the following: Funding for four of the Primary Care Transformation Fund programme budgets will be going direct to Humber, Coast and Vale Health and Care Partnership in 2019/20. The funding for the GPFV programme areas will be allocated in June 2019 (i.e. the first accounting month when allocations are made) for the whole year, the allocation will be made to the Humber Coast and Vale and Health and Care Partnership rather than individual CCGs, as one budget and not by programme area. • General Practice Resilience Programme • GP Recruitment and Retention Programme • Reception and Clerical Staff Training • Online Consultations 2019/20 Allocation: - Practice Resilience - £201,020 - GP Retention - £319,080 - Reception & Clerical - £239,682 - Online Consultation - £391,006 **Total -£1,150,788** In April 2019 NHSE invited each CCG to submit proposals against each of the programme areas, which will be collated and taken to the Programme Board for consideration and prioritisation. Vale of York have submitted their proposals for consideration and await confirmation following the decision of the Programme Board. The Programme Board to date have agreed the following Proposals: **Practice Resilience:** £18k - Jorvik and Gillygate Merger £5K - Stillington Surgery £5k - Priory Medical Group £25k - Pilot PM Support Lead £5k - Beech Tree Surgery **Online Consultation:** £25k to test video consultations across the York Locality and share the learning. **Reception and Clerical:** £9K - Thornfields Actice Signposting - to be shared across the PCN to access appropriate training. **GP Retention** £10K York Medical Group £4.5k - Tollerton Surgery
Resilience Funding	5 Productive Workflows 10 Develop of QI Expertise	The purpose of the fund is to deliver support that will enable Practices to become more sustainable and resilient and better placed to take the challenges they face now and into the future and secure continuing high quality care for patients. The menu of support ranges from helping to stabilise practices at risk of closure through to more transformed support, including if appropriate, helping practices explore new models of care. This could include: • Specialist advice and guidance e.g. Human resource, IT • Coaching / Supervision / Mentorship • Practice Management Capacity Support • Rapid Intervention and management support for practices at risk off closure • Co-ordinated support to help practices struggling with workforce issues • Change management and Improvement Support to individual practices or group of practices. Support is available to individual practices as well as being available on a greater scale to group of practices in localities.	2019/20	£201,020	Mar-20	
GP Retention Scheme	4 Develop the Team	The fund will support local systems to develop innovative local retention iniatives for: • GPs who are newly qualified or within their first five years of practice. • GPs who are seriously considering leaving General Practice or are considering changing their role or working hours. • GPs who are no longer clinically practicing in the NHS in England but remain on the National Performers List (Medical). Within the Vale of York there are currently 3 GP Retainers (Sherburn, Scott Rd, Priory) already supported with finances agreed through the Primary Care Commissioning Committee. With a budget of just over £40k from the CCGs Primary Care Allocation, which is fully committed.	2019/20	£319,080	Mar-20	
Online Consultation	2 New Consultation Types 9 Support Selfcare 3 Reduce DNA's	The GP online consultation system fund was launched in 2017 This £45 million fund over 3 years 2017 - 2020 is available to support digital Funding from NHSE allocated from 2017/18 to CCG's on a weighted capitation basis. An STP wide procurement took place to commission an online consultation solution for GP Practices. The provider appointed is Wiggly Amps and the package is called engage system. NHSE employed a project manager to support all practices within the STP with deployment. To date the Vale of York have 6 practices who have gone live with the system, covering a population of 136,791 with a further 3 practices who have expressed an interest in going live covering a further population of 58,744.	2019/20	£391,006	Mar-20	

Clinical Pharmacists	4 Develop The Team	The Clinical Pharmacists in general practice scheme closed to new approvals effective from 31 March 2019 and will close for any appointments to approved posts made after 30 April 2019. The Enhanced Service for the current scheme will continue for those practices claiming for an employed clinical pharmacist, or which are received approval and appointed a Clinical Pharmacist prior to the 30 April 2019 until either. • The Clinical pharmacist is transferred to become part of a PCN's workforce team from 1 Jul 2019 onwards. • The reimbursement for the clinical pharmacist under the terms of ES comes to an end, e.g. at the end of the three year tapered funding period. A clinical pharmacist does not have to transfer from their current practice, to working across a PCN. Practices considering transferring staff are advised to read the Network Contract DES guidance at the earliest opportunity as strict workforce additionality rules will apply to the Network Contract DES which may affect the number of clinical pharmacists that can be transferred to the new network scheme. The Network Contract DES begins on 1 July 2019 and PCN's will be able to claim reimbursement for clinical pharmacists from this date, subject to specific rules. Employing practices will be responsible for supporting their staff through these transitional arrangements.	2019/20	£ -	Mar-20	In light of the introduction of the Network Contract Directed Enhanced service (DES) the Clinical Pharmacists in General Practice Scheme will close from 30 April 2019. The Enhanced Service (ES) for the current scheme will continue for those practices claiming reimbursement for an employed clinical pharmacist, or which have received approval and appointed a clinical pharmacist prior to the 30 April 2019, until either: •The clinical pharmacist is transferred to become part of a Primary Care Network's workforce team from 1 July 2019 onwards (and in accordance with the rules set out in Table 1 of the Network Contract DES guidance); or •The reimbursement for the clinical pharmacist under the terms of the current ES comes to an end, e.g. at the end of the three-year tapered funding period. Confirmation has been received that 0.5 SCP from NIBUSCARE pPCN will transfer to the networking agreements with the remaining 3.8 remaining on the NHSE scheme.
ETTF	5 Productive Workflows	The Estates and Technology Transformation Fund (ETTF) is a multi-million pound programme to accelerate the development of GP premises and make greater use of technology. The aim is to improve facilities, increase flexibility to accommodate multi-disciplinary teams and develop the right infrastructure to enable better services for patients as well as increasing staff training facilities.	2017-2021	Based on individual schemes	Mar-21	1.)Sherburn - Practice looking to develop an improvement grant rather than pursuing a new build due to ETTF timescales to complete before the end of March 2021 2.) Beech Tree Surgery, Carlton branch - Improvement Grant to expand and develop existing premises now completed. 3.) Priory Medical Group Burnholme Health & Wellbeing Campus - New Build proposal awaiting NHS England support to develop the business case. 4.) Millfield Surgery - Improvement grant to expand existing surgery waiting for approval from NHS England 5.) Pickering Medical Practice - Improvement Grant to expand existing premises now completed
Patient Online	2 New Consultation Types	Work on uptake across Practices to meet national Aspirational targets. 30% coverage desirable to be achieved by March 2019		£ -	Aspirational Target	Currently 15 practices remain below 30% expectation and 11 practices achieving over 30%. Overall as a CCG 31.1% of all patients have access to online services.
Time For Care	4 Develop The Team 5 Productive Workflows	The Time for Care Programme is continuing beyond March 2019 with an offer of support that can be tailored to meet local needs. As well as the core elements of Time for Care that help practices to release time, improve collaboration and build improvement skills, there will be some new elements that are more relevant to primary care networks and working at scale.		£ -	2020	CCG had meeting with Charlie Keeney on the 12/12/19 from NHSE Sustainable Improvement Care Team to ascertain what support is currently available for General Practice and PCN Level under the GPFV Time for Care Programme. Discussed the national programme available of support which includes: • Primary Care Network Improvement Leader Programme - applications are now open for two cohorts commencing feb and March - communicated to practices • Productive General Practice Quick Start Programme - Practices have been invited to submit expressions of interest by 10/1/20 - 4 expressions of interest have been received and forwarded to the national team. • Vision to deliver - 6 - 9 month action focused workshop collaborative. This is being discussed with practices directly with CCG PCN Leads.
Practice Management	4 Develop The Team	The General Practice Development programme was established as part of the GPFV. The programme will: • Spread the best innovations, helping all practices to support mainstreaming of proven service improvements across all practices • Fund local collaboratives to support practices to implement new ways of working. • Provide free training and coaching for clinicians and manages to support practice redesign. In term tis will help practices lay the foundations for new models of Integrated care, and play their part in delivering a sustainable and high quality NHS as part of the sustainability and Transformation Plan process in which general practice has a key role.	2019/20	TBC	Mar-20	In previous years this was commissioned to the LMC to deliver a training programme around effective Practice Management and GPPR. NHSE are awaiting details, from the National Team, if there will be any available funding within 2019/20. NHSE have confirmed there will be no national funding within 19/20

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