NHS
Vale of York
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

23 July 2020, 1.30pm to 3.30pm

By Microsoft Teams due to Coronavirus COVID-19

AGENDA

1.	Verbal	Apologies		
2.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
3.	Pages 3-10	Minutes of the meeting held on 28 May 2020	To Approve	Julie Hastings Committee Chair
4. 4.1	Verbal Verbal	Matters Arising Hepatitis B vaccination for patients with chronic kidney disease	To Note	All Dr Andrew Lee Executive Director of Primary Care and Population Health
5. 1.50	Pages 11-21	Primary Care Commissioning Financial Report Month 3	To Approve	Simon Bell Chief Finance Officer
6. 2.05	Pages 22-28	Primary Care Networks Update	To Receive	Fiona Bell-Morritt / Gary Young Primary Care Lead Officers
7. 2.20	Verbal	Coronavirus COVID-19 Update	To Note	Dr Andrew Lee Executive Director of Primary Care and Population Health
8. 2.40	Pages 29-34	Prescribing Indicative Budgets 2 *Jamal Hussain, Senior Pharmacist, attending*	For Decision	Dr Andrew Lee Executive Director of Primary Care and Population Health
9. 3.00	Verbal	Risk Assessments for At Risk Groups – General Practice	To Note	Stephanie Porter Assistant Director Primary Care

10. 3.15	Pages 35-61	NHS England and NHS Improvement Primary Care Report	To Receive	David Iley Primary Care Assistant Contracts Manager NHS England and NHS Improvement (North East and Yorkshire)
11. 3.25	Verbal	Key Messages to the Governing Body	To Agree	All
12.	Verbal	Next meeting: 1.30pm, 24 September 2020	To Note	All
Part II meeting to follow				

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Item 3

Minutes of the Primary Care Commissioning Committee on 28 May 2020 by Microsoft Teams due to Coronavirus COVID-19

Present

Julie Hastings (JH)(Chair)	Lay Member and Chair of the Quality and Patient Experience Committee in addition to the Primary Care Commissioning Committee
Simon Bell (SB	Chief Finance Officer
David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Phil Goatley (PG)	Lay Member and Chair of the Audit Committee and Remuneration Committee
David Iley (DI)	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
Phil Mettam (PM)	Accountable Officer

In attendance (Non Voting)

Fiona Bell-Morritt (FB-M)	Lead Officer Primary Care Vale
Dr Aaron Brown (AB)	Liaison Officer, YOR Local Medical Committee Vale of York Locality
Shaun Macey (SM)	Head of Transformation and Delivery
Dr Tim Maycock (TM)	GP at Pocklington Group Practice representing the Central York Primary Care Networks
Stephanie Porter (SP)	Assistant Director of Primary Care
Michèle Saidman (MS)	Executive Assistant
Sharon Stoltz (SS)	Director of Public Health, City of York Council
Gary Young (GY)	Lead Officer Primary Care City

Apologies

Kathleen Briers (KB) / Lesley Pratt (LP)	Healthwatch York
Chris Clarke (CC)	Senior Commissioning Manager, NHS England and NHS Improvement (North East and Yorkshire)
Dr Paula Evans (PE)	GP at Millfield Surgery, Easingwold, representing South Hambleton and Ryedale Primary Care Network

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

DB welcomed everyone on behalf of JH who had been delayed. He advised that the need for a Part II meeting had arisen since circulation of the meeting papers.

Agenda

1. Apologies

As noted above.

2. 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.

3. Minutes of the meeting held on 19 March 2020

The minutes of the previous meeting were agreed.

The Committee:

Approved the minutes of the meeting held on 19 March 2020.

4. Matters Arising

PCCC38 Estates Capital Investment Proposals Progress Report - SS to facilitate engagement with City of York councillors through Members Briefings: SS apologised for the delay in responding and advised that there were a number of forums for engaging with elected members. This would be dependent on the subject and would therefore be on a case by case basis. SS offered to act as a single point of contact for such access. This action was now closed.

JH joined the meeting and took over as Chair from DB

PCCC49 Hepatitis B vaccination for patients with chronic kidney disease: AB described the background to this matter and reported that he had been working with SP and Paula Middlebrook, Deputy Chief Nurse, on an urgent resolution. They had considered this in the wider context and were currently finalising a solution which interfaced between primary and secondary care. AB outlined the proposal and agreed to present a summary at the next meeting of the Committee.

The Committee:

1. Noted the updates.
2. Agreed to receive a briefing on Hepatitis B vaccination for patients with chronic kidney disease at the next meeting.

5. Primary Care Commissioning Financial Report Month 12

SB referred to the report which provided information on the year end position for Delegated primary care commissioning, Other primary care, Allocations and QIPP (Quality, Innovation, Productivity and Prevention). He noted the £412k underspend against the delegated primary care commissioning budget and the £3m overspend on the primary care prescribing budget. In respect of the latter SB recognised that the

efficiency target had been ambitious but added that the March prescribing data had become available since writing the report which showed a significant increase in cost and number of items prescribed. In this regard he noted the effects of No Cheaper Stock Obtainable, Category M price increases and potential stockpiling in the context of the COVID-19 pandemic.

In response to DB enquiring about implications for the year-end position from the additional prescribing overspend, SB explained the risk that External Audit may regard the £554k difference between accrual and actual as sufficiently material to give a qualified regulatory opinion around break-even. SB emphasised that there were no issues with the CCG's estimation techniques, and national advice had been not to change them specifically to estimate potential COVID-19 impact and advised that a number of CCGs were in a similar position in respect of prescribing expenditure. This had been raised nationally and discussions were ongoing with External Audit. DB noted that the Finance and Performance Committee earlier in the day had fully supported SB pursuing discussion in this regard.

GY joined the meeting

AB sought clarification on behalf of PE regarding QIPP (Quality, Innovation, Productivity and Prevention) and the potential for a third Prescribing Incentive Budget scheme. SB responded that the primary care QIPP had in part been achieved through the underspend on the additional Primary Care Network roles, as discussed at previous meetings, and thanked TM for suggestions in the way this was reported. SB advised that there was currently no plan for a third Prescribing Incentive Budget scheme referring to the context of the COVID-19 pandemic and the current financial regime which was not conducive to such an approach. AL added that the second Prescribing Incentive Budget scheme had not generated the expected level of savings even taking account of the delayed start. He advised that it was currently being evaluated and he would bring a report to the next meeting.

The Committee:

1. Received the Primary Care Commissioning Financial Report as at Month 12, noting the additional information in respect of prescribing.
2. Agreed that an evaluation of the second Prescribing Incentive Budget scheme be presented at the next meeting.

6. Primary Care Networks (PCN) Update

FB-M and GY referred to an update presentation:

- Highlighting some of the achievements of the first year of PCNs
- Describing the 'place', priorities, population health needs, challenges, vision, 2020/21 priorities and partnerships for each of the PCNs
- PCN priorities and next steps 2020/21
- PCNs and Places in York and North Yorkshire including Humber Coast and Vale and North Yorkshire and Integrated Care Partnership
- Challenges for PCNs in year two and links to the wider system

- Questions for consideration in the context of the Integrated Care System focus on 'patient'; 'place' and 'system'

The PCNs and Clinical Directors were commended for their work and achievements of the first year. The coming year was noted as one of challenge and opportunity.

In response to SS enquiring about Public Health services such as Health Visitors, School Nurses, Stop Smoking and Sexual Health, being more effectively engaged in work with primary care, GY expressed the view that practices would welcome such engagement. He agreed to work with SS in this regard.

In response to AB expressing concern about representation of primary care and clinical leadership in developments, detailed discussion ensued both in the historical context, including the CCG's attempts to gain clinical engagement, and the forthcoming transformation work post the COVID-19 pandemic. PM noted that the CCG was actively considering potential for resources to support clinical engagement and emphasised that the challenge was to maintain the present impetus to bring about strategic transformational change; where possible the ambition was for the approach to be 'place' based, community based and a non medical model. Members recognised the need for a clear remit to incentivise GP engagement and highlighted that anyone participating in system development work would be party to commitment and expectations.

TM commented on the pressures emanating from the COVID-19 pandemic, the need to rebuild sustainable services, the context of the one day a week for the Clinical Directors' PCN role and the requirements of the General Medical Services contract.

JH expressed appreciation to GPs for their work and commitment.

The Committee:

Received the Primary Care Networks Update.

7. Primary Care Network Changes to Nimbuscare PCN

In presenting the report detailing proposed changes to the structure of Nimbuscare PCN, SP advised that the Primary Care Team had validated the proposals and confirmed they were compliant with the regulations for the establishment of Primary Care Networks. The current single PCN would become three separate PCN organisations, reflecting the previous neighbourhood structures. SP additionally reported that the new nominated bank account details for East of Yorkshire PCN, which had been awaited at the time of writing the report, had now been received. *Post meeting note: East of Yorkshire PCN have subsequently advised they wish to be known as York East PCN to avoid confusion.*

The Committee:

Ratified the proposed changes to the structure of Nimbuscare PCN, which will see the single PCN reorganise itself into three separate PCN organisations, reflecting the previous neighbourhood structures.

8. Primary Care IT – COVID Response in Primary Care

SP referred to the report which summarised key elements of the significant work and investment in IT hardware and software to support primary care and care home partners to develop the capability to work remotely and at scale during the COVID- 19 pandemic. This would form the basis of new models of working going forward. SP highlighted the joint working that had taken place and in particular commended SM, Cari Jones and Michael Ash-McMahon. It was agreed that AL, on behalf of the Committee, would send a personal note of appreciation.

Whilst echoing the appreciation TM requested support for upgrading current equipment as soon as practicable. SM confirmed that discussions were taking place with North of England Commissioning Support regarding business as usual and commended them for being as accommodating as possible in the current challenging environment.

The Committee:

1. Received the Primary Care IT - COVID response in primary care report.
2. Requested that AL, on behalf of the Committee, express appreciation to colleagues who had provided IT support to primary care and care homes.

9. GP Opening Bank Holidays

SP referred to the four recent Bank Holidays, two at Easter and two during May. She explained that for the former NHS England and NHS Improvement had mandated Practices to open but there had been flexibility for the Friday and Monday holidays in May. For the early May holiday three Practices had chosen to open supplementing Saturday and Sunday with Vocare services or extended hours. There had been no reported issues in the system. For the late May holiday only one Practice had opened.

SP assured members that systems had been in place to ensure both availability and communication about General Medical Service cover arrangements. She expressed appreciation to GPs for their work.

The Committee:

Noted the update.

10. Coronavirus COVID-19 Update

AL commended the digital innovation used by primary care during the pandemic noting use of ‘remote’ consultations, electronic prescribing, new approaches such as accuRx and total triage systems. This had all contributed to reducing patient footfall. However, primary care activity had now begun to increase and there was concern in the system due to issues such as the cancellation of hospital appointments and reduced numbers of tests. AL noted potential specialty waiting lists of up to 12 to18 months.

AL referred to the earlier discussion about operational pressures on primary care and reported that the CCG was offering Practices a short term Local Enhanced Service contract for care homes with effect from 1 May 2020 in response to a national mandate to mitigate impact and ongoing pressures. AL emphasised the need to maintain flexibility in the context of concern about a second wave of the pandemic.

SS explained similar challenges being faced by Local Authorities advising of a new requirement to, with partners, establish COVID-19 Health Protection Boards and local outbreak plans in the event of a 'spike' in infections. She reported that City of York Council was working with the CCG and North Yorkshire County Council to fulfil these requirements as a matter of urgency working across boundaries. SS confirmed the potential for three different levels of lock-down across the CCG's three Local Authority boundaries.

Further discussion included the potential for a vaccination, the context of the 'flu season for which planning was in progress, and concern about both a 'spike' in COVID-19 cases and 'flu.

The Committee:

Noted the update.

11. Primary Care Intravenous Pilot

AL explained that an IV Zoledronic Acid Pilot for treating osteoporosis had begun in early 2019, initially at Pickering Medical Practice in South Hambleton and Ryedale PCN area. The pilot had gone well; staff were trained and delivering the service. The Executive Committee were supportive of continuing the pilot but suggested further consultation with South Hambleton and Ryedale PCN to see if it met their needs, whether they would support continuing the pilot for a further year and potentially extending its coverage or scope e.g. to include Easingwold where the prevalence of osteoporosis was known to be high.

PM left the meeting

TM queried why it still needed to be a pilot. AL advised that any extension of scope e.g. to include cancer treatment would require further consultation with key stakeholders such as Medicines Management and Cancer Services so was not straight forward. AL recommended further support and development of the pilot.

The Committee:

Approved the further development of the IV Zoledronic Acid pilot.

AL left the meeting and nominated SP to deputise

12. NHS England Primary Care Update

DI explained that the lease for Front Street Surgery at Unit 5 Copmanthorpe Shopping Centre was due to expire on 28 September 2020. Owing to COVID-19 pressures the landlord had proposed extending the lease for an interim period of one year to 28 September 2021 under the same conditions and the same rental value with a view to negotiating a longer term lease later in the year.

The report also provided an update on the Network Contract Directed Enhanced Service; GP Forward View / Transformation relating to Digital Primary Care – Additional support

for GP Practices; and COVID-19 including as an appendix a letter detailing the requirement for CCGs to identify a clinical lead for all Care Quality Commission registered care homes.

The Committee:

1. Received the NHS England primary care update.
2. Approved the one year interim lease extension at Front Street Surgery, Copmanthorpe Shopping Centre, York.

13. Key Messages to the Governing Body

The Committee:

- Commended the joint working to resolve the issue relating to Hepatitis B vaccination for patients with chronic kidney disease.

- Noted the ongoing work to ensure primary care representation in system level developments.

- Expressed appreciation to colleagues who had provided IT support during the COVID-19 pandemic.

The Committee:

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

14. Next meeting

1.30pm, 23 July 2020.

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 28 MAY 2020 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 19 March 2020	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 • Deferred to autumn 2020	SP	9 May 2019 11 July 2019 21 November 2019 19 March 2020 24 September or 26 November 2020
PCCC 49	19 March 2020 28 May 2020	Hepatitis B vaccination for patients with chronic kidney disease	• AB to work with Paula Middlebrook, Deputy Chief Nurse, to seek an urgent resolution • Summary report to next meeting	AB AB	 23 July 2020
PCCC50	28 May 2020	Financial Performance Report	• Evaluation of the second Prescribing Incentive Budget Scheme	AL	23 July 2020
PCCC51	28 May 2020	Primary Care IT – COVID Response in Primary Care	• Personal thanks to colleagues who had provided IT support during the pandemic	AL	3 June 2020

Item Number: 5

Name of Presenter: Simon Bell

Meeting of the Primary Care Commissioning Committee **Date of meeting: 23 July 2020**	NHS Vale of York Clinical Commissioning Group

Primary Care Commissioning Financial Report Month 3

Purpose of Report
For Approval

Reason for Report

To provide the Committee with details of the financial plan for Primary Care Commissioning for 2020-21. The report also provides the Month 3 and forecast position. The report recommends how 2020-21 PMS premium monies should be allocated to Practices.

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

PMS premium monies are allocated to PCNs based on weighted list size at 1 January 2020.

Decision Requested (for Decision Log)

The Committee is asked to approve the allocation of PMS premium monies to PCNs without any constraints based upon weighted list size at 1 January 2020.

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

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

Report produced: July 2020

Financial Period: April 2020 to June 2020

1. Introduction

This report provides details on the financial plan for 2020-21 for the CCG's Primary Care Commissioning areas. It also reports the year to date financial position as at Month 3 and the forecast outturn position for 2020-21.

The report includes details on the 2020-21 PMS premium monies and recommends how they should be distributed to practices.

2. Financial Plan 2020-21

The draft plan is based upon the Month 12 2019-20 underlying position plus contract uplifts and growth.

2.1 Delegated Commissioning

The table below shows the draft 2020-21 plan for delegated primary care.

Area	19-20 FOT as at M12 £000	Non-recurrent expenditure and FYE of investments £000	Recurrent 19-20 expenditure £000	Uplifts £000	Demo-graphic growth £000	Adjustments, cost pressures and investments £000	Draft 20-21 plan £000
Primary Care - GMS	21,854	0	21,854	793	66	0	22,713
Primary Care - PMS	8,904	304	9,208	76	0	0	9,285
Primary Care – Enhanced Services	1,117	(13)	1,104	(26)	5	0	1,083
Primary Care – Other GP Services	4,145	195	4,340	(99)	0	2,276	6,518
Primary Care - Premises	4,393	4	4,397	81	0	0	4,478
Primary Care - QOF	4,431	(27)	4,404	63	41	0	4,508
Total	**44,844**	**463**	**45,307**	**888**	**113**	**2,276**	**48,584**

The 2020-21 allocation value for Primary Care Delegated Commissioning is £48,828k. The draft plan includes total expenditure for delegated primary care of £48,584k. A contingency of £244k (0.5%) as per the planning requirements is recorded within the CCG core budget, taking the total to £48,828k.

The **non-recurrent expenditure and full year effect of investments in 2019-20** are as follows:

- PMS - £313k for PMS Premium added back into plan less £9k for non-recurrent prior year costs.
- Enhanced Services – less £13k for non-recurrent prior year costs.
- Other GP Services - £239k of additional roles slippage less £44k of non-recurrent prior year costs (£36k of which relates to funding for the Tollerton new build).
- QOF- less £27k for non-recurrent prior year costs.

Uplifts are as follows:

- GMS – net global sum is £89 per weighted list size which equates to an uplift of 4.03% on 19-20.
- PMS – is now aligned with GMS at £89 per weighted list size which equates to an uplift of 0.23% on 19-20.
- Enhanced Services – full year effect of change in rate for extended hours DES.
- Other GP Services – 4.7% uplift on Dispensing Doctors offset by a £236k reduction due to Seniority payments being phased out.
- Premises - uplift of 3% included for the practices due revaluation in 2020-21 as per contracting information. Business rates uplift is as per confirmation from GL Hearn.
- QOF - uplift based upon an additional 8 points available in 2020-21.

Adjustments, costs pressures and investments in 2020-21 are as follows:

- Other GP Services – Increase to the additional roles reimbursement scheme of £1.1m, full year effect of Clinical Leadership funding of £79k (paid from July 2019 onwards), £162k for care home funding from October 2020 onwards (worth £120 per bed per year), Investment and Impact Fund funding of £233k and £722k investment reserve to bring plan up to match allocation.

2.2 Other Primary Care

The table below shows the draft 2020-21 plan for other primary care.

Area	19-20 FOT as at M12 £000	Non-recurrent expenditure and FYE of investments £000	Recurrent 19-20 expenditure £000	Tariff uplift and efficiency £000	Demo-graphic growth £000	Adjustments, cost pressures and investments £000	QIPP £000	Draft 20-21 plan £000
Primary Care Prescribing	50,533	(694)	49,839	1,047	1,069	1,000	(2,115)	50,839
Other Prescribing	2,114	(443)	1,671	7	0	37	0	1,715
Local Enhanced Services	2,048	0	2,048	29	0	6	0	2,082
Oxygen	377	0	377	5	0	0	0	382
Primary Care IT	786	(27)	760	0	0	445	0	1,204
Out of Hours	3,331	(7)	3,324	47	0	0	0	3,370
Other Primary Care	3,127	(2,266)	860	8	2	30	0	900
Total	**62,316**	**(3,438)**	**58,878**	**1,142**	**1,071**	**1,518**	**(2,115)**	**60,493**

The **non-recurrent expenditure and full year effect of investments in 2019-20** are as follows:

- Primary Care Prescribing - £507k for NCSO and £187k for flash glucose monitoring.

- Other Prescribing – removal of £330k for PIB payments and £177k for MOCH programme offset by £64k for 2 Pharmacy Technician posts transferred from running costs.
- Other Primary Care - £2.0m for Improving Access which is funded via additional allocation, £387k for GP Forward View schemes and £313k for PMS premium monies, offset by 19-20 underspends of £369k on Improving Access and DIB and £198k for Primary Care leads transferred from running costs.

The **tariff uplift** for Prescribing is 2.1%. Local Enhanced Services, Oxygen and Out of Hours have been uplifted by 2.5% which is offset by an efficiency of 1.1%. The uplifts in Other Prescribing and Other Primary Care relate to staffing costs which have been uplifted by 4%.

Demographic growth on prescribing is estimated to be 2.1%.

Adjustments, cost pressures and investments in 2020-21 are as follows:

- £1.0m for Prescribing QIPP risk reserve.
- Other Prescribing includes £37k to recognise the costs associated with the Medicines Optimisation in Care Homes after central funding is utilised.
- Primary Care IT - £445k for increased costs resulting from change in IT provider.
- £30k in Other Primary Care for SMI Health checks.

The draft plan for Prescribing also includes a £2.1m **QIPP** target.

3. Primary Care Year to Date and Forecast Position

Due to the COVID-19 pandemic, CCGs are currently operating under interim financial arrangements for the April – July period, whereby;

- Revised allocations have been issued for April – July, based on a centralised NHS England expenditure model
- Retrospective allocation adjustments will be made as follows:
  - To fund all COVID-19 related expenditure
  - Further 'true-up' allocations where expenditure variances are deemed to be reasonable – this will return CCGs to a break even position for the period.

The CCG made an update to its financial plan in March 2020 to take account of the COVID-19 interim financial arrangements. The only significant change for Primary Care was the removal of the April to July prescribing QIPP target (£372k). The budget for April to July is based on this revised draft financial plan, with an adjustment in reserves to reduce the overall plan to meet the current allocation as advised by NHSE. Expenditure for April to July has been forecast on a detailed basis. For August to March, guidance has not yet been received so the plan and forecast figures are based on an updated assessment of the CCG's draft financial plan.

3.1 COVID Expenditure

As at Month 3, the CCG has incurred £2.44m of COVID-19 related expenditure and is forecasting an additional £0.44m in July, bringing the total to £2.88m. Allocation of £1.70m was received in Month 2 to offset COVID costs incurred in April and May. The table below shows the level of COVID expenditure included within Primary Care areas and the allocation received for it to date.

Primary Care	COVID expenditure as at Month 3 £000	Forecast COVID expenditure as at Month 4 £000	COVID allocation received as at Month 3 £000	Comments
Local Enhanced Services	69	100	(31)	Care Homes LES (£28k per month starting in May), additional MECS and anti-coag costs
Primary Care IT	70	72	(68)	Care Home tablets, additional SMS and telephony costs
Out of Hours	5	5	(5)	Additional OOH costs
Other Primary Care	554	650	(450)	GP COVID costs, GP Practices opening over Bank Holidays, COVID management service, Advanced Care Planning sessions
Total	**698**	**827**	**(554)**	

3.2 Delegated Commissioning Financial Position – Month 3

The table below sets out the year to date position for 2020-21.

Delegated Primary Care	Month 3 Year To Date Position		
	Budget £000	Actual £000	Variance £000
Primary Care - GMS	5,678	5,663	15
Primary Care - PMS	2,321	2,233	88
Primary Care - Enhanced Services	270	270	0
Primary Care - Other GP services	1,579	1,359	220
Primary Care - Premises Costs	1,119	1,119	0
Primary Care - QOF	1,127	1,127	0
Sub Total	**12,095**	**11,771**	**324**
NHSE Allocation Adjustment (to bring plan back to allocation)	(343)	0	(343)
Total	**11,752**	**11,771**	**(20)**

- The **Month 3 year to date position** is £11,771k which is an underspend of £324k against the CCG's financial plan.
- **GMS** is based upon the current contract and list sizes to date and is showing an underspend of £15k due to smaller list size movements than expected.
- **PMS** contracts are underspent by £88k due primarily to PMS premium monies which are accrued in Other Primary Care (£78k).
- **Enhanced Services** have been accrued to budget. A more detailed breakdown is shown in the table below.

Enhanced Services	Month 3 Year to Date Position		
	Budget £000	Actual £000	Variance £000
Extended Access	132	132	0
Learning Disability	25	25	0
Minor Surgery	108	108	0
Violent Patients	5	5	0
Sub Total	270	270	0

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

Other GP Services	Month 3 Year to Date Position		
	Budget £000	Actual £000	Variance £000
Dispensing/Prescribing Doctors	509	470	39
PCO Administrator	236	236	0
GP Framework:			
Network Participation	156	156	0
Clinical Director	66	66	0
PCN Support	48	48	0
Additional Roles	376	376	0
Needle, Syringes & Occupational Health	7	7	0
Reserves	180	0	180
Sub Total	1,579	1,359	220

Dispensing Doctors are paid two months in arrears and is currently underspent based upon April's dispensing figures.

PCO Administrator, GP Framework payments and Needle, Syringes and Occupational Health are all accrued to budget.

The year to date budget in **reserves** reflects the amount required to balance expenditure and allocation, as required by NHS England.

- **Premises** costs have been accrued to budget at this stage.

- **QOF** is accrued to budget.

3.3 Other Primary Care – Month 3

The table below sets out the core primary care financial position as at Month 3. Note that the CCG received £554k in additional allocation to offset COVID-19 expenditure in Primary Care incurred in April and May.

Primary Care	Month 3 Year to Date Position				
	Budget £000	Actual £000	Variance £000	COVID related variance £000	Non-COVID related variance £000
Primary Care Prescribing	12,989	13,570	(581)	0	(581)
Other Prescribing	429	289	139	0	139
Local Enhanced Services	551	587	(35)	(38)	3
Oxygen	96	79	16	0	16
Primary Care IT	369	368	1	(2)	3
Out of Hours	848	869	(21)	0	(21)
Other Primary Care	675	1,258	(583)	(104)	(479)
Sub Total	**15,956**	**17,020**	**(1,064)**	**(144)**	**(920)**
NHSE Allocation Adjustment (to bring plan back to allocation)	64	0	64		
Total	**16,020**	**17,020**	**(1,000)**	**(144)**	**(920)**

The **Prescribing** position is overspent by £581k as at Month 3. This position is based upon 1 month of prescribing data and does not include any QIPP. £566k of this overspend relates to prior year due to March prescribing figures.

Other Prescribing is underspent by £139k. This is due to an underspend against the Medicines Optimisation in Care Homes funding of £131k, however this is expected to be spent in full across the financial year.

Local Enhanced Services are based upon registered list size and an agreed 1% uplift. There is an overspend of £38k for June's Care Homes LES (£28k) and additional MECS costs as a result of COVID (£9k).

Other Primary Care is overspent by £583k. £500k of this is due to Improving Access which is not in the financial plan as it is usually funded through non-recurrent allocation. This is expected to be dealt with through the 'true-up' through April to July. There is also £104k of COVID expenditure in June for which allocation is expected in July.

3.4 Delegated Commissioning and Other Primary Care Forecasts

The forecast table shows April to July plan and forecast as per the ledger, as well as August to March plan and current assessment of forecast outturn.

	Forecast Position (£000)										
	April to July			August to March			Financial Year				
	Plan	Forecast	Variance	Plan	Forecast	Variance	Plan	Forecast	Variance	Comments Apr-Jul	Comments Aug-Mar
Delegated Commissioning											
Primary Care - GMS	7,571	7,551	20	15,142	15,142	0	22,713	22,693	20		
Primary Care - PMS	3,095	2,977	118	6,190	6,190	0	9,285	9,167	118	£104k PMS (forecast included in Other Primary Care)	
Primary Care - Enhanced Services	361	361	(0)	721	721	0	1,082	1,082	(0)		
Primary Care - Other GP services	2,105	1,810	295	4,413	4,063	350	6,518	5,873	645	£240k slippage on investment reserve	Assumed slippage on investment reserve and/or additional roles
Primary Care - Premises Costs	1,493	1,492	0	2,985	2,985	0	4,478	4,478	0		
Primary Care - QOF	1,503	1,503	(0)	3,005	3,005	0	4,508	4,508	(0)		
Total Delegated Commissioning	**16,127**	**15,694**	**433**	**32,457**	**32,107**	**350**	**48,583**	**47,800**	**783**		
Other Primary Care											
Primary Care Prescribing	17,318	17,934	(616)	33,893	34,636	(743)	51,211	52,570	(1,359)	£566k prior year impact of March prescribing figures	Slippage on QIPP for remainder of financial year, partly offset by risk reserve
Other Prescribing	572	571	1	1,143	1,143	0	1,715	1,714	1		
Local Enhanced Services	725	791	(66)	1,388	1,388	0	2,113	2,179	(66)	£56k Care Homes LES in June and July and £11k additional MECS costs	
Oxygen	127	128	(1)	255	255	0	382	383	(1)		
Primary Care IT	469	469	1	803	803	0	1,272	1,272	1		
Out of Hours	1,128	1,157	(28)	2,247	2,247	0	3,375	3,404	(28)	Agreed increase in contract value for April - July	
Other Primary Care	750	1,695	(945)	600	600	0	1,350	2,295	(945)	£200k COVID spend in Jun-Jul, £667k Improving Access (not in plan, usually funded through NR allocation, expected to be funded through 'true-up' exercise for Apr-Jul), £104k PMS premium (budget on delegated line below)	
Total Other Primary Care	**21,090**	**22,744**	**(1,655)**	**40,329**	**41,072**	**(743)**	**61,419**	**63,816**	**(2,398)**		
Total Primary Care											
Total Primary Care	**37,216**	**38,438**	**(1,222)**	**72,786**	**73,179**	**(393)**	**110,002**	**111,617**	**(1,615)**		
NHSE Allocation Adjustment	(373)	0	(373)	0	0	0	(373)	0	(373)	Shortfall in notified April to July allocation compared to CCG financial plan	
Expected impact of 'true-up' exercise	0	(1,595)	1,595	0	0	0	0	(1,595)	1,595	Anticipated increase to allocation for Jun-Jul COVID spend (£273k) and Apr-Jul 'true-up' (£1.32m)	
Reported forecast position	**36,843**	**36,843**	**0**	**72,786**	**73,179**	**(393)**	**109,629**	**110,022**	**(393)**		

4. 2020-21 PMS Premium Monies

The delegated commissioning plan includes £313k in relation to PMS premium monies. This allocation should be used to benefit all of Primary Care but can be distributed as determined by the CCG. The table below shows the proposed distribution of the monies by individual practice and PCN (based upon weighted list size as at 1 January 2020 – the measure used to calculate the Network Participation payment).

Practice Name	Weighted List Size 1st Jan 2020	Practice Level PMS Premium
Dalton Terrace Surgery	8,567.35	7,584.22
Jorvik Gillygate Medical Practice	19,600.68	17,351.43
East Parade Medical Practice	2,455.75	2,173.94
Unity Health	14,549.05	12,879.50
York City Centre PCN	**45,172.83**	**39,989.09**
York Medical Group	40,006.58	35,415.69
YMG PCN	**40,006.58**	**35,415.69**
Old School Medical Practice	7,321.39	6,481.24
Front Street Surgery	7,887.64	6,982.51
Haxby Group Practice (incl. Gale Farm)	34,097.57	30,184.76
West, Outer and North East York PCN	**49,306.60**	**43,648.50**
Priory Medical Group	52,492.15	46,468.49
Priory PCN	**52,492.15**	**46,468.49**
Elvington Medical Practice	7,365.47	6,520.26
MyHealth	19,780.08	17,510.25
Pocklington Group Practice	17,333.36	15,344.30
East of York PCN	**44,478.91**	**39,374.80**
York City PCNs	**231,457.07**	**204,896.57**
Millfield Surgery	7,920.04	7,011.19
Tollerton Surgery	3,332.65	2,950.22
Stillington Surgery	4,094.88	3,624.98
Pickering Medical Practice	11,893.80	10,528.95
Helmsley Medical Centre	4,144.46	3,668.87
Terrington Surgery	1,587.10	1,404.97
The Kirkbymoorside Surgery	6,624.98	5,864.74
SHAR South Hambleton & Ryedale PCN	**39,597.91**	**35,053.91**
Beech Tree Surgery	17,514.20	15,504.39
Posterngate Surgery	18,215.56	16,125.26
Scott Road Medical Centre	10,485.24	9,282.02
Escrick Surgery	6,767.62	5,991.01
Selby Town PCN	**52,982.62**	**46,902.68**
Sherburn Group Practice	9,681.36	8,570.39
South Milford Surgery	10,426.83	9,230.32
Tadcaster Medical Centre	9,346.69	8,274.13
Tadcaster & Selby PCN	**29,454.88**	**26,074.83**
Vale of York PCNs	**122,035.41**	**108,031.43**
Total	**353,492.48**	**312,928.00**

Financial Period: April 2020 to July 2020

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

5. Recommendation

The Primary Care Commissioning Committee is asked to note the year to date and forecast financial positions set out in the report and to approve the allocation of PMS premium monies to PCNs based on weighted list size at 1 January 2020.

Item Number: 6

Name of Presenter: Fiona Bell-Morritt / Gary Young

Meeting of the Primary Care Commissioning Committee

Date of meeting: 23 July 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title: Primary Care Network Update

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

Reason for Report

To share an update with the Committee members of PCN developments which was recently shared at the Governing Body in July.

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

For information only, no recommendations.

Decision Requested (for Decision Log)

Primary Care Commissioning Committee noted the update on PCN developments

Responsible Executive Director and Title	**Report Author and Title**
Dr Andrew Lee Executive Director of Primary Care and Population Health	Fiona Morritt-Bell/Gary Young Primary Care Lead Officers

1. Central York, Primary Care Networks

PCCC ratified the changes to the Nimbus PCN, which resulted in the neighborhood groupings becoming PCNs in their own right, so Central has five PCNs summaries below.

PCN Name	Clinical Director	Practice Name/s
East of Yorkshire	Dr Tim Maycock	Pocklington Group Practice | Elvington Medical Practice | My Health
West, Outer and North	Dr Daniel Kimberling	The Old School Medical Practice | Front Street Surgery | Haxby Group Practice
Priory Medical	Dr Emma Olandj	Priory Medical Group
York Medical	Dr Rebecca Field	York Medical Group
York City Centre PCN	Dr David Hartley	Jorvik Gillygate | Unity | Dalton Terrace | East Parade

Nimbus as a federation/group now includes all central York GP practices as a unified single GP-led provider.

Central PCNs have been working much more closely together and over the last three months specifically have worked on a number of collaborative service developments in response to the Covid pandemic including:

Central Covid Hub developed by Dr Daniel Kimberling and Dr Russell Saxby, the Central York Covid Hub is hosted and managed by Nimbus as a collaboration between York GPs, City York Council, York Centre for Voluntary Services and a team of volunteers. Set up to support socially isolated patients with known/suspected Covid at risk of rapid deterioration; the hub has contacted 445 patients to date and made 11 referrals back to GP. The hub has supported PH Track & Trace and is currently exploring how to integrate Health Trainers (CYC Public Heath) as a pilot scheme to improve the health and wellbeing of patients already contacted. The hub has also been approached by respiratory consultants keen to explore how the hub can be used to proactively follow up patients who may need longer term Covid surveillance.

Nursing Home Multidisciplinary Teams York PCNs are working together to create better links with external services, including a coordinated approach to PCN nursing home MDTs. Led by Dr Emma Olandj, a proposal has been put to Tees Esk and Wear Valley FT to pilot, if successful, it will be extended to other community services, with the aim of creating a far reaching and streamlined MDT service for all York nursing Home residents.

Community INR point of care testing for housebound patients on warfarin; led by Dr Emma Olandj, a proposal has been agreed by PCN Clinical Directors and is being worked up by the community team with PCN support. **INR (International Normalised Ratio) monitoring requires patients on Warfarin traditional in practice, and during the pandemic we are looking to reduce this requirement.*

Winter Flu led by Dr Mike Holmes (Nimbus Chair), a multi-agency working party has been established to explore how a unified system approach to locality flu vaccinations can be developed this winter to minimise the risk of not being able to run other services out of GP surgeries at the same time (practice resilience).

2nd Wave Covid Planning PCNs and practices within PCNs are working together to develop plans in the event of a 2nd wave of Covid: for example, Pocklington are working with MyHealth and Elvington on a resilience plan including online consultations, sharing surgery premises, and creating a shared triage hub. They are also sharing data trends and soft intelligence to forecast if and when to respond, as well as working with community services so that Community Hubs can be quickly stepped back up. Working closely together, local partners know how to respond, depending on how the situation develops.

Urgent Care Transformation a review of urgent care contracts across Vale of York has restarted and the theme of ‘place’ dominated the Clinical Workshop held 18th June. Central York, with its proximity to York ED, is a clearly identifiable place. PCN Clinical Directors, working through Nimbus, are fully engaged in the process and jointly reviewing how the Improving Access contract can be considered an ‘urgent care asset’ when the contract moves to the PCN DES in April ‘20, as well as collaborating with Vocare (OOH) and York ED as a next step to developing a 24/7 fully integrated urgent care offer for York that aligns with Talk Before You Walk (being developed with YAS/111 regionally)

System Leadership York Health and Care Collaborative continues to be co-chaired by PCN Clinical Director Dr Rebecca Field, and Dr Emma Broughton, supported by Lisa Marriott (VOYCCG), to continue developing collaborative and integrated community relationships. The examples above further demonstrate Central PCNs, through their Clinical Directors, are actively engaging with health and care partners across the local system, including 3rd sector. They are doing this at a practice to practice level within PCNs, at a PCN to PCN level across York, and as a single community of Central York PCNs/GPs with system partners

Central PCNs: Challenges

Unlocking General Practice unlike the coordinated approach to de-prioritising work in General Practice in the face of Covid, the approach to reinstating de-prioritised work, or 'unlocking' General Practice, has felt largely uncoordinated. While this allows individual practices to be responsive to local patient needs PCNs broadly agree guidance (national, regional or local) would be helpful. The East PCN has agreed a traffic light system to restart work (Green: what can and can't be restarted. Amber: can do/difficult. Red: can't restart). Of note is that Pocklington said phlebotomy is at about 50% of pre-Covid activity (7000>3500).

Premises Covid continues to place increasing pressure on GP practice premises with the two largest practices/PCNs reporting they are at maximum capacity and even needing to ask other health partners, who have been sharing practice premises, to vacate to allow the practices to continue to function effectively.

Additional Roles Recruitment The PCN DES supports recruiting additional roles which, in many cases, has been delayed due to Covid. There's a general concern that much of this additional funding, hence resource, may be lost this year.

2. 'Vale' Primary Care Networks

Vale System Group established with membership comprising NYCC; 3 x District Councils; Community services; TEWV; Stronger Communities teams; Clinical Directors and Lead GPs; CCG. The group was initially meeting weekly at the start of Covid response, but has now moved to monthly meetings to allow locality working to progress. Locality groups have also been established.

Focus on Frailty, practices and community services joint working has matured together will greater integration with mental health services, PCNs are developing more resilient communities with wider community partners.

System Leadership – developing through the Vale System Group and next steps will include the voluntary sector and opportunities to secure consistent input into partnership discussions, particularly around creating more resilient communities. Work with NYCC and the District Councils is supporting this.

Testing of symptomatic patient service working in partnership with NYCC using customer call centre and AccuRx texting service to provide support this will give the PCNs and partners the ability to step up if needed for wave 2.

Care Home MDTs significant work to align care homes to single practice and lead GP. MDTs in place and developing how to optimise impact from wider partners (community services and TEWV).

Closer working between district nurses and practice nurses, regular discussions around caseloads, prioritisation etc in each locality to support patient care and optimise staff resources.

Winter Flu Vale PCNs are involved in discussions being led by Mike Holmes but likely, due to geography, to develop PCN level solutions.

2nd Wave Covid Planning: work ongoing to ensure ability to restart hot and cold sites in case of second wave.

Premises, pressure on premises particularly as additional roles develop and are put in place. Exploring options for co-location for roles such as link workers etc.

Additional Roles Recruitment – progressing now with additional recruitment. Main priority across Vale is for Care Co-Ordinator roles and for FCP's (Selby Town and SHaR): working collaboratively with other providers wherever possible to avoid destabilising other services. Concern re ability to use resource in year.

Reinstating core services suspended due to Covid-19

Vale PCN Challenges Capacity and time to take forward the work priorities (links to additional roles and affordable capacity within the PCNs) particularly for those below 50,000 population.

Vale PCN Specific projects

Selby District: (Selby Town and Tadcaster and Rural Selby PCN's) Development of a population health management needs assessment – Selby Town.

Selby Town PCN Pilot of a mental health MDT approach - Work with TEWV to embed mental health link workers into primary care.

Smoking cessation pilot: population health focus: Scott Road.

Improving support for people with mild to moderate frailty – linking health to colleagues in North Yorkshire Sport and other partners to explore opportunities to enhance support including CRT.

Building on system - workshop from Escrick

Tadcaster and Rural Selby as above re population health data

Time for Care- restart of support re virtual

Focus on obesity and cancer and care co-ordination

South Hambleton and Ryedale :

Community nursing and practice nurse MDTs: Protected Learning Time shared learning

Discussions with PCNs in neighbouring localities re potential for joint working

Focus on frailty, dementia and mental health

Item Number: 8

Name of Presenter: Dr Andrew Lee

Meeting of the Primary Care Commissioning Committee **Date of meeting: 23 July 2020**	NHS Vale of York Clinical Commissioning Group

Report Title – Prescribing Indicative Budgets 2 (PIB2)

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

Reason for Report

PIB2 started in all PCNs in Vale of York in September 2019 and was due to end 31st March 2020. However, due to the COVID19 pandemic, CCG Executive agreed to end the contract sooner, in Feb 2020.

This paper is to inform PCCC of the rationale for that decision, summarise the position at the end of PIB2 and ask PCCC to consider the options for future schemes.

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

See below

Decision Requested (for Decision Log)

See below

Responsible Executive Director and Title	**Report Author and Title**
Dr Andrew Lee Executive Director of Primary Care and Population Health	Laura Angus Head of Prescribing/Strategic Lead Pharmacist

Background

All Primary Care Networks (PCNs) in Vale of York CCG signed up to the PIB2 contract/Memorandum of Understanding (MoU) in August/September 2019. There was a delay in implementation (i.e. it was not implemented in April 2019 at the start of the financial year) due to the need to wait for the formation of PCNs in July 2019.

The PIB2 MoU incorporated 'efficiency saving key performance indicators', with a mandatory gateway scheme 'stopping managed repeats'; and 'quality indicators. PCNs are paid % of any PIB2 gainshares made, on completion of the indicators.

The CCG medicines management team have worked with the CCG finance team regarding how many efficiency saving key performance indicators and quality indicators had been achieved to calculate the PIB2 2019-20 year-end accrual.

The PIB2 MoU was due to run until 31st March 2020, hence any gainshare payments would be calculated using prescribing data up to and including 31st March. However, due to the COVID-19 pandemic prescribing costs rose significantly in March 2020, due to patients ordering early, increased quantities on prescriptions and an increase in drug costs.

Overall, there has been growth in items and spend when comparing 18/19 vs 19/20. In the final quarter vs. March alone, this percentage increases significantly and cost per item also increases – see table 1.

Table 1:

18/19 vs 19/20		18/19 Q4 vs 19/20 Q4		March 19 vs March 20	
% Increase in cost	% Increase in items	% Increase in cost	% Increase in items	% Increase in cost	% Increase in items
5.14%	1.36%	9.4%	4.2%	19%	10.3%

Another significant factor is the significant increase in concession and NCSO (no cheaper stock obtainable) on the total actual cost of Category-M, this was £151,625 cost pressure in March 2020, which is ~25% of the cost pressure for the financial year (£586,590) – see table 2.

Table 2: Concession & NCSO pressure on total act cost of Category-M

YTD	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
£586,590	£46,256	£47,251	£59,595	£31,552	£36,718	£30,114	£23,042	£39,261	£46,510	£39,150	£35,515	£151,625

Therefore, due to these unprecedented circumstances, it seemed unfair to end the PIB2 contract in March 2020.

CCG Executive were provided with financial information regarding if the contract ended in January, February or March 2020.

Only 3 PCNs (out of 8) made savings in January 2020.
Only 1 PCN made savings in February and March 2020 (same PCN).

The financial data demonstrated that ending PIB2 in March had a significant impact on the gainshare owed to the one PCN who had a made a gainshare, ending PIB2 in March would have reduced the gainshare by 72% compared to ending PIB2 in February.

Prescribing data shows that the COVID-19 pandemic only had an impact on prescribing costs in March 2020, aligning with the COVID-19 pandemic outbreak timeline.
It was therefore recommended to CCG Executive that PIB2 contract ended in February 2020, to negate the unprecedented impact on the COVID-19 pandemic that only affected March 2020 prescribing data.

Summary of PIB2

Overall, PIB2 has been unsuccessful in that only 1 PCN made any financial savings on their prescribing budget and received a gainshare of those savings.

This is disappointing but it should be acknowledged that the factors that affect prescribing are multifaceted and there is no one single reason or explanation for the lack of financial savings. Contributing factors that have played a role include:

- Starting the contract too late in the financial year but this was due to the PCNs only forming until July 2019. Much of the focus of the PCNs in 2019/20 has been quite rightly on settling into their new networks.

- Overall total cost pressure (concessions plus NCSO plus products off concession but back into the drug tariff at a higher price) totalling £1,624,900 for 19/20. Table 3 shows that the effect from the total cost pressures increased, having a greater impact on prescribing costs in the months when PIB2 was active

Table 3: Total cost pressure by month, total = £1,624,900

Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
£73,393	£101,857	£109,587	£135,027	£163,787	£153,169
Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
£121,699	£131,324	£148,559	£130,922	£117,262	£238,313

- Lack of buy-in from all prescribers

For PIB to be successful it needs engagement from all prescribers, considering their prescribing habits every time they prescribe a medicine. To date, PIB1 and PIB2 have been led by key leaders from each PCN, who have been very engaged with the work set-out in the key performance indicators but it is not felt like that has cascaded to all prescribers within the PCN to create a sizeable change in prescribing habits. There are many influences on GP prescribing decisions and these were listed in the 2007 National Audit Office report 'Prescribing costs in primary care' (National Audit Office, 2007), for example, NICE guidance; CCG prescribing advisors; area prescribing committees; peers; bulletins e.g. Drug and Therapeutic bulletin; patients; the BNF; guidance from professional organisations e.g. British Hypertension Society; practice nurses; drug company literature; software, such as OptimiseRx; magazines e.g. Pulse; conferences; scientific journals e.g. The Lancet; hospital consultants and; pharmaceutical company representatives. With all these influences it can be a challenge for prescribers to adhere to the local formulary and ultimately cost-effective prescribing choices. For PIB to be successful it needs buy-in from all prescribers within the PCN, not just key leaders.

Future of Prescribing Indicative Budgets

Due to the COVID-19 pandemic both the CCG and the PCNs have had little capacity to think about prescribing budgets, costs and the possibility of prescribing indicative budgets version 3.

There are many other issues relating to prescribing that have been more pressing during the COVID-19 pandemic to ensure prescribing has been safe and high-quality. The CCG medicines management team have been cascading national guidance to GP Practices/PCNs to implement concerning prescribing during the COVID-19 pandemic, the guidance has been vast and rapidly changing/updated. There are have been significant changes to some aspects of prescribing, some have been temporary, others will endure.

To continue to aid GP Practices/PCNs throughout the pandemic, and as we hopefully move to the recovery phase, some key areas have been identified that would improve the quality and safety of prescribing but also the efficiency of prescribing and hence freeing up GP Practice capacity to focus on other areas. The CCG Medicines Management team have identified that, at present, it would be more appropriate to support the PCNs, in conjunction with the GP Practice/PCN employed clinical pharmacists, to develop robust systems and processes for repeat prescribing; increase the utilisation of electronic prescription service and electronic repeat dispensing; deliver high-quality structured medication reviews to appropriate patients and; work with YTHFT pharmacy department to improve the medicines discharge process.

It is felt, at this time, that activity related to cost-saving initiatives would not be advantageous to PCNs. However, the NHS Long Term Plan has significant ambitions for PCNs that include an element of prescribing cost-efficiencies via the Investment and Impact Fund (IIF), which was to be introduced as part of the Network Contract Directed Enhanced Service (DES) in 2020/21, There were due to be 8 IIF indicators for 2020/21 and 5 of these related to improving the quality and cost-

effectiveness of prescribing and hence it may be appropriate to wait until the national implementation of this before considering local options.

For 2020/21 suggested 3 possible options:

1) Do nothing – at present, do not have a prescribing incentive scheme in 2020/21. Focus on systems, processes and the quality of prescribing, as described above. Wait for the introduction of the PCN DES and IIF indicators and develop a scheme that complements the IIF indicators. Requires collaboration from PCNs but anticipated that, if it deemed appropriate to introduce IIF indicators at a national level the PCNs will have the capacity to develop and then deliver a suitable scheme.
2) Continue with PIB, moving to PIB3 – which would be elements of PIB2 KPIs that have yet to be achieved plus new KPIs to replace those already completed in PIB2. This would require a re-set of the financial base-line and thresholds, updated to reflect 20/21 budget.
3) Consider alternative prescribing incentive schemes, for example, setting a target per PCN to keep its overall prescribing spend below a certain threshold. PCNs will be paid, for example, £X per patient if they keep within their prescribing budget and achieve some, e.g. 5, quality-related KPIs. This would require significant input and collaboration from PCNs to develop the new contract, which at present they may not have the capacity to develop and deliver, and input from finance to develop the thresholds/payments to deliver efficiency savings.

Recommendation

The recommended option from the CCG Medicines Management team is option 1, ‘do nothing’, i.e. do not actively seek to develop a prescribing incentive scheme for 20/2021 at present. It would be more worthwhile focusing the efforts of both the CCG medicines management team and the PCNs on improving the systems and processes in relation to prescribing, ensuring they are robust, reduce the risk of any adverse prescribing/medicines events and ideally develop capacity within primary care to focus on other areas during the pandemic and recovery. When the PCN DES and IIF are implemented the CCG medicines management team can review the position and consider a scheme, in collaboration with the PCNs that compliments the DES/IIF.

Ends

Item Number: 10

Name of Presenter: David Iley

Meeting of the Primary Care Commissioning Committee

Date of meeting: 23 July 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Primary Care Report

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

Reason for Report

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

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

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

Risk Rating

Emerging Risks

Impact Assessments

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

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

Risks/Issues identified from impact assessments:

N/A

Recommendations

For the Committee to receive the report.

Decision Requested (for Decision Log)

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

Annexes (please list)

- Appendix 1 – NHS Support for Patients who are Shielding
- Appendix 2 – Update to GP contracts and income protection arrangements

Vale of York CCG
Delegated Commissioning
Primary Care Update
July 2020

Prepared by David Iley

Primary Care Assistant Contracts Manager

NHS England and NHS Improvement – (NE and Yorkshire)

14th July 2020

1.0 Quality and Outcomes Framework (QOF) 19/20

QOF this year was automatically signed off due to COVID-19. On looking at the achievement figures, there were some discrepancies between QOF achievement 18/19 and 19/20. NHS England and NHS Improvement received the breakdown of QOF data for Humber, Coast and Vale (HCV) for 19/20 achievement in comparison to 18/19 achievement from NHS Digital as well as a letter from CQRS which contained instructions for CCGs in relation to protecting practice income in line with national guidance published during COVID-19.

This letter suggested that:

In making a fair adjustment, Commissioners should consider practice performance from September 2019 onwards and discuss with their individual practices if necessary. Where the points difference between 2018/19 and 2019/20 is minimal i.e. a fall of less than 30 points, we would expect Commissioners to offer income protection to 2018/19 payment values

In the Vale of York this related to 12 practices and, in line with the letter, the CCG made payments that protected practice income.

There was a further practice in the Vale of York whose points difference was more than 30. In this instance, the letter suggested that:

Where there is a significant fall in achievement at year end which is also apparent in reported achievement through the year then this is unlikely to be solely due to Covid-19 activities. Commissioners will need to consider what would be a reasonable adjustment in these circumstances, if any.

The CCG was provided with further information around QOF achievement for this practice during 19/20 which enabled it to make an informed decision and a payment was made to the practices that protected practice income.

All CCGs within HCV took the same decisions.

2.0 Covid-19

2.1 Primary Care and General Practice updates and guidance

Links below to regular updates provided to primary care and general practice regarding the emerging COVID-19 situation
https://www.england.nhs.uk/coronavirus/primary-care/
https://www.england.nhs.uk/coronavirus/primary-care/general-practice/

2.2 Minimising the Spread of Infection

A letter was issued on 9th June 2020 setting out specific actions that NHS organisations should take to minimise the spread of infections. This included actions for primary care contractors to undertake whilst maintaining patient access to services.

https://www.england.nhs.uk/coronavirus/publication/minimising-nosocomial-infections-in-the-nhs/

2.3 GP Standard Operating Procedure (SOP)

Version 3 of the GP SOP for general practice in the context of coronavirus has been published and is available in the following weblink https://www.england.nhs.uk/coronavirus/publication/managing-coronavirus-covid-19-in-general-practice-sop/

2.4 Clinical Negligence Indemnity arrangements during COVID-19

NHS Resolution has published guidance in relation to its indemnity schemes and claims management during the COVID-19 pandemic. General practice specific guidance aims to clarify how the management of claims interactions between general practice indemnity beneficiaries and NHS Resolution will proceed during the pandemic. It also provides answers the most common questions regarding Clinical Negligence Scheme for General Practice (CNSGP) indemnity cover under COVID-19 working arrangements https://resolution.nhs.uk/scheme-documents/covid-19-guidance-for-general-practice/

2.5 NHS Support for Patients who are Shielding

A letter was published confirming actions for the NHS after the Government published updated guidance on shielding. The letter is included as appendix 1

2.6 Rick Assessment for at-risk staff groups

In a letter from NHS England and NHS Improvement on 24th June regarding the completion of staff risk assessments (weblink below) a request was made to NHS employing organisations to ensure that risk assessments were completed within 4 weeks. CCGs have been asked to submit a sit rep containing the following information for every GP Practice, the initial deadline for the return is 17th July.

- Have you offered a risk assessment to all staff?
- What % of all your staff have you risk assessed?
- What % of risk assessments have been completed for staff who are known to be ‘at-risk’, with mitigating steps agreed where necessary?
- What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary?

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/06/C0625-risk-assessments-for-at-risk-staff-groups-letter.pdf

2.7 Second Phase of the General Practice Response to Covid-19

On 9th July NHS England and NHS Improvement published a letter on the second phase of the general practice confirming contractual arrangements from July and income protection. A copy of the letter is included as appendix

2. The key elements highlighted in the primary care bulletin that accompanied it were;

- General Practice is being asked to continue its vital role in supporting high-risk patients with ongoing care needs, but also to resume as soon as possible services which may have been paused, managing pre-existing conditions and urgent demand.

- Practices will need to re-prioritise aspects of care not related to COVID-19, the Quality and Outcomes Framework (QOF) requirements for 2020/21 will be modified to support this.

- General Practice is being asked to resume new patient reviews, routine medication reviews, over-75 health checks and clinical reviews of frailty – but to prioritise these using their clinical judgement and a risk-based approach. The letter also describes how flexibilities under the GP contract may be reinstated to support with management of local outbreaks.

3.0 Primary Care Network (PCN) Workforce Planning

PCNs are required to complete a workforce planning template which asks each PCN to confirm their plans for this financial year as well as intentions for future years. The deadlines PCNs need to be aware of are;

- 31st August 2020 to provide details of recruitment plans for 20/21
- 31st October 2020 to provide details of indicative recruitment intentions through to 2023/24

A link to the workforce planning template can be found through the following weblink
https://www.england.nhs.uk/publication/pcn-workforce-planning-template-2020-21/

4.0 Contract Merger between Jorvik Gillygate Surgery and East Parade Medical Practice

On 1st July 2020 The Jorvik Gillygate Practice formally merged with East Parade Medical Practice. The merger, which was approved by the Committee in January 2020 was affected through simultaneous termination of the East Parade Medical Practice contract and the variation of the Jorvik Gillygate Medical Practice to incorporate the East Parade Medical Practice as a branch site. The merging of the clinical systems is due to take place on 22nd July 2020.

The Committee is asked to note the updates in the paper

To: NHS Trust Medical Directors
NHS Trust Chief Nursing Officers
GPs
CCG AOs
ICS/ STP CEOs

Dear Colleagues,

NHS SUPPORT FOR PATIENTS WHO ARE SHIELDING

Since the start of the pandemic, you and your teams have devoted a great deal of time and effort identifying and advising patients who are clinically extremely vulnerable to COVID19, ensuring they are put on the Shielded Patient List (SPL), and most importantly of all, changing how the NHS provides care for this group of over 2 million people who were strongly advised to stay at home. We are hugely appreciative of your invaluable work in continuing to support these patients and helping to keep them safe and well.

The Government's updated advice

On Sunday evening 31 May, the Government published updated guidance on shielding on its website. This letter confirms the actions for the NHS.

The Government states that it has revised its advice by a small degree to reflect that COVID-19 disease levels are substantially lower now than when shielding was first introduced, with the most recently estimated prevalence in the community being, on average, 1 in 420 people.

The Government's advice is that people who are shielding should continue to take precautions but can now leave their home if they wish, as long as they are able to maintain strict social distancing. If they choose to spend time outdoors, this can be with members of their own household. If they live alone, they can spend time outdoors with one person from another household. Ideally, this should be the same person each time. If they do go out, they should take extra care to minimise contact with others by keeping 2 metres apart.

The Government's shielding guidance remains advisory. Some patients may well choose to remain in their own home at all times if they do not feel comfortable with any form of contact with others. The Government's advice is that for many people who are in the clinically extremely vulnerable group, the opportunity to go outdoors while maintaining social distancing may enhance their physical and mental health, without exposing them to significant risk of catching covid-19.

The Government has also confirmed that everyone who has been advised to shield and added to the SPL is able to access government support, including food and medicines deliveries.

The Government is currently advising everyone who is considered clinically extremely vulnerable to continue to 'shield' at home, in this modified way, until the end of June 2020 to protect themselves from COVID-19.

The Government has committed to reviewing the shielding guidance alongside each review of the wider social distancing measures to ensure that the latest epidemiology is directly considered with advice to clinically vulnerable groups. They have confirmed the next review will take place the week commencing 15 June 2020. The government plans to write to all individuals on the SPL with information about next steps on shielding advice and the support that will be available to them after this review point.

Maintaining the Shielded Patient List

In the meantime, the Government has asked the NHS to continue to maintain the Shielded Patient List, using the existing criteria and processes. Individual clinical conversations with patients, helping them to make informed choices through shared decision making is central to this.

The NHS has been asked to continue to identify those who are clinically extremely vulnerable. It is important patients who are newly diagnosed as clinically extremely vulnerable are advised to take extra precautions and receive a letter, as this allows them access the government support offer, including access to food and medicines deliveries, and the letter also acts as necessary evidence for their employer as to why they cannot leave their home to go to work. The letter to patients being newly added has been updated to reflect the latest Government advice and is attached.

Many of the people meeting the shielding criteria have been identified by the national algorithm run by NHS Digital (see NHS Digital website). These people are sent the letter via a national distribution system. GPs or specialists are able to add individual patients to the SPL where they consider them to be clinically extremely vulnerable. They may also remove people from the list where they believe someone has been identified in error through the national process, or if they no longer think someone is clinically extremely vulnerable. This should only ever be done in consultation with the patient and other clinicians where appropriate. The process for additions and removals is in annex A.

If you have added or removed someone from the list and not yet been in contact with them, please do that now, before the next government review on 15 June.

Any national additions and additions or removals by specialists are updated in GP records and the Summary Care Record Application weekly.

Meeting the ongoing health and care needs of those who are shielding

People who are shielding may be less likely to seek and access the NHS care. The NHS has already significantly changed how it operates to meet the needs of those who are advised to stay at home, for example using digital technology. Based on learning from this, and input from an expert advisory group, we attach at annex B guidance to support the NHS in providing ongoing care to the shielding group. **The guidance lists 9 actions that the NHS**

should continue to take or implement now, if not already in place. Systems (STPs/ICSs) have the overall lead responsibility for ensuring that these actions are fully in place in their geography. These actions apply to all providers of NHS care.

Your sincerely,

Ruth May
Chief Nursing Officer, England

Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement

ANNEX A – ADDITIONS OR REMOVALS FROM THE LIST

When adding or removing someone from the list, the following steps must be taken:

a. **Additions:**
People identified as clinically extremely vulnerable should be contacted and made aware that they may be at high risk from COVID-19 and are being advised to shield in line with revised guidance. Any clinician adding a patient to the list should also speak to the patient and send them the updated letter. This explains how to access government support and can be used as evidence for their employer if needed.

All patients who are clinically extremely vulnerable should have their ongoing care needs considered and adjusted in line with the actions set out in Annex 1.

To process an addition:

- **GPs** should add the 'High risk category for developing complication from coronavirus disease' flag to the individual's GP record. Guidance on how to do this can be found on the NHS Digital website.

- **Specialists** should submit the individual's details to NHS Digital via their Trust's SEFT system. Guidance on how to do this can be found on the NHS Digital website. They should also inform the patient's GP.

b. Removals:
Patients can only be removed from the list by either their GP or specialist. No one is removed by the national algorithm.

Where a clinician thinks a patient should not have been added to the list or is no longer considered to be clinically extremely vulnerable, they should contact the patient to let them know that they are not considered to be high risk and are no longer advised to shield. As part of this discussion, the patient should be made aware that as they can return to more routine patterns of daily life access to the government support for food, basic supplies and medicines will be stepped down and end. A template patient letter to support this communication is available on NHS Digital's website.

Where the individual is receiving treatment from a specialist hospital team, or teams, there must also be a clear communication between the specialist and the individual's GP. This is critical whether it is the GP or the specialist proposing to remove someone from the list.

A removal should only be processed once there has been a discussion with the patient and, where necessary, agreement reached between their GP and specialist.

If you have removed someone from the list and not yet contacted them, please do so now.

To process a removal:

- **GPs** should adjust the flag in the patient record, marking the person as 'moderate' or 'low' category for developing complication from coronavirus disease. Guidance on the definitions of the risk categories can be found on the NHS Digital website.

- **Hospital clinicians** should mark the individual for removal in their Trust's SEFT system. Guidance on how to do this can be found on the NHS Digital website.

Once removed from the list, the individual may be contacted to confirm they are no longer on the list and will not get access to government support. It is therefore critical they have heard from their GP or specialist before they are removed.

People who still need help with the delivery of shopping and medicines during the pandemic can access support via the NHS Volunteer Responders Service. They can be referred by their GP practice or via local schemes run by councils or can contact the service directly using the phone line (0808 196 3646). These services are free to access, but payment for food may be required.

Please contact splquery@nhs.net if you have any questions about the process to add or remove patients from the list.

GPs and specialists in acute hospitals are able to add or remove patients from the list through the routes set out above. Mental health and community trusts are not expected to add patients to or remove patients from the Shielded Patient List. Any suggested changes to an individual's position should be discussed with the individual and their GP or specialist.

ANNEX B – ACTIONS FOR PROVISION OF NHS CARE TO PEOPLE SHIELDING AT HOME

Whilst people are continuing to shield at home, they may be less likely to seek and access the NHS care they need, because of the advice to stay at home.

The NHS has already significantly changed how it operates to address that risk. In the light of that initial experience, an advisory group has informed this guidance. It provides a list of 9 actions that the NHS should continue to take or implement now, if not already in place.

Systems (STPs/ICSs) have the overall lead responsibility for ensuring that these actions are fully in place in their geography. These actions apply to all providers of NHS care.

Although focused on people shielding at home, most of the actions have a wider relevance for the proactive provision of coordinated and convenient NHS care for patients with significant ongoing needs.

The NHS should:

1. **Put in place a lead, named care coordinator/team.** Every patient shielding at home should have a lead, named care coordinator or single point of contact to help support patient-led follow up or provide regular check ins, where these are required. For most patients this will be someone from their GP practice. In some cases where the main ongoing care is with a specialist, it may be a secondary care or community health team. For children and young people, it may be paediatricians at secondary or tertiary hospitals or Advanced Nurse Specialists in all environments. In some cases, it may be appropriate to identify a (clinical or non-clinical, e.g. social prescribing link worker) care coordinator who can coordinate activities between different healthcare teams, for example pharmacies, mental or community health services.

2. **Proactively contact** those in the 'shielding' cohort to ensure they know how to access care if they need it and have an appropriate personalised care plan for when this needs to happen. Mental health, learning disability and autism teams should ensure that patients under their care who are known to be shielding are proactively contacted and supported through this time; for example, with helplines / websites staffed by trust teams.

3. **Review and adjust personalised care plans.** Given the diverse health, care and wellbeing needs of shielding patients, personalised care plans should be adjusted on the basis of individual circumstance, preference and an assessment of clinical risk. A particular focus should be placed on tackling health inequalities. Care plans should focus on meeting the mental, physical and wider social needs of patients. In balancing risks, priority should be given to care which supports quality of life, autonomy, dignity and daily functioning. The plan, or as a minimum a discussion on key decisions for care and treatment, should:

    a. be developed through shared decision-making with the individual, and with parents, carers and community teams if appropriate (e.g. learning disability liaison nurses)

b. take account of an individual's clinical condition(s), preferences and circumstances, including access to, and confidence in, using digital tools / technology
c. include the named care co-ordinator or single point of contact where needed
d. balance wellbeing, treatment needs and social vulnerabilities with risks of exposure
e. cover all aspects of the individual's needs (physical, mental health and wellbeing)
f. include arrangements for medicines delivery at home, as required of community pharmacy
g. ensure that patients have direct access to the appropriate clinical team via e-mail, telephone or in any other way that facilitates communication between the patient and their contact point
h. incorporate any reasonable adjustments they need[1]
i. be owned by the individual who should where possible, have a (digital) copy of their plan / record of decisions taken

4. **Support self-management** to help patients to have the knowledge, skills, confidence and support they need to manage their own health and wellbeing effectively in the context of their everyday life during this pandemic. This includes information to parent / carers and age specific information. More information on self-management support is available here.

5. **Provide NHS care at home, wherever possible**; virtually or online by preference. This includes GP and hospital outpatient appointments, e.g. using tools such as AttendAnywhere. Particular focus should be paid to supporting those who may have the greatest challenges in accessing care remotely, to reduce health inequalities. Where remote service delivery is not possible, it should be via safe (i.e. infection controlled) general practice or community health service home visiting where clinically necessary. Systems should expand and resource all relevant home-based services, such as a home-visiting phlebotomy service.

6. Wherever care at home is not possible, **provide safe NHS care in infection-controlled clinical settings**, in line with latest infection prevention and control guidance. For, example for invasive treatments, diagnostic tests or procedures. In such cases, identify a safe location and ensure the patient has safe 'door-to-door' transport (see requirements for patient transport). All NHS providers can access the Summary Care Record Application (SCRa) which has a specific flag for every patient currently recorded as being shielded. Advance warning should be given when a clinically extremely vulnerable patient is to attend an NHS site and can make additional adjustments, wherever possible, to further reduce exposure. This can be confirmed via pre-appointment checks or the Summary Care Record application[2]. Ambulances should also let emergency departments know where they are conveying a patient who is clinically extremely vulnerable. Any paperwork or information about their care plans should accompany the individual and be given to the hospital team. Clinically extremely vulnerable patients have been asked to prepare a single hospital bag for these situations.

[1] In line with current policies and procedures, care should be adjusted to reflect and adequately respond to an individual's disability, ability to comprehend and converse; ensuring everyone can access the same safe care
[2] Patients identified as being clinically extremely vulnerable are recorded as such in their summary care record, and this is also visible in the "additional information" section of the SCR which is shared across the system unless the patient has dissented from this

7. **Provide regular checks and treatment.** Ensure patients continue to access regular checks, screening and treatment[3] where needed, both for both physical health and mental wellbeing. In specialties such as audiology, dentistry and eye care careful consideration should be given to the benefits of intervention against the potential risks, if remote checks are not possible. These regular checks and treatments should form part of an individual's care plan or health 'passport'. Everyone in the clinically extremely vulnerable group should be given access to the seasonal flu vaccine.

8. **Ensure rapid access urgent and emergency care**. In the event of a rapid deterioration, and in alignment with the patient's wishes, patients needing urgent or emergency treatment should be conveyed to hospital as quickly as possible. Before attending hospital, they should call 111 or 999, so that the ambulance service and hospital can make necessary arrangements to deliver safe care.

9. **Make every contact count**, to deliver more than one check or treatment when visiting someone's home and coordinating activity across primary, community, mental health and hospital care, i.e. taking a multi-disciplinary approach to care. This is particularly important to ensure regular mental health and safeguarding checks, which may involve upskilling some staff, or clinicians working in innovative ways across disciplines. It is as true for urban as rural areas.

[3] Examples of regular checks and treatments include: immunisations and vaccinations, developmental checks, safeguarding checks, flu jabs, dental care, eye care, audiology, chiropody, phlebotomy, medicine reviews, physical health checks for people with severe mental illnesses, learning disabilities and autism, mental health assessment and treatment (by IAPT or secondary mental health care services)

ANNEX C: Patients identified as being Clinically Extremely Vulnerable

Clinicians in England identified specific medical conditions that, based on what we knew about the virus so far, place someone at greatest risk of severe illness from COVID-19. These were signed off by the UK Senior Clinicians Group (including four United Kingdom Chief Medical Officers and clinical leadership at NHSE, NHSD, and PHE).

Patients were identified in four groups:

Group 1: Identification of a core group of patients who have been contacted centrally by the NHS. Most patients with the conditions below have been identified by NHS Digital and letters have been sent to them advising that they should follow shielding measures for the next 12 weeks.

- Category 1 – Solid organ transplant recipients
- Category 2 – People with specific cancers
  - People with cancer and are having chemotherapy
  - People with lung cancer and are having radical radiotherapy
  - People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
  - People having immunotherapy or other continuing antibody treatments for cancer • People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
  - People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
- Category 3 – People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD
- Category 4 – People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell disease)
- Category 5 – People on immunosuppression therapies sufficient to significantly increase risk of infection
- Category 6 – People who are pregnant with significant heart disease, congenital or acquired

The methodology for the extraction can be found here: https://digital.nhs.uk/coronavirus/high-risk-vulnerable-patients-list/vulnerable-patient-list-methodology

Group 2: Identification of people in medical subspecialties in secondary care not identifiable centrally. Patients in Group 1 category 5 should be contacted by specialists in secondary care across six subspecialties (rheumatology, dermatology, gastroenterology, renal, respiratory and neurology). Some specialty organisations have developed decision-support tools to help identify these patients.

Group 3: Academy of Medical Royal Colleges (AoMRC) cascade of general guidance to allow other hospital specialties to identify further at highest clinical risk patients from their caseload. We are working closely with the AoMRC who have picked up a further group of

immunocompromised patients in ophthalmology via this route. A decision-support tool for this group is available here: https://rcophth.ac.uk/2020/03/covid-19-update-and-resources-for-ophthalmologists/ .

Group 4: Identification of a small number of patients in primary care considered to be at highest clinical risk. We envisage that the majority of these patients will have been included in the shielding cohort through identification routes in Groups 1-3 (above). We have given GPs the discretion to add further people to this group, bearing in mind the highly restrictive nature of the intervention and practical limitations on the number of patients able to shield effectively.

ANNEX D: Other useful resources

Useful examples of how care and treatment has been modified for patients during this pandemic and that can be adapted or used for shielded patients:

- University Hospitals Birmingham is using its Solihull Hospital for mainstream elective inpatient activity in a COVID-free setting
- Video consultations can reduce the need for physical attendance; existing services such as Consultant Connect could be combined with home visits for this, where appropriate
- Community pharmacies and dispensing doctors can deliver medicines to shielded patients
- The Project Surgery in London is minimising contact time for children's immunisations with a drive-through service
- Leicestershire Partnership NHS Trust are using a remote monitoring platform for patients who were discharged from hospital earlier than usual due to the pandemic
- Guidance on providing IAPT services remotely is available here
- Cystic Fibrosis Trust has provided patients with medical information cards to alert care teams of their treatment needs should they need to attend hospital

Service planning and Standard Operating Procedures (SOPs):

- The Primary Care SOP has a section on shielded patients and further information on conducting home visits, managing face to face appointments and social prescribing
- The Community Services SOP also has information on home visits and seeing shielded patients in healthcare settings
- DHSC has published FAQs on the provision of home care during COVID, including for shielded individuals, see also PPE guidance for domiciliary care
- Patient Transport Requirements includes information on transport for shielded patients
- Guidance on providing IAPT services remotely is available here
- RCGP has guidance on caring for shielded patients in secure environments
- Shielded patients are included in guidance on supporting those with mental health needs, a learning disability, autism or dementia in inpatient settings

Information on the existing support offer for shielded patients

- Guidance on the local and national government support offer (food deliveries, access to supermarket deliveries, details of social contact and basic care provision)
- Information on NHS Volunteer Responders, the patient referral form is available here

Shared decision-making and personalised care and support planning

- Shared decision-making: summary guide
- Social Prescribing Academy: Personalised wellbeing plan template

Further information on shielding

- Public Health England Shielding Guidance
- NHS Digital website describing the process for creating the Shielded Patient List

Publications approval reference: 001559

9 July 2020

An electronic copy of this letter, and all other relevant guidance from NHS England and NHS Improvement can be found here:
https://www.england.nhs.uk/coronavirus/primary-care/.

Dear GPs and their commissioners,

UPDATE TO GP CONTRACTS

1. We continue to be very grateful for the care you are delivering to your patients as the Covid-19 pandemic continues. This letter confirms contractual arrangements and income protection arrangements.

2. Over the coming weeks, we expect the level of demand on general practice to continue to grow, reflecting your critical role in the NHS in keeping the population well.

3. We need general practice to continue its vital role in supporting high-risk patients with ongoing care needs, including those who have been in the 'shielding' cohort, those who may need to shield in future, care home residents, as well as the increasing need for Covid-19 aftercare and support. But we also need practices to resume as soon as possible services which may have been paused, managing pre-existing conditions and urgent demand.

4. To support general practice to deliver this, we are:
    - Continuing to support an expansion of the workforce
    - Focussing in on cutting bureaucracy
    - Refocusing QOF
    - Making more funding available – a separate letter will be shared shortly on the Covid Support Fund for general practice

5. Practices have made great progress over the past few months in delivering remote total triage and online consultations – and we want to encourage this to continue. All practices must now also deliver face to face care, where clinically appropriate. It should be clear to patients that all practice premises are open to provide care, with adjustments to the mode of delivery. No practice should be communicating to patients that their premises are closed. Nor should they be redirecting patients to other parts of the system, except where clinically assessed as appropriate.

6. Our success as a health system will rest not only on our management of patients with Covid-19, but also how we maintain wider healthcare provision. Recent reports by PHE show that the virus itself has had a disproportionate effect on certain sections of the population - including older people, men, people living in deprived areas, people from Black, Asian and Minority Ethnic (BAME) groups, those who are obese and who have other long term health conditions mirroring and reinforcing existing health inequalities. We therefore need to ensure that patients are able to access comprehensive primary care. Further, the long-term economic impact of the pandemic may exacerbate health inequalities among these and other population groups. For these reasons, there is an urgent need to prioritise key aspects of primary care not directly related to Covid-19 itself. We are asking that practices and networks do this in a way which is both proactive and sensitive to the range of needs in each practice population.

7. The best way to successfully manage the combined demands of on-going care for patients with, or at risk, of Covid-19 and non Covid-19 services will be by sustaining many of the transformations in ways of working adopted during the height of the pandemic. This includes local system working; strong clinical leadership; a continuation of total triage; a continuation of hot hubs where these have been established and make sense in a longer term offer; flexible and remote working where possible; and rapid scaling of technology-enabled service delivery options.

8. Digital consultation should be offered as standard unless there are good clinical reasons otherwise.

Expanding the workforce

9. Expanding the workforce is a top priority for PCNs this year. It is critical to relieving the workforce pressures felt by many in general practice, enabling primary care to be sustainable into the future.

10. Over 98% of practices are now signed up as members of a PCN, with access to up to £430m of investment that will be made available in primary care where PCNs employ new staff across 10 workforce roles (with at least a further two roles to follow in 2021/22). The DES reimburses 100% of actual salary costs plus employer on-costs (up to the maximum levels set out in the scheme), thereby significantly reducing the financial investment being asked of practices and PCNs from their core funding. We urge all PCNs to take immediate steps to plan to expand capacity now, by using this funding rather than it being lost to primary care in 2020/21. Support for staff recruitment and deployment is available from CCGs and other community services partners; the PCN development funding for 2020/21 will enable support for staff induction and retention.

11. PCNs concerned about employment liabilities should be assured that NHSE/I is committed to the continued funding of these roles. Additionally, if all the practices

in a PCN were to withdraw from the DES in future, commissioners would seek to support the transfer of relevant staff from the outgoing practices to the new provider of network services as part of the appointment process, unless there were exceptional circumstances not to do so.

12. We are committed to increasing the number of GPs. We are asking systems, working with training hubs, to implement GP recruitment and retention initiatives in their area. Guidance will be published on each of the initiatives through the summer. The New to Partnership Payment has recently been launched. Systems should deploy PCN development funding, which will be provided in August, in line with guidance to support their PCNs.

Cutting bureaucracy

13. We are reviewing bureaucratic burdens in general practice in order to free up valuable time for patient care – a new Bureaucracy Review is being jointly led by DHSC and NHS England and NHS Improvement, involving the GPC and RCGP. We will engage with GPs and practice staff to inform the approach taken and to shape the outcome.

14. A priority area for action is to re-purpose the appraisals process in the context of the pandemic. We are working with partner organisations to redesign the current process. We intend to take a flexible approach to its re-introduction and accommodate doctors who are prepared for appraisal, perhaps prior to their revalidation date, and want to press ahead. We want to anchor the new approach around professional development and support, focusing on well-being as well as minimise the supporting information requirements. We do not plan to require doctors to use different documentation for their appraisal, many will have a lot information already recorded in various on-line platforms, though we would be keen to signal flexibility in what is required this year.

15. Whilst this work is underway, we continue to recommend that appraisals are suspended, unless there are exceptional circumstances agreed by both the appraisee and appraiser. The GMC has also announced that doctors who were due to revalidate between 17 March 2020 and 16 March 2021 have had their revalidation submission dates moved back by one year. Read more here.

Quality and Outcomes Framework

16. We recognise that practices will need to reprioritise aspects of care not related to Covid-19 and we intend to modify the QOF requirements for 2020/21 to support this.

17. In 2020/21, we are proposing that practices will be:

- Asked to gear up for a major expansion of the winter flu programme. We are discussing this with the GPC and further information will follow in the coming weeks;
- Asked to focus on early cancer diagnosis and care of people with a learning disability in the quality improvement domain but that the requirements will be recast to focus upon restoring care delivery in these two key areas. Payment of this domain will be conditional on practices working to these revised requirements. We are still working through the detail of this with GPC England and will publish full details shortly;
- Asked to maintain accurate disease registers, prescribing indicators and the delivery of cervical screening indicators, where we expect the rate of delivery to be as close as possible to normal performance. We acknowledge that practices will have to make extra efforts to encourage patients to attend;
- Offered income protection on other indicators, subject to the delivery of revised and simplified requirements focused upon care delivery to those patients at greatest risk of harm from Covid-19, uncontrolled long term condition parameters and those with a history of missing reviews. These are being discussed with GPC and published shortly. Practices will need to agree their approach to patient prioritisation and service delivery with their CCG.

18. By guaranteeing financial support and temporarily reducing the current QOF requirements, we are releasing capacity in general practice to focus on COVID recovery – and support those patients most in need of long-term condition management support.

19. Absent to national agreement to the contrary, QOF will be reintroduced fully from April 2021.

Investment and Impact Fund

20. The Investment and Impact Fund will commence from 1 October 2020. The first six months of IIF monies have been recycled into the Network Contract DES as a PCN support payment without conditions attached. The remaining monies will be used to reward PCNs for performance in relation to the IIF indicators set out in the GP contract deal 2020/21 over the second half of the financial year – with the detail subject to further discussions with GPC England.

Dispensary Services Quality Scheme (DSQS) – for dispensing practices only

21. The Dispensary Services Quality Scheme will be reinstated from the 1 August 2020. We are talking to GPC about the details and further information will follow. Practices intending to participate in the scheme should provide a written undertaking to their commissioner in line with Section 24.4 of the Statement of Financial Entitlements.

GP contractual position

22. On 14 April, we wrote to practices setting out activities that could be deprioritised if necessary to free up capacity[1]. This was enabled using the powers granted by the National Health Service (Amendments Relating to the Provision of Primary Care Services During a Pandemic etc.) Regulations 2020.

23. From 1 July 2020 practices should resume the following services if these have been deprioritised:
    - *New patient reviews (including alcohol dependency)*
    - *Routine medication reviews*
    - *Over-75 health checks*
    - *Clinical reviews of frailty*

24. We recognise that practices will likely have a backlog of reviews and checks to undertake and they will need to sequence these using their clinical judgement and a risk-based approach. Healthcare professionals should discuss with the patient, their carer or their advocate the most suitable and safe way to conduct reviews and checks. Where they can be delivered safely on a face to face basis this should be offered. Where this care cannot be delivered safely face to face or where the patient has other medical conditions which still require them to shield or socially isolate the review could be conducted remotely, with as much of the physical review completed as is practicable in these circumstances - or in exceptional cases by home visit.

25. PHE colleagues have also recommended that the routine call for shingles vaccination programme is re-instated from 1 July 2020. Some individuals who were eligible for the Shingles (catch-up) vaccination programme may have turned 80 years during the COVID-19 pandemic. PHE advises that, if someone who has previously not been vaccinated for shingles and has turned 80 years since 1 February 2020, they could still benefit from the vaccine and should be offered this on an opportunistic basis (unless contraindicated) between now and 31 December 2020. Payment for this should be at the same rate as other shingles vaccines and will be managed by local commissioners.

26. From 1 July the requirement for practices to engage with and review feedback from Patient Participation Groups (PPG) is also reinstated as it is important that practices continue to engage patients and citizens in the development and transformation of services over the rest of the year. It is particularly important that practices engage with their PPGs to help understand and shape the changes in access to services to ensure that no one is inadvertently excluded. We encourage practices to conduct PPGs remotely.

[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0264-GP-preparedness-letter-14-April-2020.pdf

27. We will keep the situation under review and may reinstate some flexibilities under the GP Contract nationally using the powers of the Pandemic Regs, if necessary to help manage subsequent outbreaks. See below.

28. The following provisions will continue under the National Health Service (Amendments Relating to the Provision of Primary Care Services During a Pandemic etc.) Regulations 2020 **until 30 September 2020** for GP practices in England at the earliest:

- ***A suspension of the requirement that practices report to commissioners about the Friends and Family Test returns;***

- ***A temporary suspension of the requirement for individual patient consent in certain circumstances, in order to encourage increased use of electronic repeat dispensing (eRD)***[2]***.*** Use of eRD has many benefits for patients, practices and wider systems and this temporary provision aims to make it easier for practices to transfer patients to e-RD in defined circumstances, where this is clinically appropriate.

- ***A continuation of the temporary increase in the minimum number of appointment slots that practices must make available for direct booking by 111 to a minimum of 1 slot per 500 patients***. This is because they remain necessary to support phase 2 of the NHS response, in particular the important role NHS 111 is playing in reducing the face-to-face transmission risk for patients and NHS staff. Under this model, the slots, which will be booked following clinical triage, are not appointments in a traditional sense; instead practices should clinically assess the patients remotely and arrange their ongoing management. This ensures that only those who need further care (in-person or via telephone / video consultation) are presenting to services, and they are managed as appropriate for their clinical condition.

Flexibilities to respond to local outbreaks

29. Local commissioners may be able to offer some flexibilities in a specific location if local general practices services are compromised as a result of a new local Covid 19 outbreak. For example, this could be because:
    - The impact on an individual practice triggers an adverse incident;
    - There are high sickness absence levels across practices in an area which means demand cannot be fully met;

30. In these extreme circumstances where services are compromised CCGs may agree changes to planned services as follows:

a) Business continuity and practice resilience measures

[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0546-electronic-repeat-dispensing-letter-4-june-2020.pdf

- The local commissioner should engage with the practice to understand the pressures identified by the practice, and consider solutions.
- Practices to enact business continuity plans. It may be necessary to enter into temporary buddying arrangements with other providers.
- The impact of the outbreak will need to be monitored through daily situation reporting.

b) Locally managed suspension of activities

- In extreme circumstances, CCGs may need to coordinate a suspension of activities across practices in local outbreak areas. This could include, in addition:
    - submitting a request to NHSE/I to suspend the following GP contract requirements:
        - New patient reviews (including alcohol dependency)
        - Routine medical reviews
        - Over 75 health checks
        - Clinical reviews of frailty
        - Engagement with and review of Patient Participation Groups
        - As well as a suspension of LESs/LISs

  If approved, NHSE/I will write to the practices concerned to notify them of the new contractual arrangements in place. Further details on the process will be communicated to CCGs and regions soon.

31. Other than in exceptional cases where support and financial assistance (Section 96) may be appropriate (e.g. adverse incident), CCGs would need to apply to the national NHSE/I GP contracts team, via the NHSE/I regional team, to request income protection on any schemes e.g., QOF, Childhood Immunisation DES etc.

LESs/LISs and local pilots

32. We encourage local commissioners to reintroduce local enhanced services, local incentive schemes and local pilots as part of their wider plans to step up routine and non-urgent services. Local audit and local assurance activities that support the delivery of high quality services should also be reintroduced as soon as practicable.

33. Commissioners are asked to consider which local data collections are essential to re-introduce and how they can minimise administrative demands on general practice.

Further updates

Complaints

34. Practices are asked to resume normal complaints management activities from 1 July 2020.

List accuracy and updating

35. Primary Care Support England (PCSE) will resume routine list reconciliation and data quality checks from June 2020. Some practices have undertaken list cleansing activities during the pandemic and we ask that practices continue to ensure their lists are accurate and up-to-date in the interests of patient safety and clinical care. This is particularly important to support the transition of the GP payment system from NHAIS to PCSE online later this year. Dispensing practices are also asked to resume dispensing list cleansing activities from 1 July 2020.

Covid-19 PCR Swab Testing

36. We are advised by NHS Test and Trace that test results from national COVID-19 PCR swab testing will soon be sent to GP systems and appear in patients' records as laboratory test results. Results from tests undertaken in the past will also be sent to GP systems, whenever they are able to identify the patient's NHS number. Patients will have received the results by text and email together with guidance and advice, so there will be no action necessary from GP practices on receipt of these results. There will also be no requirement to communicate these results to Public Health England, as communication to PHE should have already taken place by NHS Test and Trace.

Funding

37. Annex A sets out further details of income protection arrangements for general practice in 2020/21. Given our commitments to maintain GP practice income during the outbreak, we want to remind practices that GP practice staff who are shielding because they are at highest clinical risk from Covid-19 or have completed a risk assessment and been advised not to deliver face to face care, should continue to receive full pay. They should also be encouraged and supported to work remotely while they are doing so, in light of the home working solutions we are facilitating.

38. In conjunction with the Department of Health and Social Care, further details will be issued soon on the Covid Support Fund for general practice to assist with the legitimate additional costs of the response, borne by practices.

Nikki

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Ed

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Annex A: Income protection arrangements for general practice

39. The income protection arrangements seek to ensure that practices do not lose significant income as a result of the outbreak, supporting the deployment of general practice staff to activities of the highest clinical priority.

40. The income protection arrangements described below apply to GMS, PMS and APMS contractors with a registered list.

41. All payments made under the income protection arrangements will be made to GP practices under Section 96 of the NHS Act 2006 (as amended) "Assistance and support: Primary Medical Services". GP practices will receive the payments via the usual mechanisms. Local commissioners may be required to request manual adjustments to payment systems to implement the arrangements set out in this letter.

42. These arrangements apply to practices that continue to deliver services. Income protection arrangements are intended to support all practices, including those who were redeploying core practice staff to work in "hot sites" etc. Income protection arrangements are provided on the basis that practices will co-operate with their local CCGs and deliver care to their local patients, with due regard to guidance issued by NHS England and NHS Improvement.

43. Income protection arrangements are intended to support practices with fixed practice costs including staffing costs. As such GP practices must not also use the Government's Coronavirus Job Retention Scheme to claim for the pay of publicly funded staff, including those who are shielding. In exceptional circumstances where practices find that practice staff cannot be fully utilised in their normal place of work, consideration should be given to whether they could be temporarily redeployed to support the Covid-19 response in another part of the NHS.

44. The income protection arrangement is not a new or additional source of funding. CCGs must be assured that support provided under these income protection arrangements to a practice is appropriate.

45. In recognition of the impact of Covid-19 on practice activity, income protection will be offered in relation to the following in 2020/21 up until 30 June 2020 unless otherwise indicated:

Core practice contract

- **Global sum** will continue to be paid at the agreed rates for the whole of 2020/21.
- **QOF:** we will share further details soon on arrangements for QOF in 2020/21, further to the advice in this letter.

- **Dispensary Services Quality Scheme (DSQS)**: Local commissioners must continue to make the same monthly payments for DSQS from 1 April 2020 until 31 July 2020. The DSQS will be re-introduced from 1 August 2020. We are talking to GPC about the details and further information will follow.

Directed Enhanced Services

- **Network Contract DES:** The Network Participation Payment will continue to be paid to individual practices that have signed up to the DES and meet the requirements set out in the Statement of Financial Entitlements (SFE). The Clinical Director funding will also continue to be paid. Practices will be able to continue to seek reimbursement for any Additional Roles Reimbursement Scheme roles recruited to on the basis of the current Scheme rules, and can undertake further recruitment in line with the Scheme. A workforce planning template to support this process is available as part of contract documentation.

- **Investment and Impact Fund (IIF) has been deferred until 1 October 2020.** The first six months of IIF monies (£16.25m) have been recycled into the Network Contract DES as a PCN support payment, worth £0.27 per weighted patient. This supports further work by PCNs and their Clinical Directors on the pandemic.

- **Minor Surgery DES:** Local commissioners should make the same monthly payments to practices for the Minor Surgery DES in line with the previous year's achievements – from 1 April 2020 up until 30 June 2020.

- **Violent Patients Scheme DES:** Local commissioners should make the same monthly payments to practices for the Violent Patients Scheme DES in line with the previous year's achievements – from 1 April 2020 up until 30 June 2020.

- **Childhood Immunisation Scheme DES:** Local commissioners may offer income protection to practices for Q4 of 2019/20 and Q1 of 2020/21 only. To be eligible for income protection practices will need to demonstrate that they have submitted data through Open Exeter by the required dates, that their planned performance had been negatively impacted by Covid-19 related activities and that this had a material impact upon payment i.e. it resulted in them dropping a payment bracket.

Local enhanced services

- **Enhanced Services/Local Incentive Schemes in Q1 of 2020/21:** Recognising the importance of this local funding, it should be maintained where services were being fully delivered. Where services were unavoidably impacted by COVID, commissioners will set a fair payment arrangement.

Temporary closure of services as a result of Covid-19

46. Income will also be protected for those few practices who were forced to close to patients because their services and staff were consolidated onto another site, to work as part of another practice team, in order to provide a full service.

47. Practices must secure prior permission from the commissioner to temporarily close in these circumstances and any practice staff still able to work must be offered to other practice sites, and must do so to maximise clinical capacity.

48. We recognise that in exceptional circumstances some practices e.g., single handed practices may have had to close temporarily if their GPs or most practice staff were unable to work through illness. Where it has not been possible to identify alternative staffing arrangements for these practices and it has been agreed by the local commissioner those practices should temporarily close, income protection should be provided, as long as all available staff are actually redeployed to another NHS role over that period.

49. As closures should be very short term, commissioners should normally look at what the practice was paid in total in the month prior to closure and pay the same pro rata. Where the previous month's funding was not typical, commissioners should look at funding levels for the previous three months and consider applying an average. Practices may continue to claim reimbursement of premises costs via the Premises Costs Directions.