NHS
Vale of York
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

26 November 2020, 1.30pm to 3.30pm

'Virtual' Meeting

AGENDA

1.	Verbal	Apologies		
2.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
3.	Pages 3-11	Minutes of the meeting held on 24 September 2020	To Approve	Julie Hastings Committee Chair
4. 4.1	Verbal Pages 12-17	Matters Arising Medicines Safety Governance Processes in Primary Care	 To Approve	All Laura Angus Head of Prescribing/ Strategic Lead Pharmacist
5. 1.50pm	Pages 18-26	Review Primary Care Commissioning Committee Terms of Reference and Effectiveness	To Approve	Abigail Combes Head of Legal and Governance
6. 2.00pm	Pages 27-34	Primary Care Commissioning Financial Report Month 7	To Receive	Simon Bell Chief Finance Officer
7. 2.10pm	Pages 35-55	Primary Care Network Plans for use of General Practice Forward View Organisational Development and Winter Resilience Funds	To Approve	Fiona Bell-Morritt / Gary Young Primary Care Lead Officers
8. 2.25pm	Verbal	Coronavirus COVID-19 Update	To Note	Stephanie Porter Interim Executive Director of Primary Care and Population Health

9. 2.50pm	Pages 56-97	Risk to Primary Care Commissioning Committee	To Receive	Abigail Combes Head of Legal and Governance
10. 3.10pm	Pages 98-103	2019/2020 Annual Chair's Report	To Approve	David Iley Primary Care Assistant Contracts Manager NHS England and NHS Improvement (North East and Yorkshire)
11. 3.15pm	Pages 104-108	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)
12. 3.25pm	Verbal	Key Messages to the Governing Body	To Agree	All
13.	Verbal	Next meeting: 1.30pm 28 January 2021	To Note	All

EXCLUSION OF PRESS AND PUBLIC

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

Vale of York
Clinical Commissioning Group

Item 3

Minutes of the Primary Care Commissioning Committee on 24 September 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) - part	Accountable Officer

In attendance (Non Voting)

Laura Angus (LA)	Head of Prescribing/Strategic Lead Pharmacist
Fiona Bell-Morritt (FB-M)	Lead Officer Primary Care, Vale
Shaun Macey (SM)	Head of Transformation and Delivery
Dr Tim Maycock (TM)	GP at Pocklington Group Practice representing the Central York Primary Care Networks
Dr Andrew Moriarty (AM)	North Yorkshire and York, YOR Local Medical Committee Limited
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

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 23 July 2020

The minutes of the previous meeting were agreed.

The Committee:

Approved the minutes of the meeting held on 28 May 2020.

4. Matters Arising

The matters arising were either on the agenda or had not reached their scheduled date.

5. Primary Care Commissioning Financial Report Month 5

SB explained that the CCG's position at month 5 was break-even in line with the national interim financial arrangements which were also expected to continue for month 6. The associated adjustments and forecasts relating to primary care were as detailed in the report with the October to March position being based on the assumption of the CCG's draft plan of a forecast £16.3m deficit.

SB advised that the allocation for October to March had been received since publication of the meeting papers and noted that work was required as a system to break-even for the remainder of the year. This had been discussed in detail at the Finance and Performance Committee earlier in the day.

The Committee:

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

6. Primary Care Networks Update

Central Locality

GY provided an update on the urgent care transformation programme advising that four clinically led workshops had taken place and agreement had been reached for three different approaches in each of the CCG's localities. He noted that a number of GP Practices currently using EMIS were considering migrating to SystmOne to enable full integration with the proposed urgent care delivery. The proposed pathways, defined by 'place', had been well received and supported at a public and patient engagement focus

group earlier in the week which had comprised of representatives from the three localities. The proposals would now be presented to the York, North Yorkshire and East Riding of Yorkshire Overview and Scrutiny Committees. Work was also taking place on governance arrangements.

GY and FB-M commended the engagement of the Primary Care Networks in the urgent care transformation work highlighting that the locality specific models would result in a more robust service for each area.

GY also reported on an OPEL (Operational Pressure Escalation Levels) framework being piloted by a number of Practices. This provided an operational response framework for all providers to report on whether they were at a position of 'business as usual' or at a level of pressure. The Local Medical Committee had also been involved in this work and the approach had been well received. GY additionally noted that the Central Locality Primary Care Network Clinical Directors supported this and highlighted the context of winter planning as well as urgent care.

Vale

FB-M highlighted work in Selby in response to increasing levels of COVID-19 noting plans for 'hot' and 'cold' sites and business continuity were being confirmed. She also noted increased demand on primary care and commended the partnership working with Selby District Council to deliver the 'flu vaccination programme.

FB-M explained that work was taking place to establish fixed posts in year through the Additional Roles funding. The focus was on care coordinators and health coaches, i.e. non clinical roles to enhance support. These opportunities were also being optimised in York.

FB-M reported on a pilot in South Hambleton and Ryedale, funded by the Sustainability and Transformation Partnership, whereby British Red Cross volunteers were working with the Community Response Team to provide six weeks' support to patients who did not have clinical need but would benefit from some assistance. This approach was also being extended to Selby.

FB-M noted that the Population Health Management Programme, which focused on intelligence to enable resources to be targeted based on need and inequality, had restarted. Selby Town Primary Care Network was represented on the programme and would share learning across the CCG.

AL additionally reported that a request had been submitted to the Humber, Coast and Vale Primary Care Operations Group for ratification of use of First Contact Practitioners in City and Vale. A model of sub contracting from York Teaching Hospital NHS Foundation Trust had been developed in the Vale to support MSK services with additional physiotherapist time in Practices as well as their hospital based commitment. For the Central Locality the private provider market was being utilised in this regard. TM commented on the benefits of First Contact Physiotherapists being part of the primary care team, particularly in terms of prevention of need for further services.

Discussion ensued regarding the potential migration from EMIS to SystmOne, as referred to above. AL, FB-M and GY emphasised that this was not a CCG policy. It was entirely locality driven in the context of aligning services. However, the CCG as a commissioner was scoping costs of migration via NECS and from the Practice perspective with a view to developing a capital bid to offer support to Practices.

The Committee:

Noted the updates.

7. Coronavirus COVID-19 Update

SS reported that for City of York numbers of cases of COVID-19 were volatile but currently lower than both the regional and national averages. Positive tests from Pillar Two sites were also lower than the regional and national levels.

In respect of care homes in City of York SS reported that at the start of the week there had been single cases in 10 homes and outbreaks of infection in two; confirmed infections had also been reported in three further care homes as at the day of the meeting. SS also noted that testing of whole care homes was resulting in asymptomatic positive tests and that work was taking place with colleagues in Adult Social Care to try and influence staff behaviours outside of work following a number of infections resulting from socialising.

SS reported that there were outbreaks in two schools with a further “live” situation in another. Access to tests was an issue and discussions were taking place regarding self isolation for staff and students.

SS advised that daily updates were received from York Teaching Hospital NHS Foundation Trust regarding admissions of City of York residents, including to intensive care. In respect of excess deaths SS explained that the position had changed from that of no excess deaths for approximately the three months to September but that as of the first week in September there had been nine excess deaths compared with the same week for the previous three years. She also noted an increase in workforce outbreaks.

SS noted that the current position was manageable but expressed concern in the context of winter pressures.

AL reported from the Vale perspective that there were no specific concerns about COVID-19 in the North Locality but that the infection rate in Selby was currently double the national average. He noted a cluster in Selby Town and also concern about schools and workplaces and, whilst numbers had considerably reduced from the previous week, an increase in cases was expected as winter approached. AL also advised that the Selby Practices had activated ‘hot’ clinic arrangements.

Detailed discussion ensued in the context of concerns about testing availability for both NHS staff and the public. SS explained the national portal for booking tests was only opened twice each day, morning and evening, for a limited time. It was closed on each occasion as soon as all test slots were booked as a means of controlling the backlog of swabs for processing. She also noted the issue of tests being offered but requiring considerable travel. Private tests were noted as a further concern in the context of laboratory capacity.

SS reported that locally York Teaching Hospital NHS Foundation Trust had agreed to support testing for primary care staff and that a walk-in test centre was being established on the University of York site which would also be open to residents. Work was also taking place through the Local Resilience Forum to provide a solution to testing for key workers but the overall risk to the system was significant. AL additionally noted that the CCG was in discussion with Nimbuscare about extending testing to family members of General Practice staff.

The Committee:

Noted the update.

8. Introduction of a Primary Care Practice Managers Group

SP explained that the CCG and Local Medical Committee had funded a project for work with Practice Managers who had now requested that the CCG replicate arrangements for a Practice Managers Development Group similar to those in place in the former NHS Scarborough and Ryedale CCG, now transferred to NHS North Yorkshire CCG. She noted that SM would lead work to develop a forward plan and that periodic reports would be brought to the Committee, initially in the form of terms of reference. This was very much a response to a request from the Practice Managers and would be kept under review to assess the value it added and the ability of all to support during winter. In addition to formal arrangements there were monthly telephone check-in with the group.

JH welcomed the proposal in the context of partnership working and resilience. AL added that Practice Pharmacists had a similar arrangement.

The Committee:

Noted the establishment of a Primary Care Practice Managers Group and supported the proposal for a Practice Managers Development Group.

9. Three Month Social Prescribing Impact Report from York CVS

SP referred to the report presented to inform the Committee of the impact of the first three months of the year one appointments for social prescribing link workers as part of the Additional Roles for Primary Care Networks. In our central locality these roles were provided by York CVS and the report looked to assess their impact. It was acknowledged that it was very much a snap shot but SP highlighted the success of the collaborative approach with the voluntary sector and the benefits which can result when we give our voluntary sector partners more confidence around long term funding which allows them to plan.

SP explained that the social prescribers, known in some areas as link workers, were being funded through the Primary Care Networks Additional Roles Reimbursement Scheme. While welcoming the support TM expressed concern about the future of these roles when the funding under the Primary Care Networks contract ended in 2023/24 by NHS England.

AL noted that South Hambleton and Ryedale Primary Care Networks innovative development of care coordinators paralleled this work in the City; this would be presented at a future Committee meeting.

The Committee:

1. Received and commended the Three Month Social Prescribing Impact Report from York CVS.
2. Noted that South Hambleton and Ryedale Primary Care networks Care Coordinators approach to be presented at a future meeting.

10. Update on Online Consultations

SM recalled that funding for online consultations had been introduced through General Practice Forward View funding in 2018 when the Sustainability and Transformation Partnership, in an attempt to standardise solutions across the Humber, Coast and Vale, had procured Engage Consult and offered free licenses to Practices. Uptake had initially been slow but increased rapidly in response to COVID-19 to enable patients to access services remotely.

SM explained that the online consultations market had developed and Practices were now exploring other platforms which they were self funding. Examples included Klinik being used by Haxby Group Practice and Priory Medical Group and EMIS Online Consult being used by Elvington Medical Practice and MyHealth. A request had been made to the Integrated Care System Primary Care Board earlier in the year to allow online consultations funding to be used for other solutions in addition to Engage Consult. This had been supported but receipt of the funding was awaited.

SM reported that Integrated Care System digital leads were also exploring accuRx which provided online consultations, video consultations and SMS messaging from the same 'app' and integrated with EMIS and SystmOne. He emphasised the need for more work on communication and engagement with Practices and patients to increase use of digital access to General Practice. Online consultations would only develop if they worked and were both easy and safe to use for Practices and patients. However, it was necessary to be mindful that digital access was not appropriate for everyone and that some traditional access must be maintained to ensure inclusivity.

TM expressed appreciation to SM for his support through these developments and enquired as to whether lessons had been learnt through the initial inflexible single system approach. DI confirmed that lessons had been learnt from the pilot, noted the competitive market that had since evolved and explained that CCGs were advised to adopt more than one option and offer a fair share solution. He also noted that the Integrated Care System was undertaking a full review with a view to making an offer to Practices and Primary Care Networks from April 2021.

GY reiterated the need for communication with patients noting that it had become evident in the urgent care transformation work that some A&E attendances were as a result of patients not being offered face to face access to a GP. AL added that it had been agreed at the Finance and Performance Committee earlier in the day that a focus on managing patient expectations was required.

The Committee:

Noted the update.

11. Medicines Safety Programme

PM left the meeting during this item

LA explained that the extensive remit of the Medicines Management Team included quality and safety. She was seeking the Committee's view on a proposal to introduce a systematic rolling programme of seeking assurance for such as ensuring appropriate action had been taken to alerts sent to Practices instead of the current ad hoc approach to following up a major safety issue.

LA's proposal was that alerts be issued on a monthly basis, unless urgent, with a timescale of a month for Practices to feedback completion of any requisite implementation potentially through a pro forma approach. In the event of this not being provided LA proposed a follow-up approach of two timescales of two weeks for response and thereafter reporting to either the Primary Care Commissioning Committee of Quality and Patient Experience Committee, or potentially both, for assurance. Communications would be sent to GPs and dispensing pharmacists. Concerns about community pharmacists would be raised via NHS England and NHS Improvement who commissioned this service.

From the GP perspective of TM and AM detailed discussion included: the context of resources and contract requirements; the role of the Local Medical Committee; emphasis that Practices are fully cognisant of their responsibility for safety; the potential to work with Primary Care Network Clinical Pharmacists; the need for added value; the potential for assurance to be through an online approach; and emphasis on collaborative working.

From the CCG perspective LA referred to the aspect of the commissioner seeking assurance from providers and AL highlighted the fact that prescribing clinicians do carry risk. The aim was for there to be assurance of safe service delivery preferably through a collaborative approach. AL proposed that he and LA progress discussion with the Local Medical Committee to develop a "light touch" approach. DB additionally suggested this as a potential topic for the Practice Managers Development Group, as discussed at item 8 above.

The Committee:

Noted that LA and AL would progress discussions with the Local Medical Committee with a view to developing a "light touch" approach to provide the CCG with assurance where appropriate.

12. NHS England and NHS Improvement Primary Care Report

DI referred to the report that provided information on COVID-19 in terms of the NHS Third Phase Response, support fund for General Practice, changes to the General Medical Services Contract for 202/21 and the Pharmacy Home Delivery Service. Workforce updates were provided in respect of the Additional Roles Reimbursement

Scheme, expanding the primary care workforce in 2020/21, accelerating the recruitment of social prescribing link workers, the GP Retention Scheme and Workforce Minimum Data Set.

DI also highlighted that the Humber, Coast and Vale Integrated Care System was involved in Wave 2 of a national estates programme to gather primary care data to evidence and identify areas of need, opportunities for investment and demonstrate Primary Care Network cases for change.

Discussion included the funding for social prescribing link workers and pressures on GP Practice premises particularly in the context of new roles.

The Committee:

Received the NHS England and NHS Improvement Primary Care Report.

13. Key Messages to the Governing Body

The Committee:

- Expressed concern at the challenges and impact relating to the current COVID-19 testing availability.
- Welcomed the Three Month Social Prescribing Impact Report from York CVS and the British Red Cross Pilot in South Hambleton and Ryedale Primary Care Network.

The Committee:

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

12. Next meeting

1.30pm, 26 November 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 24 SEPTEMBER 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 26 November 2020
PCCC53	24 September 2020	Three Month Social Prescribing Impact Report from York CVS	• South Hambleton and Ryedale Primary Care networks Care Coordinators approach to be presented at a future meeting.	FB-M	26 November 2020
PCCC54	24 September 2020	Medicines Safety Programme Medicines Safety Programme	• Discussion to take place with the Local Medical Committee with a view to developing a “light touch” approach to provide the CCG with assurance where appropriate.	LA	

Item Number: 4

Name of Presenter: Laura Angus

Meeting of the Primary Care Commissioning Committee

Date of meeting: 26 November 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Medicines Safety Governance Processes in Primary Care

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

Reason for Report

The CCG Medicines Management Team (MMT) send out information/updates/alerts to GP Practices, focussing on specific medicine safety areas. To date, GP Practices have been requested to implement any changes required and provide assurance to the CCG MMT that they have taken the required action.
Some GP Practices do not respond to repeated requests for assurance.
PCCC was asked at the meeting 24th September regarding their view on how the CCG should respond to this lack of response and PCCC requested for it to be discussed further with the Local Medical Committee (LMC).
LMC has provided a view and below is a proposed pathway for seeking assurance regarding medicines safety.
PCCC is requested to approve the flowchart.

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 PCCC is requested to approve the flowchart
Decision Requested (for Decision Log) PCCC is requested to approve the flowchart – see below.

Responsible Executive Director and Title	**Report Author and Title**
Stephanie Porter Executive Director of Primary Care	Laura Angus Head of Prescribing/Strategic Lead Pharmacist

Background

Medication has a huge potential to do good, but errors can occur at many points in the medication cycle – prescribing, dispensing, administering, monitoring and use.

The World Health Organisation (WHO) identified 'Medication Without Harm' as the theme for their third Global Patient Safety Challenge which aims to reduce severe avoidable medication-related harm by 50% globally in five years by targeting health care provider's behaviour, systems and practices of medication, medicines, and the public (World Health Organisation, 2016). In response to this challenge, the DH commissioned a report on the prevalence and cost of medication errors which reported that an estimated 66 million potentially clinically significant errors occur per year, 71% of which are in primary care (Department of Health and Social Care, 2018). While the majority of these errors are spotted (and corrected) at the point of error or do not threaten patient safety, a drastic reduction in the number of errors is now being called for. There is a need to develop and implement interventions to reduce medication error associated with avoidable harm.

The Medicines and Healthcare products Regulatory Agency (MHRA) regulates medicines, medical devices and blood components for transfusion in the UK. The Medicines Management Team supports the cascade of messages from MHRA to prescribers, support prescribers to develop action plans and ensure they have acted on any relevant safety alerts.

National Patient Safety Alerts (NPSA) patient safety alerts that relate to medications that were published between 2002 and 2012 by the National Patient Safety Agency, this is now hosted by NHS Improvement. Again, MMT supports the cascade of these alerts and ensure that GP Practices have appropriate action plans relating to the alerts.

The Medicines Safety Programme is an on-going programme of regular 'known' medicines safety issues.

Examples of known areas are:

- Valproate pregnancy prevention programme
- Prescribing errors associated with drugs that require regular blood test monitoring e.g. clozapine, digoxin, gentamicin, lithium and methotrexate.
- Prescribing errors related to anticoagulants – warfarin, DOACs, injected heparin and low molecular weight heparins.
- Prescriptions for medicines were omitted or delayed
- Prescribing errors relating to opioid analgesics
- Prescribing errors related to insulin
- Paraffin based skin products – the risk of fire

The MMT send out information/updates/alerts approximately every month and will focus on a specific medicine safety area. To date, GP Practices are requested to implement any changes required and provide assurance to the CCG that they have taken the required action.

The MMT will also flag any ad-hoc medicine safety issues, for example, a significant MHRA alert, as and when they arise and ensure that GP Practices are aware and have taken any relevant action.

The Medicines Management Team works with the CCG Quality Team to support the investigation of medicines-related safety incidents and develop systems and processes, as appropriate, to share learning from medicines-related safety incidents to our providers and partners and prevent them from recurring.

The Medicines Management Team do not always receive assurance back from GP Practices to say that they have acted on the patient safety update/alert/advice, as requested.

On 24th September 2020, the matter was brought to the Primary Care Commissioning Committee (PCCC) for further discussion.

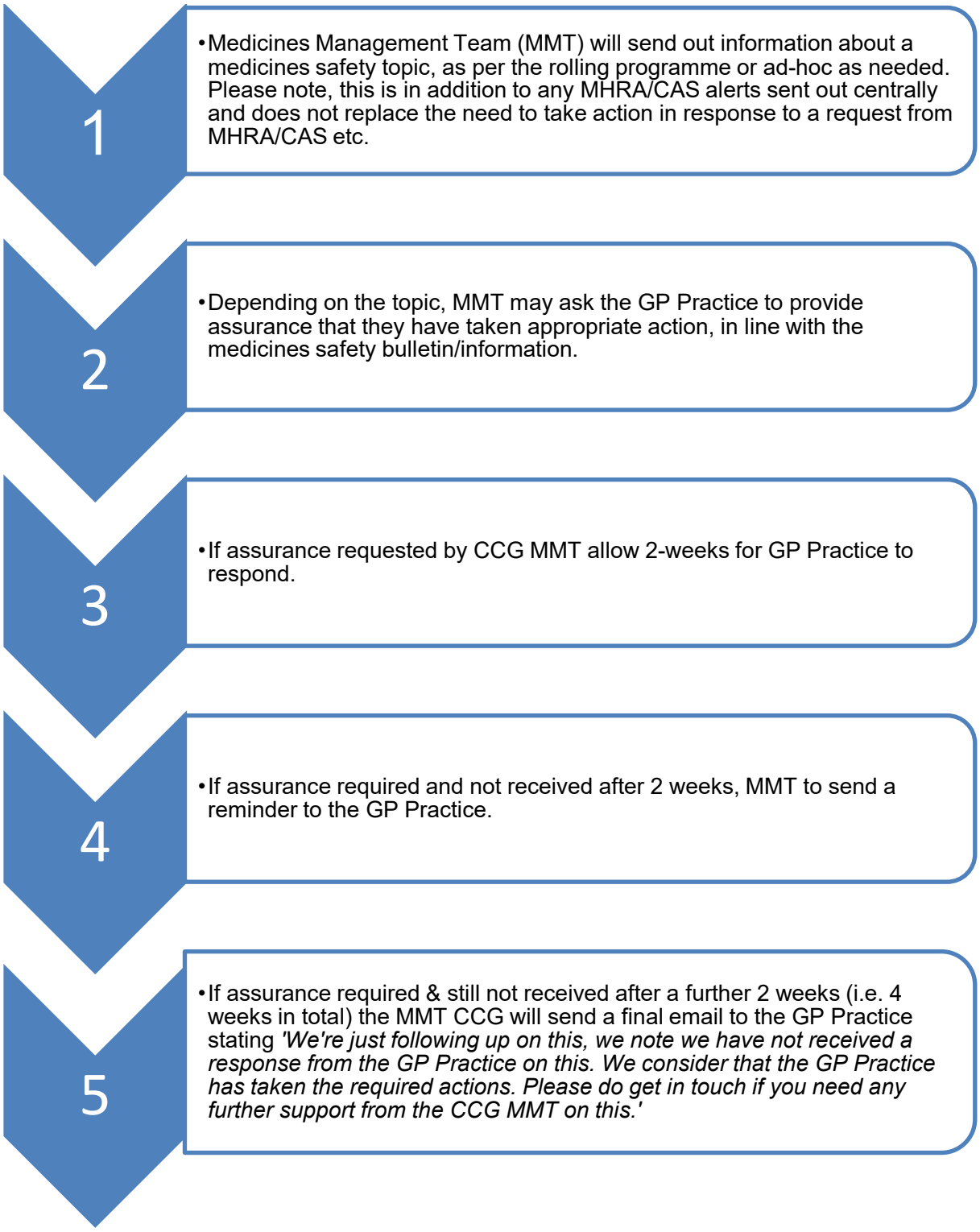
PCCC agreed that the issue should be raised with the Local Medical Committee (LMC) with the aim for there to be the assurance of safe service delivery preferably through a collaborative and 'light touch' approach.

MMT met with LMC to discuss the issue. LMC agreed that a) individual GPs and b) individual GP Practices had their own professional and regulatory responsibilities to ensure they act upon any medicines safety updates as required, and are answerable to, for example, the General Medical Council and Care Quality Commission.

LMC agreed a 'light touch' response – see proposed flowchart below – with CCG providing only 2 reminders and then a final offer of support to the GP Practice. The responsibility to act upon any medicines safety alerts remains with the GP Practice. LMC stated if the CCG MMT had any specific concerns about a GP Practice regarding medicines safety issues then we should seek support from the LMC to address and resolve the issues.

GP Practices will still be requested to submit information to the MMT regarding action they have taken, for specific medicines safety alerts, even if they are not mandated to provide this information, as this is useful for sharing and learning from best practice.

Flowchart: DRAFT - Medicines Safety Assurance From GP Practices Flowchart



*If MMT have specific concerns with a GP Practice, raise with GP Practice and/or LMC Medical Director and escalate as appropriate within the CCG.

** MMT to keep a record of emails sent/received.

Action Required

PCCC are requested to approve this flowchart/response to medicines safety alerts.

References:

1. World Health Organisation. The third WHO Global Patient Safety Challenge: Medication Without Harm. *https://www.who.int/patientsafety/medication-safety/en/.* [Online] May 2016.
2. Department of Health and Social Care. The Report of the Short Life Working Group on reducing medication related harm. *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/683430/short-life-working-group-report-on-medication-errors.pdf.* [Online] Feb 2018.

Ends

Item Number: 5

Name of Presenter: Abigail Combes

Meeting of the Primary Care Commissioning Committee **Date of meeting: 26 November 2020**	NHS Vale of York Clinical Commissioning Group

Report Title- Terms of Reference

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

Reason for Report

The Committee is required to review the Terms of Reference annually. This review includes one amendment as the Director for Primary Care and Population Health has now left the organisation and has been replaced with the Interim Director for Primary Care and Population Health. This is reflected in the amended terms of reference.

Strategic Priority Links

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

Local Authority Area

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

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

Emerging Risks

Impact Assessments

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

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

Risks/Issues identified from impact assessments:

N/A

Recommendations

Approve this version of the Terms of Reference

Decision Requested (for Decision Log)

Approve this version of the Terms of Reference

Responsible Executive Director and Title	**Report Author and Title**
Stephanie Porter Interim Director of Primary Care and Population Health	Abigail Combes Head of Legal and Governance

NHS
Vale of York
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

Terms of Reference

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 01 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

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

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

4. It is a committee comprising representatives of the following organisations :

   - NHS Vale of York CCG
   - NHS England
   - Healthwatch
   - Health and Wellbeing Board(s)
   - Director of Public Health

Statutory Framework

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

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

7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:
   a) Management of conflicts of interest (section 14O);

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

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

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

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

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

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

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

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

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

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

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

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

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

Role of the Committee

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

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

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

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

15. This includes the following:

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

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

16. The CCG will also carry out the following activities :
    a) To plan, including needs assessment, primary care services in the Vale of York CCG area;
    b) To undertake reviews of primary care services in Vale of York CCG area;
    c) To co-ordinate a common approach to the commissioning of primary care services generally;
    d) To manage the budget for commissioning of primary care services in Vale of York CCG area.

Geographical Coverage

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

Membership

18. The Committee shall consist of :
    Lay Chair of Quality and Patient Experience Committee (Chair)
    Lay Chair of Audit Committee
    Lay Chair of Finance and Performance Committee
    Accountable Officer
    Chief Finance Officer
    Interim Director of Primary Care and Population Health
    Representative of NHS England
    (voting members)

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

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

21. The following standing attendees (non-voting) will be invited :
    - A representative from each of the Primary Care Networks
    - LMC representative
    - Director of Public Health
    - Assistant Director, Primary Care
    - Healthwatch Representative

- Health and Wellbeing Board Representative
- Practice Manager

Meetings and Voting

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

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

Quorum

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

- At least four members.

Frequency of meetings

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

26. Meetings of the Committee shall :

    a) be held in public, subject to the application of 26(b);

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

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

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

Primary Care Commissioning Delivery Group may be established to ensure the delivery of arrangements agreed by the Committee.

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

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

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

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

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

Links to other Committees and Groups

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

Accountability of the Committee

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

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

Procurement of Agreed Services

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

Decisions

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

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

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

Conflicts of Interest

41 Conflicts of Interest, both actual and perceived, shall be managed in line with NHS Vale of York CCG Conflicts of Interest policy and recorded at the start of every meeting.

Secretary

42 The secretary will be responsible for supporting the Chair in the management of the Committee's business.

The Committee will also be supported administratively by the secretary, whose duties in this respect will include :

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent areas

[Signature provisions]

Schedule 1 : Delegation
[Delegation from NHS England attached separately]

Schedule 2 : Delegated Commissioning Functions

Delegated commissioning functions are as follows :

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

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

Item Number: 6

Name of Presenter: Simon Bell

Meeting of the Primary Care Commissioning Committee **26th November 2020**	NHS Vale of York Clinical Commissioning Group

Primary Care Commissioning Financial Report Month 7

Purpose of Report
For Information

Reason for Report

To provide the Committee with details of the Month 7 and forecast position for Primary Care expenditure areas.

Strategic Priority Links

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

Local Authority Area

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

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

Emerging Risks

Impact Assessments

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

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

Risks/Issues identified from impact assessments:

Recommendations

The Committee is asked to receive the report.

Decision Requested (for Decision Log)

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: November 2020

Financial Period: April 2020 to October 2020

1. Introduction

This report provides details on the year to date financial position as at Month 7 and the forecast outturn position for 2020-21.

2. Primary Care Year to Date and Forecast Position

October is the first month under the 'system envelope' financial arrangements, with the CCG now reporting its financial position against the organisational financial plan submitted on 22nd October.

The CCG's financial plan for M7-12 was a break even position against allocation, however at the time of submission there was uncertainty around two specific primary care funding streams as detailed in the table below. The related spend was added into the financial plan submission to ensure that the risk associated with not receiving these allocations was recognised on a system, regional and national level. This means that the final financial plan submission showed a deficit of £1.33m for M7-12, which is reflected in the reported overall financial position. Arrangements for accessing these allocations are yet to be confirmed.

Description	£m	Comments
Position as per CCG financial plan	0.00	Breakeven position against financial envelope
Primary Care allocation adjustment	(0.32)	This relates to an additional allocation that was notified in March 2020 during the original planning process. NHS England included this on their schedule of additional allocations to follow, however it was not reflected in planning templates and has not yet been transacted.
PCN Additional Roles reimbursement central funding	(1.01)	Funding for PCN Additional Roles for 2020/21 is partly from CCG baselines and partly to be reclaimed from central funding. Arrangements for accessing this funding are still to be confirmed. The amount included is the CCG's full eligibility for M7-12, actual costs and therefore reimbursement may be lower.
Submitted CCG financial plan deficit	(1.33)	

The final retrospective allocation relating to Month 6 will be transacted in November. The Year to Date (YTD) and Forecast Outturn tables in this report are adjusted to show the position following receipt of this adjustment.

In line with NHS England (NHSE) guidance, several categories of expenditure are classed as 'outside of envelope' for M7 to M12. Spend on these areas will be reimbursed centrally, in a similar arrangement to that for COVID related spend in M1-6. Expenditure on these categories within Primary Care includes influenza vaccines, asylum seekers and GP returners. The YTD and Forecast Outturn tables in this report are adjusted to show the position excluding 'outside of envelope' spend. As per NHSE guidance, only YTD spend is included in the CCG's financial position for these areas, with no additional forecast spend for M8 to M12.

2.1 Delegated Commissioning Financial Position – Month 7

The table below sets out the YTD position for 2020-21.

Delegated Primary Care	Month 7 Year To Date Position					
	Budget	Actual	Variance	M1 - M6 Allocation Adjustment	M7 'Outside Envelope'	Adjusted Variance
	£000	£000	£000	£000	£000	£000
Primary Care - GMS	13,249	13,210	40	(35)	0	5
Primary Care - PMS	5,416	5,198	218	(185)	0	33
Primary Care - Enhanced Services	323	290	33	(14)	0	19
Primary Care - Other GP services	4,134	3,580	554	(438)	7	123
Primary Care - Premises Costs	2,612	2,580	22	(17)	0	5
Primary Care - QOF	2,630	2,630	0	0	0	0
Sub Total	**28,365**	**27,497**	**867**	**(689)**	**7**	**186**

- The Month 7 YTD actual expenditure position is £27.5m which is an underspend of £867k against the CCG's financial plan. Excluding the Month 1 to 6 allocation adjustment and outside of envelope spend, there is an underspend of £186k**.**
- **GMS** is based upon the current contract and list sizes to date and is showing an underspend of £40k due to smaller list size movements than expected.
- **PMS** contracts are underspent by £218k due to PMS premium monies which are accrued in Other Primary Care (£183k) and smaller list size movements than expected.
- **Enhanced Services** are underspent due to slippage on Minor Surgery claims received to date. A more detailed breakdown is shown in the table below.

Enhanced Services	Month 7 Year to Date Position		
	Budget	Actual	Variance
	£000	£000	£000
Learning Disability	59	59	0
Minor Surgery	253	220	33
Violent Patients	12	12	0
Sub Total	**324**	**291**	**33**

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

Other GP Services	Month 7 Year to Date Position		
	Budget £000	Actual £000	Variance £000
Dispensing/Prescribing Doctors	1,188	1,163	25
PCO Administrator	551	565	(14)
GP returners	0	16	(16)
GP Framework:			
Extended Hours	308	308	0
Network Participation	363	363	0
Clinical Director	153	153	0
PCN Support	95	95	0
Additional Roles	878	878	0
Care Homes Premium	27	26	1
Impact and Investment Fund	23	24	(1)
Needle, Syringes & Occupational Health	17	(12)	28
Reserves	530	0	530
Sub Total	**4,134**	**3,580**	**554**

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

PCO Administrator payments are overspent due to CQC reimbursements.

GP returners relates to a Yorkshire and Humber pilot scheme whereby GPs return to General Practice to support Primary Care during covid. This scheme is funded separately as an 'outside of envelope' item.

GP Framework payments are being paid in line with plan with the exception of Additional Roles. Additional Roles have been accrued to budget.

Needle, Syringes and Occupational Health are all accrued to budget but offset by the release of some prior year accruals.

The year to date budget in **reserves** reflects the uncommitted investment reserve that was provided for in the CCG's draft plan (£361k) and M7 Additional Roles to be funded centrally (£169k).

- **Premises** costs are based upon payments made for the year to date with slippage on clinical waste.

- **QOF** is accrued to budget.

2.2 Other Primary Care Financial Position – Month 7

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

Primary Care	Month 7 Year to Date Position					
	Budget £000	Actual £000	Variance £000	M1 - M6 Allocation Adjustment £000	M7 'Outside Envelope' £000	Adjusted Variance £000
Primary Care Prescribing	30,360	31,380	(1,021)	1,147	0	126
Other Prescribing	1,000	966	35	76	0	111
Local Enhanced Services	1,297	1,185	112	(9)	0	103
Oxygen	223	174	49	(40)	0	9
Primary Care IT	809	821	(12)	40	0	28
Out of Hours	1,985	2,015	(30)	30	0	0
Other Primary Care	1,402	2,753	(1,351)	1,263	72	(16)
Sub Total	**37,077**	**39,295**	**(2,218)**	**2,508**	**72**	361

The **Prescribing** position is overspent by £1.02m as at Month 7. This position is based upon 5 months of prescribing data and does not include any QIPP. £566k of this overspend relates to prior year due to March prescribing figures, but which has been absorbed within the overall retrospective top-up process.

Local Enhanced Services are underspent by £112k. Quarter 2 payments have now been made based upon actual activity. The underspend is made up primarily of underspends in Anti-coagulation (£46k), Diabetes (£34k) and Ophthalmology (£44k).

Oxygen is underspent by £49k as at Month 7 as activity is lower than expected.

Other Primary Care is overspent by £1.35m which includes £1.02m for Improving Access which was not in the financial plan as it is usually funded through non-recurrent allocation. The overspend also includes £183k of PMS premium monies which are budgeted for within delegated co-commissioning. Other Primary Care also includes £72k of expenditure which is funded separately as 'outside of envelope'. This is made up of £70k for influenza vaccinations and £2k for asylum seekers.

2.3 COVID Expenditure

As at Month 7, the CCG has incurred £6.54m of COVID-19 related expenditure against which allocation of £4.29m has been received. The table below shows the level of COVID expenditure included within Primary Care areas and the forecast for the rest of the year.

Primary Care	COVID expenditure as at Month 7 £000	Forecast COVID expenditure as at Month 7 £000	Comments
Primary Care – Other GP Services	16	77	GP returners scheme
Local Enhanced Services	98	115	Care Homes LES, additional MECS and anti-coagulation costs
Primary Care IT	109	109	Care Home tablets, additional SMS and telephony costs and firewall upgrade
Out of Hours	18	18	Additional OOH costs
Other Primary Care	906	1,143	GP COVID costs, GP Practices opening over Bank Holidays, COVID management service, Advanced Care Planning sessions, Flu vaccines, winter resilience schemes
Total	**1,147**	**1,463**	

2.4 Delegated Commissioning and Other Primary Care Forecasts

The forecast position in the table covers the full financial year. The first three columns show the position as per the CCG's financial ledger. As per the YTD tables, this is adjusted for the M6 retrospective allocation and outside of envelope spend, to give a true comparison to the financial plan.

	Forecast Position (£000)						
	Ledger Position			Adjusted Position			
	Plan	Forecast	Variance	M1-M6 'True Up'	M7 'Outside envelope'	Adjusted variance	Comments
Delegated Commissioning							
Primary Care - GMS	22,713	22,651	62	(35)	0	27	
Primary Care - PMS	9,285	8,900	385	(185)	0	200	£156k PMS premium (forecast included in Other Primary Care)
Primary Care - Enhanced Services	554	521	33	(14)	0	19	
Primary Care - Other GP services	7,700	7,371	329	(438)	7	(102)	£77k forecast for GP returners
Primary Care - Premises Costs	4,478	4,439	38	(17)	0	21	
Primary Care - QOF	4,508	4,508	(0)	0	0	(0)	
Total Delegated Commissioning	**49,238**	**48,391**	**847**	**(689)**	**7**	**165**	
Other Primary Care							
Primary Care Prescribing	52,272	53,682	(1,410)	1,147	0	(263)	Current forecast position is based on extrapolating M1-6 overspend against CCG plan. August figures have shown some improvement against this trajectory but spend has been highly variable between months
Other Prescribing	1,715	1,828	(114)	76	0	(37)	
Local Enhanced Services	2,180	1,970	210	(9)	0	201	Forecast based upon Q2 payments which were lower than Q1 income protected payments
Oxygen	383	334	49	(40)	0	9	
Primary Care IT	1,311	1,320	(8)	40	0	32	
Out of Hours	3,389	3,419	(30)	30	0	0	
Other Primary Care	2,816	4,323	(1,508)	1,263	72	(173)	£156k PMS premium (budget on Primary Care - PMS)
Total Other Primary Care	**64,065**	**66,876**	**(2,811)**	**2,508**	**72**	**(231)**	
Total Primary Care							
Total Primary Care	**113,303**	**115,267**	**(1,963)**	**1,819**	**79**	**(66)**	

Item Number: 7

Name of Presenters: Fiona Bell-Morritt and Gary Young

Meeting of the Primary Care Commissioning Committee

Date of meeting: 26 November 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title: Primary Care Network Plans for use of General Practice Forward View Organisational Development and Winter Resilience Funds

Purpose of Report - For Approval

Reason for Report

To inform the Committee of the Primary Care Network plans and priorities for winter resilience and organisational development in line with identified funding. These are attached to the report.

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 PCCC to approve the Primary Care Network submissions and plans to release national GP forward view funding.

Decision Requested (for Decision Log)

OD and winter resilience plans submitted by the PCNs approved and release of identified funding as per allocations in the paper supported.

Responsible Executive Director and Title	**Report Author and Title**
Stephanie Porter Interim Director of Primary Care and Population Health	Fiona Bell-Morritt and Gary Young Lead Officers Primary Care

1: Purpose of the paper:

The aim of this paper is to update PCCC on the planning and priorities that the PCN's are identifying to support their ongoing development against the maturity matrices. The PCN's have submitted these priorities in appendix 1 as areas for funding under the above organisational development allocations. Plans for the GPFV winter resilience funding are also shown.

Assurance for these plans is requested from PCCC

2. Background:

The Humber, Coast and Vale ICS has recently received notification of the allocation for GP Forward View and Primary Care Network Organisational Development Funding for 2020/2021. This money aims to both support primary care to deliver resilient services over the winter period, and to continue the development of PCN's as mature organistions. The STP Primary Care Programme SRO and Director have agreed an approach of 'learning by doing' as a pragmatic way to demonstrate the development journey for PCNs and have secured agreement to combine uncommitted GPFV monies along with the PCN OD funding. This has created a single pot of circa £2m which has been allocated on a weighted capitation basis to all PCN's across the Humber Coast and Vale area.

To release the identified allocations, PCN's have been requested to develop and agree a plan for how the money will be spent. These plans should be approved by the CCG's Primary Care Commissioning Committee. The aim is to give PCNs the opportunity to develop the best local plan to support capacity and resilience for primary care throughout the winter, whilst providing the opportunity for learning and development of the PCN along the way. Whilst monitoring re achievement of the plan is required for governance and assurance purposes, CCGs will take assurance primarily from PCNs delivering on what has been outlined within the plan, rather than through any formal oversight.

The funding for the PCNs will be allocated to the CCGs on the next available payment run subject to approval by PCCC. Allocations, by PCN, are shown in the table below.

3. GPFV Funding Allocations: Vale of York Primary Care Networks:

PCN	Weighted Population @ 01/01/20	OD Money	GPFV	Total
Priory Medical Group PCN	52,492	197,499.32	109,453.23	306,952.56
West, Outer and North East York (WoNE York)	49,307	185,513.84	102,810.93	288,324.77
York City Centre PCN	45,173	169,961.36	94,191.82	264,153.17
York East PCN	44,479	167,349.87	92,744.54	260,094.42
York Medical Group PCN	40,007	150,522.94	83,419.13	233,942.07
Selby Town PCN	52,983	199,344.70	110,475.93	309,820.63
South Hambleton and Ryedale PCN	39,598	148,985.33	82,567.00	231,552.33
Tadcaster & Selby Rural Area PCN	29,455	110,822.64	61,417.41	172,240.05
Total Weighted Population	353,493	1,330,000	737,080	2,067,080

PCN plans are expected to link to the 5 key headings for PCN organisational development in the PCN maturity matrix:
- Leadership, Planning and Partnerships
- Use of data and population health management
- Integrating Care
- Managing resources
- Working with people and communities

Supported by the Lead Officers for Primary Care, all PCN's have submitted plans against these themes– (see appendix 1 for PCN level detail and priorities). Plans have been shared across City and across Vale as they have emerged to share learning and thinking about opportunities.

4. Core Themes: Under the five organisational development headings in the maturity matrix for PCN's some key themes have emerged in the plans across the Vale of York. Plans are bespoke to the needs of the PCN localities.

a. Leadership, Planning and Partnerships

The majority of PCN's have submitted plans to use some OD money to develop a range of supporting roles to help with PCN development and maturity. These include:
- enhancing the input from practice managers in PCN and system activity and developing their leadership ability and capacity;
- Establishing PCN level managers to develop governance frameworks and structures, --
- developing deputy CD Roles in some localities.
- development of clinical leadership for a range of key pathways and services as identified within the localities: eg: mental health, end of life care, heart failure, community services,

b. Use of data and population health management

- project management and data support for PCN's to gather, understand and manipulate data.

- time for a lead clinician for population health management approach with partners

c. Integrating Care

- resource to support integrating services with system partners
- contribution towards migrating EMIS practices onto SystmOne
- contribution towards implementing online consultations (Klinik) to support patient flow and resilience

d. Managing resources

- funding to bring forward mental health practitioner roles in advance of the additional roles funding for 2021/22
- management time to optimise delivery of the DES, ensure that submissions are completed on time for reporting, and to ensure that payment for additional activity is able to be secured.

5. Winter Resilience:

A separate allocation is identified in the table above specifically to "Support a Winter plan to increase capacity and resilience timed with the traditional increase in urgent care needs in the Christmas and New Year period and the second wave of Covid-19". Key themes in the PCN plans:

- a predominant focus on the delivery of additional clinical sessions across primary care (including GP, nurse led clinics, pharmacy and phlebotomy) to offer additional capacity over the winter period. Plans bespoke to the needs of each locality.

- in some localities the focus is on providing additional sessions to support some of our most vulnerable patients, incuding additional sessions for people with learning disabilities or serious mental illness or complex frail patients – aim to improve care planning and to provide proactive support throughout winter. These sessions will complement those provided under Improving Access for general same day urgent care.

6. Recommendation

PCCC are asked to note the OD and winter resilience plans submitted by the PCNs and to support release of identified funding as per allocations in the paper.

OD 2020-21

Income

OD monies £ 38,463.36

	Sum	Detail	NETWORK DEVELOPMENT PLAN	
			Maturity Matrix Theme	Priority Area
Expenditure	£10,000	Contribution to support migration from Emis to S1 (Beech Tree Surgery)	Integrating care	Support needed to implement the interface between EMIS and S1 and shared records etc.
	£12,500	Contribution to PCN wide on line consultation system (Klinik) to replace Engage Consult	Integrating care	Aligning systems & proceesses
	£16,215	2 x MHP from Feb - Mar 2021 (Based on Band 7/£48,645 p/a) Aim to do this via collaborative working with existing system partners to avoid destabilising currnent system	Managing resources	To recruit in advance of April 21, 2 x Mental Health Practitioners to support the PCN priority agenda & population health management work
	£38,715			

Note

Balance from 2019/20 OD monies @ 31.10.20 was £1,121.40

GPFV 2020-21

Income

GPFV monies £ 21,316.22

	Sum	Detail	Breakdown	Narrative
Expenditure	£11,922	Contribution to practices to support 20/21 Flu season		Additional costs incurred as a result of Covid secure requirements
		Beech Tree	£4,021	
		Posterngate	£4,356	
		Scott Road Medical Centre	£2,753	
		Escrick	£793	
	£9,100	26 x additional clinical sessions (Dec 20 - Mar 21) Costs based on £100 p/h for a GP. No of sessions could be increased if carried out by nurse/pharmacist who are calculated at £50 p/h		To allow for care plans to be produced for those identified as severely frail/ the cohort of Pts identified via Population Health Management Programme To provide additional support for patients with learning disabilities/SMI
	£21,022			

Note

The clinician providing any additional session will depend on timing & staff requirements re the Covid vaccination campaign

TADCASTER AND SELBY RURAL PCN - OUTLINE PLAN FOR ORGANISATIONAL DEVELOPMENT FUND AND GPFV/WINTER RESILIENCE FUND

OD FUND

The PCN has reviewed its maturity matrix and the needs identified to tie our organisational development funding into moving this forward.

Our proposed plan is as follows;

Area	Approx Costing	Maturity Matrix
PCN Manager role	£20,000	'Managing Resource' – in order to drive forward our additional roles portfolio and create a cohesive PCN team we need s dedicated resource to developing the individuals, processes and systems and helping to embed those successfully in practice 'Leadership Development' – the role will develop into a leader for the PCN economy and work alongside our partners in the ICS to bring improved health outcomes and reduce health inequalities
Estate – rental of space	£3000	'Service improvement – creating a cohesive team to support PCN practices. The surgeries have no space to host the PCN as it expands and they need to be able to create a team ethos whilst embedding their services into all the surgeries. Staff retention is paramount for these roles and isolation has been identified as a key cause for people to leave PCN roles. We want to create a strong team that will work together to achieve PCN objectives

GPFV/WINTER RESILIENCE FUND

Area	Costing	Plan
Additional locum / staff sessions to increase availability of services during winter pressure periods.	£11,850	The surgeries will devise a winter pressure plan for the allocation of funds to additional sessions and services. This is to include additional clinical cover at times of pressure

		and support services affecting direct patient care (e.g. such as dispensing). This will allow additional resource and also offer a level of protection should staff be off isolating or after positive COVID tests. Each surgery will have flexibility to produce a plan to their patients' needs rather than a 'one size fits all' approach. This additionality will also be a way of improving individual staff resilience and improved mental health over the winter pressure period.

South Hambleton and Ryedale Primary Care Network

SOUTH HAMBLETON AND RYEDALE PCN: Organisation Development workstreams currently in progress November 2020

Maturity matrix theme	Proposal	Resource	Cost
Leadership, planning & partnerships	Backfill for practice managers attending the STP Incubator programme to develop PM skills and competencies	6 Practice Managers & 2 project managers 7x2.5 hour sessions	£4550
Leadership, planning & partnerships	Backfill for Practice Manager to undertake PCN priority projects and to make links with other system partners, applying QI training above.	6 Practice Managers 10 hours per project	£2100
Leadership, planning & partnerships	Time to support clinical leadership for the mental health in primary care pathways and development of MDTs	Dr. Sarah Utting 1 session per month	£4800
Leadership, planning & partnerships	Primary care member of York Trust's Joint Planned Care Board	Dr. Paula Evans 1 session alternate months	£2400 pa
Use of data and population health management	Funding for one day a week project management support to progress PCN priorities and 1 day a week for a PCN data lead to support population health management data and looking at variation across practices/data submissions etc. Plus dedicated training in QI & creation of real time data.	Gill Barrett Cheryl Secker (starting 1/12/20)	£19,500 pa
Use of data and population health management	Time for a lead clinician to undertake some of the population health management work (as not part of the current STP programme)	GP Clinical Leads (Drs. Paula Evans & Helena Ebbs) 4 sessions	£1600

	to enable PCN to shape locality priorities based on need.		
Leadership, planning and Partnerships, and use of data and population health management., Integrating Care	Funding to support participation in the redesign of St Monicas community hospital to shape new integrated pathways with system partners based on a population health management approach and needs analysis	Dr Paula Evans 6 sessions	£2400
Leadership, planning and partnerships; integrated care; use of data and population health management	Time for clinical leadership to revise current commissioning pathways and support for end of life care/ specialist palliative care with the aim of integrating services and supporting patients to remain at home	Dr. Helena Ebbs 6 sessions	£2400
Leadership, planning and partnerships; integrated care	Urgent & Same Day Emergency Care system redesign	Dr. Sarah Utting 6 sessions	£2400
Leadership, planning and Partnerships, and use of data and population health management., Integrating Care	Heart Failure community service re-design. SHaR PCN has the highest prevalence of heart failure in the CCG	Dr. Sarah Watson 4 sessions	£1600

Total cost

I. Defined projects **£21,850**
II. Contribution to per annum ongoing costs **£6896** (=3.78 months)

Allocation: £28,746.57

South Hambleton and Ryedale
Primary Care Network

Winter resilience proposal

The aim of these sessions is to maximise the completion of health checks, refine & embed preventative & anticipatory care for patients with Learning Disabilities (circa 110 reviews) and Serious Mental Illness (circa 190 reviews). They will be delivered in the 4 weeks period from mid December 2020. Once this work is completed, the sessions will be used to augment practice capacity.

	£ per hour	4h session	No. sessions	£
GP	100	400	21	8400
Nurse	50	200	15	3000
Clinical Pharmacist	50	200	15	3000
Phlebotomy	25	100	15	1500
		Total		**15900**

Allocation: £15,931.22

Paula Evans Clinical Director 13th November 2020

WONE PCN GPFV and Organisational Development Funding Plan

Principles

1. *Support the establishment of a new three practice PCN with appropriate governance and involvement of practice teams to fulfil the PCN DES aims.*
2. *Facilitate PCN CD involvement in system working to benefit all patients in the city and work with all practices.*
3. *Support a Winter plan to increase capacity and resilience timed with the traditional increase in urgent care needs in the Christmas and New Year period and the second wave of Covid-19.*

AIM	**COST (£)**
Establishing and supporting good governance in the PCN	
Julie Lund – PCN manager	6000
HR support for recruitment	3000
Gwen Johnson – PCN Finance manager	6000
Involvement of practice teams	
Practice managers and GP partner involvement in monthly PCN planning	6000
Mel Bradshaw - Business information support	500
Palliative Care Project Leads in each practice	4000
Mental Health and Learning Disability Project Leads in each practice	4000
PCN CD involvement in System Working (includes "learning by doing" and by the example of other system leaders)	**COST across all projects**
	7000
Covid Monitoring Hub	
Peppermill Court Covid Step Down	
Opel 4 practice safety net development	
Primary Care/Community Covid response team meeting	
York Health and Care Collaborative	

Winter Plan to increase capacity and resilience

December and January injection of extra urgent appointments, aiming to limit A+E attendance and leave patients without unaddressed health care needs during the holiday season.

Including telephone and face to face access. Plan for adding extra in and out of hours care.

4 hour GP clinics x 40	**Cost £16000**
4 hour nurse/ACP clinics x 15	**Cost £3000**
2 hour phlebotomy clinics x 4	**Cost £200**
	TOTAL SPEND £55700

Priory Medical Group PCN's GPFV and OD plan

OD Monies (total budget = £38,107)

- PCN finance and governance meetings
- Ongoing Internal PCN (Executive) meetings
- Internal CD meetings (shared post)
- Palliative Care leads training and meetings
- Prescribing Leads meetings
- Releasing CD time towards forward planning and their own development
- Development/training of an in-house mental health team in response to increased demand/impact of COVID
- Setting up an education training programme for our PCN Additional Roles team & Allied Professionals

GPFV monies (total budget = £21,118.9)

- Ongoing External PCN meetings (System Involvement)
- Population Health Management:
    - Active engagement in the York ICS development work, including attendance at PHM workshops, YHCC, York Health and Well Being attendance.
- Winter pressures:
    - 30 'additional' GP sessions
    - 30 'additional' practice nurse sessions

If you require any further information please do let us know.

Kind regards,

Emma Olandj & Emma Broughton
Clinical Directors
Priory Medical Group

York East PCN Organisational Development and Winter Resilience Plan

Principles:

1. Develop and provide continuing support of the new York East PCN, which encompasses MyHealth Group, Pocklington Group Practice and Elvington Medical Practice.
2. Establish appropriate governance principles through the involvement of all practice teams to ensure the aims of the PCN DES are met and provide benefit to the patient population
3. Ensure PCN CD involvement within the system to build relationships and cohesion, to ensure patients within the East Riding area of our geography have the same access to care as patients within the City of York.
4. Develop a winter plan (with GPFV monies) to increase capacity and resilience to support the anticipated increase in urgent care needs during the Christmas Period and Covid-19.

Aims:

Establishing and continued support of good governance in the PCN

Joanne Rowe PCN Manager and Berni Judge Development of Legal Schedules and Governance	£6,000
Eleanor Cox – Administrative Support	£ 500
Lisa Watson – HR support/recruitment	£3,000
Jayne Bone – Financial Support	£3,000

Involvement of Practice Teams

Management and GP Partner involvement in weekly PCN meetings	£6,000
Emma Bone – Business Information Support	£ 500
Cancer Care/Palliative Care Leads from each Practice	£3,000
Mental Health and Learning Disability Leads from each Practice	£3,000

PCN CD Involvement in System Working –cost all projects **£7000**

Covid Monitoring Hub

Peppermill Court Covid Step Down

Opel 4 Practice Safety Net Development

Primary Care/Community Covid response team working

York Health and Care Collaborative attendance

Total OD Monies **£32,000**

Winter Plan to increase capacity and resilience

The months of December and January are traditionally a time of increased demand. This has been further exacerbated by the current situation and changes in ways of working. In previous years similar funding has helped reduce these pressures and improve access to patients at a traditionally busy time.

Proposal for extra clinics to be put provided across the PCN (pro rata) in the following areas:

4 hour GP clinics (£450/clinic)	x 33	**Cost £14,850**
4 hour nurse/ACP clinics (£250/clinic)	x 10	**Cost £2,500**
3 hour Diagnostics/HCA clinics(£100/clinic)	x 5	**Cost £500**
TOTAL		**£17,850**

(the above are for illustration and may flex depending on need/demand)

TOTAL SPEND £49,850

YMG PCN GPFV and Organisational Development Funding Plan

Principles

1. *Support the development of our PCN with appropriate governance and involvement of practice teams to fulfil the PCN DES aims.*
2. *Facilitate PCN CD involvement in system working to benefit all patients in the city and work with all practices.*
3. *Support a Winter plan to increase capacity and resilience timed with the traditional increase in urgent care needs in the Christmas and New Year period and the second wave of Covid-19.*

AIM	**COST (£)**
Establishing and supporting good governance in the PCN	
HR support for recruitment	3000
Parson's finance support for PCN	6000
Involvement of practice teams	
Practice managers and GP partner involvement in monthly PCN planning	3000
Tom Dolman - Business information support	500
Palliative Care Project Leads- clinical site leads, and admin support	3000
Mental Health and Learning Disability Project Leads in each practice	3000
Social prescribing project lead	4000
Care home clinical and administration leads/ planning meetings	3000
PCN CD involvement in System Working	**COST across all projects**
	3500
York Health and Care Collaborative	
York Place Leaders Board	
Fortnightly CD meetings across York.	
Development of integrated MSK provision- planning meetings.	
Covid/ community interface meetings	
Primary Care Ops Group meetings	

SUB-TOTAL £29,000

Winter Plan to increase capacity and resilience (GPFV MONEY)

Centralised Contact Centre to manage remote and digital demand	3000
Backlog LD checks/ smears	2000
Work on LTC stratification/ prioritisation	1000
YMG Wellbeing and personal resilience Programme	2000

Increased Capacity to support winter pressures & Wave 2 Covid-19

Employing 6 session GP for 6 months to cover winter pressures- this money (£17,000) will contribute to this

SUB-TOTAL £17,000

TOTAL £46,000

York City Centre has been allocated:

GPFV	£32793.88
Organisational Development Plan	£18174.22
Total	£50968.10

York City Centre PCN		
AIMS:- • Support the three practice PCN with appropriate governance and involvement of practice teams to fulfil the PCN DES • Support a plan to increase capacity during the Christmas period and the second wave of COVID-19 • Facilitate PCN CD involvement in system working to benefit all patients in the city and work with all practices		
Leadership Planning and Partnerships	Succession planning – Training/developing a Deputy Clinical Director who will be able to step into the role when the current Clinical l Director retires.	5000
Leadership Planning and Partnerships	Leadership training via a profession body i.e. NHS leadership academy for the newly appointed Deputy Clinical Director.	2000
Leadership Planning and Partnerships	Leadership training for Practice Managers to include system change and coaching.	2000
Leadership Planning and Partnerships	Board development and continued facilitated setting of shared vison and PCN priorities to ensure we are aligning our future development planning to current needs. Inter PCN liaison meetings Palliative Care and Mental Health/Learning Disability Meetings with clinical leads Meetings with PCH, Better health care fund and CCG Meetings with LMC Meetings with York hospital Meetings with NIMBUS Meetings with TEWV Meetings with Practice Managers and Business and Finance Managers Mental Health and learning Disability Leads in each practice	3000

	Palliative Care Leads in each practice Meetings with TEWV	
Use of data and population health management	Recruiting and training a QI assistant to assist with identify PCN population needs. Meetings with Social Prescribers to review patient outcomes, increase appointments.	5000
Use of data and population health management	RAIDAR training to assist with identifying population health needs.	2500
Integrating Care	Development of PCN IA service. Engaging in Mass flu vaccination service. Engaging with COVID vaccination service/training. Engaging with Asylum Seeker service. Engaging with York Health and Care Collaborative Engaging with Peppermill Court Covid Step Down Engaging with service delivery from mass vaccination site.	2000
Managing Resources	Recruitment/Training for two x First Contact Physiotherapists. Recruitment /Training of Care – Coordinator Management of additional PCN staff Networking between PCN practices Continued funding of DPO to ensure governance	6000
Working with people and communities	Backfill utilised in the following areas: 1. Monthly Central York CD meetings 2. David Hartley additional CD role 3. PCN neighbourhood meetings 4. NIMBUS meetings 5. Better Care meetings 6. PM meetings 7. PPG meetings	4500
Working with people and communities	Meetings with CVS	500
Increasing winter capacity	Development of Care Home Model, to include expansion of clinical team to inc. additional GPs and nurses to assist with winter and COVD pressures which will provide additional appointment. Expansion of clinical team to inc. Pharmacists, Pharmacy Technician and Care-coordinator, providing additional F2F appointments and release GP time.	18200

	Early recruitment of two Mental Health Workers to assist with winter and COVD pressures, providing additional appointments. As a result of the capacity released by expanding these areas, the PCN has recruited one extra GP (5 sessions/week) and one extra nurse (2 sessions/week) to provide additional sessions	
TOTAL SPEND		51500

Prepared by City of York PCN – DCH/WS 17.11.2020

Item Number: 9

Name of Presenter: Abigail Combes

Meeting of the Primary Care Commissioning Committee

Date of meeting: 26 November 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title - Risk to Primary Care Commissioning Committee

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

Reason for Report

The CCG has adopted a risk policy and strategy which includes a risk appetite statement and a risk matrix scoring system. The Covid-19 pandemic has led to the CCG reviewing which committees hold and manage risk and there is a view that there is an urgent need for Primary Care Commissioning Committee to review its role in this process and to recommend to the Governing Body the approach that it would like to take.

At the adoption of the Risk Appetite statement the CCG was clear that quality and safety risks were risks which the CCG had a low tolerance for. This, in practice, means that these risks should be reported more swiftly through the organisational structure and will appear more regularly and readily at Governing Body however the CCG have an open appetite to other areas of risk and therefore are tolerant of senior officers in the CCG or committees managing those risks.

The CCG Governing Body is responsible for determining the organisations risk appetite and does so on the basis of a series of scenarios.

It has become apparent that during the pandemic, service delivery risks in primary care are a significant concern along with service delivery of medicines in the event of a no deal EU Exit which is approaching at the end of January.

This committee is invited to consider what recommendation it would make to the Governing Body about a revision of the risk appetite statement for these two areas and any others relating to primary care which it believes require review.

The strategy and policy is attached as an appendix. Pages 15-16 seek to provide a description of the risk appetite along with a table setting out the thresholds for each of the areas.

The wording for Service Delivery Risks is currently:-

‘The CCG is open to risk in service delivery except where this compromises patient safety. For example should staffing be an issue which may cause difficulties with meeting service needs, the CCG is tolerant of this and does not seek escalation of the issues above the operational managers. The CCG is, however, concerned where this puts patients at risk.’

This is where the CCG would support a tolerance of significant impact/serious inconvenience. The committee may take a view that in the current situation the CCG should have a moderate or cautious approach to risk which would be small or medium impact and inconvenience.

The committee is also asked to confirm that it would want to be aware of risks relating to primary care and community pharmacy service delivery risks and secondly risks relating to the availability of medicines either because of the pandemic or because of the EU Exit arrangements.

Strategic Priority Links

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

Local Authority Area

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

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

Emerging Risks

Impact Assessments

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

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

Risks/Issues identified from impact assessments:

N/A

Recommendations

To review the risk appetite statement for service delivery and recommend any amendments to Governing Body

Decision Requested (for Decision Log)
To confirm adoption of a risk process for the Primary Care Commissioning Committee.

Responsible Executive Director and Title	**Report Author and Title**
Stephanie Porter Interim Executive Director for Primary Care and Population Health	Abigail Combes Head of Legal and Governance

NHS
Vale of York
Clinical Commissioning Group

RISK MANAGEMENT POLICY AND STRATEGY
January 2020

Policy Ref:	COR03
Date Issued:	
Date to be reviewed:	January 2022

Authorship:	Head of Legal and Governance
Reviewing Committee:	Audit Committee
Date:	
Approval Body:	Governing Body
Approved Date:	
Review Date:	January 2021
Equality Impact Assessment:	Yes
Sustainability Impact Assessment:	Yes
Related Policies:	NHS Vale of York CCG Constitution (including Standing Orders); Information Risk Management Strategy NHS Vale of York CCG Policies
Target Audience:	All employees, members, committee and sub-committee members of the group and members of the governing body and its committees
Policy Reference No:	COR03
Version Number:	5.0

APPROVAL RECORD

	Committees / Groups / Individual	**Date**
Consultation:	Governing Body	October 2019
	Senior Management	November 2019
	Specialist Advice (if required)	N/A
Approved by Committees:	Audit Committee	28 November 2019
	Governing Body	January 2020

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1. INTRODUCTION

1.1 Good risk management awareness and practice at all levels is a critical success factor for Vale of York Clinical Commissioning Group (the CCG). Risk is inherent in everything that we do, from determining service priorities, taking decisions about future strategies, or even deciding not to take any action at all.

1.2 Although we manage risk continuously – sometime consciously and sometimes without realising it, we do not always manage risk systematically and consistently.

1.3 In accordance with the guidance contained in The Health NHS Board 2013: Principles for Good Governance (The NHS Leadership Academy); and ISO31000; the CCG will undertake a systematic approach to the management of risk that builds public confidence. It is clear, however, that the future sustainability of the NHS and its founding values will require creative and innovative solutions to ensure that risk and innovation are not perceived to be mutually exclusive. The CCG proposes to implement a system of internal controls which will encompass financial controls, organisational control and clinical governance. The system of internal controls is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:

- Identify and prioritise the risks to the achievement of the CCG's priorities, aims and objectives;
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

2. POLICY STATEMENT

2.1 The CCG is committed to a strategy, which minimises risk to all its stakeholders through a comprehensive system of internal controls, whilst maximising potential for flexibility, innovation and best practice in delivery of its strategic objectives to improve the health of all the residents within the CCG.

3. IMPACT ANALYSIS

Equality

3.1 As a result of performing the screening analysis, the policy does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage. The results of the screening are attached.

Sustainability

3.2 A Sustainability Impact Assessment has been undertaken. Positive and negative impacts are assessed against the twelve sustainability themes. The results of the assessment are attached.

4. SCOPE OF THE POLICY

4.1 This policy applies to all employees of the CCG in all locations including temporary employees, locums and contracted staff.

5. POLICY PURPOSE/AIMS AND FAILURE TO COMPLY

5.1 The purpose of this document is to provide guidance to all staff within the CCG on the management of strategic, operational and project risks within the organisation and will describe the procedures to be used in identifying, analysing, evaluating and monitoring risks to the delivery of key objectives.

5.2 The objectives of this strategy and policy are to:

- Promote awareness of business risk and embed the approach of its management throughout the Group
- Ensure that risk management is an integral part of the CCG's culture;
- Seek to identify, measure, control and report on any risk that will undermine the achievement of the CCG's priorities, both strategically and operationally, through appropriate assessment criteria; and
- Monitor and measure the overall performance of the Risk Management Policy and Assurance Framework and the way in which it contributes to the achievement of business activities.

5.3 Failure to comply with policy may result in risks not being appropriately identified and effectively managed.

6. PRINCIPLE LEGISLATION AND COMPLIANCE WITH STANDARDS

6.1 The CCG needs to ensure that appropriate arrangements are in place to comply with CCG statutory duties, including:

- Health and Social Care Act 2012
- Data Protection Act 1998
- Mental Capacity Act 2005
- The Human Rights Act 1998
- Equality Act 2010
- Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
- United Nations Convention on the Rights of the Child
- Employment Rights Act 1996
- Health and Safety at Work Act 1974
- Management of Health and Safety at Work regulations 1999
- The Workplace (Health and Safety and Welfare) Regulations 1992
- Freedom of Information Act 2000

- Information Governance Toolkit standards and requirements

The CCG Constitution

6.2 The CCG Constitution requires that the Audit Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk across the whole of the Clinical Commissioning Group's activities that supports the achievement of its objectives.

7. ROLES/RESPONSIBILITIES/DUTIES

Governing Body

7.1 The Governing Body has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes and controls in place to mitigate those risks and the impact that they have on the organisation and its stakeholders. The Governing Body discharges this duty as follows:-

- Identifies risks to the achievement of its strategic objectives;
- Monitors these via the CCG Board Assurance Framework;
- Ensures that there is a structure in place for the effective management of risk throughout the CCG;
- Approves and reviews strategies for risk management on an annual basis;
- Receives regular reports from the Finance and Performance Committee; the Quality and Patient Experience Committee; the Executive Committee and the Primary Care Commissioning Committee identifying significant risks; and
- Demonstrates leadership, active involvement and support for risk management.

7.2 The CCG Governing Body is responsible for approval of arrangements for risk sharing or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commission groups or pooled budget arrangements under section 75 of the NHS Act 2006)

7.3 Where the CCG makes arrangement with another CCG to co-commission services, the CCG shall agree how risk will be managed and apportioned between the parties.

The Audit Committee

7.4 The Audit Committee is responsible for providing assurance to the Governing Body that the CCG's Assurance Framework is valid and suitable for the significant risks to achieving its strategic objectives and that these controls are operating effectively.

7.5 The Chair of the Audit Committee is the Lay Member lead for risk management.

The Accountable Officer

7.6 The Accountable Officer has overall accountability for the management of risk and with support from the Head of Legal and Governance is responsible for:

- Continually promoting risk management and demonstrating leadership, involvement and support;
- Ensuring an appropriate committee structure is in place, with regular reports to the Governing Body;
- Ensuring that Directors and Senior Managers are appointed with managerial responsibility for risk management;
- Ensuring that appropriate Policies, Procedures and Guidelines are in place and operating throughout the CCG;
- Ensuring risk management systems are in place throughout the CCG;
- Ensuring the Board Assurance Framework is regularly reviewed and updated;
- Ensuring that there is appropriate external review of the CCG's risk management systems, and that these are reported to the Governing Body;
- Overseeing the management of risks as determined by the Executive Group;
- Ensuring risk action plans are put in place, regularly monitored and implemented.

The Executive Director of Quality and Nursing

7.7 The Executive Director of Quality and Nursing supports and promotes risk management processes where they link with the Quality Strategy and those Regulatory Factors associated with the Quality and Nursing team, e.g. Serious Incidents and CQC Regulation.

7.8 The Executive Director of Quality and Nursing is the Caldicott Guardian for the organisation and oversees the Caldicott log. The Director may be supported by their Deputy in the discharge of this function provided that Deputy has been appropriately trained as a Caldicott Guardian.

The Executive Director for Primary Care and Population Health

7.9 The Executive Director for Primary Care and Population Health, support by the Assistant Director for Primary Care will be responsible for promoting risk management processes with all NHS Vale of York CCG member practices. This ensures that practices continuously improve quality of primary care and report risks to the CCG for assessment and mitigation.

The Chief Finance Officer

7.10 The Chief Finance Officer is the organisation's Senior Information Risk Owner (SIRO). The SIRO is responsible for reviewing and approving information asset risk assessments and ensuring that information risks are managed appropriately.

Senior Managers

7.11 Senior Managers should incorporate risk management within all aspects of their work and are responsible for directing the implementation of the CCG Risk Management Policy by:

- Demonstrating personal involvement and support for the promotion of risk management
- Ensuring that staff accountable to them understand and pursue risk management in their areas of responsibility
- Setting personal objectives for risk management and monitoring their achievement
- Ensuring risks are identified and managed and mitigating actions implemented in functions for which they are accountable
- Ensuring action plans for risks relating to their respective areas are prepared and reviewed on a regular basis
- Ensuring project/programme risk registers are established and maintained that relates to their area of responsibility and involve staff in this process to promote ownership of the risks identified.
- Ensuring risks are escalated where they are of a strategic nature.

The Head of Legal and Governance

7.12 The Head of Legal and Governance has responsibility for:

- Ensuring that a risk register and Assurance Framework is developed and maintained;
- Ensuring that sub-committees of the Governing Body receive regular risk reports and have the opportunity to review risks jointly;
- Providing advice on the risk management process;
- Ensuring that the CCG Assurance framework and corporate risk register is up to date for the Governing Body and all of its sub committees;
- Working collaboratively with Internal Audit

All Members of Staff

7.13 All members of staff are responsible for:

- ensuring that the risk register and Assurance Framework are updated;
- ensuring that the relevant Executive Director is made aware of any risk associated with their area of business prior to the risk being added to the Register;
- being aware that they have a duty under legislation to take reasonable care of their own safety and the safety of others who may be affected by the CCGs business and to comply with appropriate CCG rules, regulations, instructions, policies, procedures and guidelines;
- Take action to protect themselves and others from risks;
- Identify and report risks to their line manager;
- Ensure incidents, claims and complaints are reported using the appropriate procedures and channels of communication;
- Co-operating with others in the management of the CCG's risks;
- Attending mandatory and statutory training as determined by the CCG

or the individuals line manager;
- Being aware of emergency procedures relating to their particular department locations
- Being aware of the CCG's Risk Management Policy and complying with the procedures.

Contractors, Agency and Locum Staff

7.14 Managers must ensure that where they are employing or contracting agency and locum staff they are made aware of and adhere to, all relevant policies, procedures and guidance of the CCG, including the Incident reporting Policy and Procedure and Health and Safety Policy.

- Take action to protect themselves and others from risks
- Bring to the attention of others the nature of risks which they are aware of

8 DEFINITIONS

8.1 **Assurance –** Assurance is a holistic concept based on best governance practice. It is a process designed to provide evidence that the CCG is doing its 'reasonable best' to manage itself so as to meet its objectives, protect patients, staff, the public and other stakeholders against risks of all kinds. It is a fundamental process of governance that will assist us in identifying risks, determining unacceptable levels of risk and deciding where best to direct our limited resources to eliminate or reduce those risks. It exists to inform the CCG Governing Body about significant risks within the CCG for which they are responsible.

NHS Vale of York CCG use a Board Assurance Framework document to undertake the assurance role. This details progress against the strategic objectives and also covers the areas which are assuming the majority of the CCG Director input. This document is intended to provide the Governing Body with assurance that the matters discussed at Governing Body are broadly those which the CCG has on its risk register.

8.2 **Risk -** risk is the "effect of uncertainty on objectives" and an effect is a positive or negative deviation from what is expected

8.3 **Risk Management -** Risk management refers to a coordinated set of activities and methods that is used to direct an organisation and to control the many risks that can affect its ability to achieve objectives.

The term risk management also refers to the programme that is used to manage risk. This programme includes risk management principles, a risk management framework, and a risk management process.

8.4 **Risk Management Plan -** An organisation's risk management plan describes how it intends to manage risk. It describes the management components, the

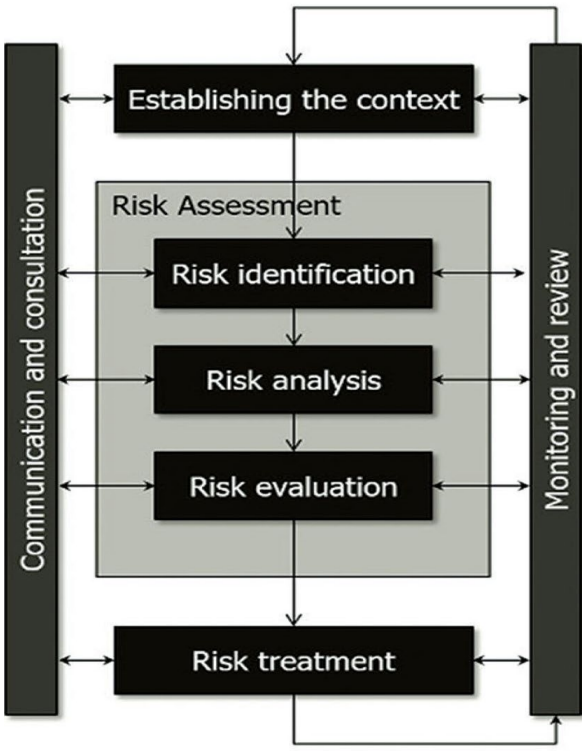
approach, and the resources that are used to manage risk. Typical management components include procedures, practices, responsibilities, and activities (including their sequence and timing). Risk management plans can be applied to products, processes, and projects, or to an entire organization or to any part of it.

8.5 **Risk Management Process -** According to ISO 31000, a risk management process systematically applies management policies, procedures, and practices to a set of activities intended to establish the context, communicate and consult with stakeholders, and identify, analyze, evaluate, treat, monitor, record, report, and review risk.

8.6 **Risk Owner -** A risk owner is a person or entity that has been given the authority to manage a particular risk and is accountable for doing so.

8.7 **Risk Treatment (also referred to as Mitigation) -** Risk treatment is a risk modification process. It involves selecting and implementing one or more treatment options. Once a treatment has been implemented, it becomes a control or it modifies existing controls.

You have many treatment options. You can avoid the risk, you can reduce the risk, you can remove the source of the risk, you can modify the consequences, you can change the probabilities, you can share the risk with others, you can simply retain the risk, or you can even increase the risk in order to pursue an opportunity.



PROCESS

8.8 **Significant Risks –** Significant risks are those which, when measured according to the risk matrix at Appendix 3 are assessed to be high or extreme or threaten an objective. The CCG Governing Body will take an active interest in the management of significant risks and will consider whether they need to be included on the Assurance Framework for on-going assurance.

8.9 **The Assurance Framework –** The assurance framework provides the organisation with a simple but comprehensive method for the effective and focused management of the principal risks to meeting objectives. It also provides a structure for the evidence to support the Annual Governance Statement. This simplifies Governing Body reporting and the prioritisation of action plans, which, in turn allow for more effective performance management.

9. PRINCIPLES OF RISK MANAGEMENT

9.1 The CCG is committed to a risk management strategy that enables the CCG to achieve its key priorities which are as follows:

Strengthen	• GP services and support practices working closer together within their communities • Breaking down the barriers between community services at a local level • Clinical engagement focused on the patient pathway • Partnerships to support the transformation of hospital services
Improve	• Access and quality of mental health services for adults and children • Cancer outcomes and quality
Facilitate and influence	• Strategic partnerships with local government and providers • Greater focus on working locally • The creation of Integrated Care System or Partnership that provides safe,high quality services for the local population
Develop	• Leaders for the future
Deliver	• Financial sustainability of the local health and care system

9.2 The CCG will seek to strike a balance between mitigating all risks and encouraging innovation and experimentation, within acceptable limits and where the potential benefits justify the element of risk.

10. WHAT IS AN ACCEPTABLE RISK?

10.1 The CCG recognises that it is impossible and not always desirable to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve

health benefits for local residents. In order to establish a consistent framework for the assessment and management of risk, the CCG has adopted a risk assessment tool and has determined the levels of authority at which risks should be addressed. Risks identified as being in the extreme of high categories are regarded as significant risks and should be reported to the appropriate Committee.

10.2 The CCG will, however, as a general principle, seek to eliminate or reduce all identifiable risk to the lowest practicable level and control all risks which have the potential to: harm its staff, patients, visitors and other stakeholders; have a high potential for incidents to occur; would result in loss of public confidence in the CCG and/or its partner agencies; would have severe financial consequences which would prevent the CCG from carrying out its functions on behalf of its residents. The CCG is committed to achieving this through its holistic approach to risk management within the clinical and corporate governance agendas.

10.3 All identified risk should be brought to the attention of the relevant member of the CCG Deputies group highlighted in the structure at Appendix 4. They will have the responsibility of assessing the risk in accordance with the risk assessment tool.

11. RISK APPETITE

11.1 The adoption of a risk appetite statement is considered a fundamental aspect of risk management and is set out in a number of authoritative sources:

- Treasury guidance: it is essential that both private and public organisations set out the Boards attitude to risk and that this is used to inform decision making
- British Standard (BS31100) states “the organisation should prepare a risk appetite statement which may provider direction and boundaries on the risk that can be accepted at various levels of the organisation, how the risk and any associated reward are to be balanced and the likely response”
- The UK Corporate Code of Governance sets out that “The board is responsible for determining the nature and extent of the principal risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management and internal control systems.”

11.2 The CCG recognises the importance of having a documented statement that reflects its approach to risk appetite/tolerance in line with British Standard BS31100 which provides direction and boundaries on the risk that can be accepted at various levels of the organisation and how the organisation responds to risk to ensure that the level of risk and any associated reward are to be balanced.

11.3 The CCG is not risk averse and recognises that decisions with the potential to improve services or performance can also carry risks. This should not deter from making the decision, but is considered when making the decision so that

the decision is informed based on the risk assessment and a decision on the level of tolerance of any risks.

11.4 The CCG's approach to risk is that:

- The lower the appetite for risk the less the CCG is willing to tolerate the consequence and there is a requirement for higher levels of controls and assurance to manage the risk.
- The higher the CCG appetite for risk, the more the CCG is willing to accept potential consequences in order to achieve objectives. The CCG will accept business as usual activity for established systems of internal control, and will not necessarily seek to strengthen those controls above all else.

11.5 The CCG shall prepare a risk appetite statement that shall be reviewed annually in line with the refresh of the CCG's Board Assurance Framework.

12. THE CCG RISK APPETITE STATEMENT

12.1 The CCG's Risk Appetite Statement establishes risk tolerance in the following four categories:-

i. Safety risk – The risk that the CCG will not be able to deliver services which are safe for patients.
ii. Compliance risk – The risk that the CCG will not comply with the requirements of legislation and regulation including the NHS Constitution
iii. Financial risk – The risk that the CCG fails to operate within its allocation and therefore operate in deficit
iv. Service Delivery risk – The risk that the CCG is unable to deliver services to patients and is linked to the risks above

12.2 The CCG considered a number of factors to determine risk appetite. With due regard to the risk appetite, when a risk is recorded in the register, it will be categorised as high risk (red), medium risk (amber) or low risk (green) and will be based on an assessment of risk by staff in possession of this statement of risk appetite.

12.3 The risk appetite of the CCG was established by the CCGs Governing Body in October 2019 using the criteria below.

	Finance	Compliance	Safety	Service delivery
Adverse	Minor loss < £1000	Trivial, very short term single non-compliance	Insignificant injury (no intervention)	Negligible impact/unnoticed by service users
Cautious	Small loss £1,001-£10,000	Small, single short-term non compliance	Minor injury (local intervention)	Small impact/small inconvenience
Moderate	Moderate loss £10,001 - £100,000	Sustained single or a few short-term non-compliances	Moderate injury (professional intervention)	Medium level impact/moderate inconvenience
Open	Significant loss £100,001 - £1,000,000	Multiple sustained non-compliances	Major injury (hospital stay)	Significant impact/serious inconvenience
Hungry	Substantial loss > £1,000,000	Multiple, long-term, significant non-compliances	Fatal injury	Substantial/complete service failure

	Approach to Achieving aim/objectives	Potential reward/benefit from risk taking	Organisational culture
Adverse	Safe; exposure to only the very lowest levels of risk	Very low	Little or no empowerment beyond most senior team considerable control over all activities
Cautious	Guarded; as little risk as reasonably possible	Low	Empowerment to senior and key middle managers; strong control over most activities
Moderate	Balanced; exposure to middle-ground risks	Medium	Empowerment to front-line managers; control over some activities, more latitude for others
Open	Creative; elevated levels of risk exposure	High	Empowerment to all managers, supervisors and selected staff; control over small core of activities, considerable latitude for others
Hungry	Pioneering; substantial levels of risk exposure	Extremely High	Widespread empowerment to all managers and staff; very few controls, individual initiative strongly encourage and supported

Overall Risk Appetite Statement

12.4 The CCG has an overall open/moderate risk appetite. The CCG will act in accordance with this risk appetite statement to support its strategic objectives.

12.5 The Governing Body has determined current risk appetite for the CCG as follows:

	Finance	Compliance	Safety	Service delivery
Adverse	Minor loss < £1000	Trivial, very short term single non-compliance	Insignificant injury (no intervention)	Negligible impact/unnoticed by service users
Cautious	Small loss £1,001-£10,000	Small, single short-term non compliance	Minor injury (local intervention)	Small impact/small inconvenience
Moderate	Moderate loss £10,001 - £100,000	Sustained single or a few short-term non-compliances	Moderate injury (professional intervention)	Medium level impact/moderate inconvenience
Open	Significant loss £100,001 - £1,000,000	Multiple sustained non-compliances	Major injury (hospital stay)	Significant impact/serious inconvenience
Hungry	Substantial loss > £1,000,000	Multiple, long-term, significant non-compliances	Fatal injury	Substantial/complete service failure

12.6 This statement must be kept under review as the CCGs mission, objectives and values develop over time and positions change.

12.7 **Safety Risks**

The CCG has a moderate appetite for risk relating to safety. This will cut across a number of areas including where constitutional targets not being met puts patient safety at risk as well as the commissioning of safe services. The CCG must understand the impact of decisions on patients and the safe delivery of services must be the paramount consideration of the organisation.

12.8 **Compliance Risks**

The CCG has an open appetite for compliance risks except where these risk the safety of patients. The CCG understands that it is required to comply with its duties and obligations under legislation and the NHS constitution however the CCG is content that necessary plans are in place to address these as far as this is within the CCGs control. For this reason the CCG is content to accept a level of risk which is associated with a failure to comply with these requirements as steps are taken to address these.

Whilst this is the case the CCG is keen to ensure that where a failure to comply with a requirement directly impacts on patient safety, the CCG has a

low appetite for these risks.

Information Governance Risks also fall under this heading.

12.8 **Finance Risks**

The CCG is currently in deficit and is in Legal Directions in part as a result of this. The CCG therefore has an open risk appetite for financial risks. Broadly speaking this means that the CCG will tolerate a risk of financial loss of between £100,001 and £1,000,000 however this is dependent upon the circumstances. For example where this is unplanned expenditure that ought to have been anticipated had proper horizon scanning or risk management been undertaken this is less tolerable than a change in system position etc.

The Governing Body also views loss as a situation where a projected saving is not going to be delivered and this should be assessed in the same way.

12.9 **Service Delivery Risks**

The CCG is moderate to risk to service delivery. This is the case whether service delivery is put at risk as a result of financial challenges, recruitment challenges or planned staffing changes. The impact of the failure to deliver a service should also be described.

12.10 Whilst the CCG has a moderate to open tolerance of risk generally where there are risks which cut across a number of categories and may fall into a more tolerant category (for example compliance risks); where these are also related to patient safety they should be reported through the relevant committee; a safety risk will take priority over a compliance risk.

12.11 ***Examples***

(i) The CCG has become aware that the local provider of Acute Services has had a significant rise in the number of 12 hour trolley waits. The information which the CCG holds is that this is not uncommon regionally and that the provider is not an outlier on the basis of the figures provided. 12 hour trolley waits is a target that is recorded and provided to regulators and breaches should be reported accordingly. As this matter is a single incident and is not one which the CCG is concerned about, Managers would be in a position to deal with this without escalation to a committee.

The CCG have however become aware that two of the 12 hour trolley waits resulted in significant harm to patients and the Provider did not report these incidents to the CCG in accordance with the escalation requirements. For that reason patient safety becomes a greater concern than compliance with the target and the risk should be recorded as such and escalated to Quality and Patient Experience Committee.

(ii) The CCG has become aware of a service which was commissioned by NHSE from Primary Care has moved to be commissioned by the Trust however there is no specific envelope of money being provided to the Trust to commission the service. There appears to have been a breakdown in communication and the Trust have not accounted for the need to provide this service and are unable to do so.

The CCG are approached to offer a LES to practices to cover this service in the meantime. The CCG are not the commissioners of this service however NHSE are leaving this to be resolved with the Trust and if the CCG want to offer a LES to cover the gap that is a matter for the CCG. This additional cost is not in the CCG financial plan and would come at a cost of approximately £150,000. Patients who do not receive this service may be at risk of harm as a result.

This risk may be reported to Finance and Performance Committee as a variance from plan however should be managed by Quality and Patient Experience Committee.

13. ASSURANCE STANDARDS

13.1 The CCG will maintain a Board Assurance Framework which is based upon the strategic priorities of the organisation and risk. This process will be reviewed annually. Individual directors are responsible for identification and grading of risks together with producing and monitoring action plans and formally reporting to the Committees on a regular basis.

14. RISK AWARENESS TRAINING FOR SENIOR MANAGEMENT (EXECUTIVE DIRECTORS AND GOVERNING BODY MEMBERS)

14.1 The Governing Body will receive ad hoc risk awareness training through Governing Body workshops. Minutes and notes will provide evidence of attendance. Any members that are not able to attend will receive a copy of the minutes and the presentation.

15. RISK REGISTER PROCESS

15.1 All risks, clinical, strategic, organisation and financial will need to be assessed rigorously, thus creating a continuum of risk assessments across the length and breadth of the organisation. Risks will need to be systematically identified, assessed and analysed on a continual basis. The effort and resources that are spent on managing a risk should be proportionate to the risk itself. The CCG should therefore have in place efficient assessment processes covering all areas of risk. It is also a legal requirement that all NHS staff actively manage risk.

15.2 Risk Identification

Risk identification involves examining all sources of risk, from the perspective of all stakeholders, both internal and external. Within the CCG, risks are

identified using a number of sources.

Internal Methods of Identification:

- Adverse Incidents, Serious Incidents (SIs), complaints, patient advisory liaison service (PALS) enquiries and claims reporting.
- Internal audit recommendations, identifying the CCG's gaps in control
- Self-assessment workshops
- Strategic level risks highlighted by CCG Governing Body, Senior Clinicians and Directors
- Risks highlighted via sub-committees of the Governing Body
- Patient satisfaction surveys
- Staff surveys
- Clinical audits, infection control audits, PEAT inspections etc
- Risks highlighted by the Unions
- Risks highlighted by new activities and projects
- Risks highlighted via the Whistleblowing (Raising Concerns) Policy
- Risks highlighted through business and local development plans

External Methods of Identification:

- External Audit opinion
- Reports from assessments/inspections from external bodies i.e. Audit Commission, Care Quality Commission, NHSLA Risk Management Assessors, Health and Safety Executive (HSE), etc.
- National reports and guidance
- Coroner's reports
- Media and public perception
- National Patient Safety Agency (NPSA) alerts
- Central Alerting System (CAS) alerts
- Health Ombudsman reports

15.3 Clear communication lines have to be established to enable all the systems above to report all risks and allow for the population of both the corporate and directorate and sub-committee risk registers.

15.4 **Risk Assessment**

The methodology for the assessment of risk can be complex. Risk assessment involves examining the level of risk posed by a hazard, consideration of those in danger and evaluating whether risks are adequately controlled, taking into account any measures already in place. Risk assessment involves two distinct stages:

- Analysing risk e.g. in terms of consequence and likelihood
- Evaluating risk in order to set priorities

15.5 Risk assessment should identify the significant risks arising out of the tasks or activities undertaken within the organisation and assess their potential to:

- Cause injury or ill health to individuals
- Result in civil claims or litigation
- Result in enforcement action e.g. from the Health and Safety

Executive or the Local Authority
- Cause damage to the environment
- Cause property damage/loss
- Result in operational delays
- Result in the loss of reputation

15.6 Risk assessments will be carried out locally by identified staff

15.7 **Risk Analysis and Evaluation**

Risk analysis involves systematically using available information to determine how often specified events occur and the magnitude of their consequences. In order to grade the risks identified the CCG utilises the risk assessment tool.

15.8 All risks highlighted to the CCG need to be graded using this risk matrix. If other quantitative methods are used then risk analysis will be inconsistent, and the population of the risk register will be unreliable.

15.9 Risk identification and risk assessment is a continuous process and should not be considered as a one off exercise. In order to ensure a well-structure systematic approach to the management of risk an action plan or work programme has been produced as follows:

- Adverse incidents (including Serious Incidents and Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) incidents), PALS, complaints and claims will be analysed on a six monthly basis.
- A report will be produced annually on Risk Management issues, including clinical and non-clinical risk for the Governing Body.

15.10 **Project Risk Registers**

All projects should develop a risk log which captures risks relating to the work stream. The process of risk identification should capture principal threats and opportunities associated with the project. A risk assessment should be completed for each risk identified and documented in the risk log for the project.

15.11 Responsibility for identified risks will then need to be allocated to individuals

15.12 Decisions will have to be made as to whether the risk should be:
- Terminated (Eliminate the risk entirely);
- Treated (Reduce the likelihood or the consequence of the risk (there is a trade-off between the level of risk and the cost of reducing it to an acceptable level);
- Tolerated (The decision could be to tolerate acceptable risk until reasonable action can be taken. Action should always be taken to treat unacceptable or principal risks)
- Transferred
- Shared

16. MONITORING AND REVIEW

16.1 It is necessary to monitor risks, the effectiveness of the treatment plan and the adequacies of controls that have been implemented. It is essential for the CCG to be aware of and monitor all risks as even risks deemed acceptable or tolerable may become unacceptable due to external forces such as adverse publicity or political agenda.

16.2 The monitoring and review of risk management systems is embedded within the CCG. The Governance Structure at Appendix4 provides assurance to the CCG Governing Body that the risk management arrangements are working effectively at all levels of the organisation.

16.3 The Audit Committee provides independent assurance(s) that a risk management system is in place to the CCG Governing Body.

16.4 Reviews by independent bodies, both external and internal will assist the CCG in demonstrating performance and will highlight any areas that need to be addressed.

The Process of Escalating Risks

16.5 The process that should be followed to escalate a risk to the corporate risk register is detailed below. The Head of Legal and Governance will:

- Work with the Executive Team to complete the Board Assurance Framework
- Once the risk register has been completed, the Executive Team will decide which risks they feel should be escalated to the Governing Body with the Board Assurance Framework. Risks to consider for escalation are those where the risk:
    - Has an overall risk rating of over 20
    - Impacts on a corporate objective or;
    - Is not within their remit to rectify (for example, fire safety)

Finance and Performance Committee

16.6 The Finance and Performance Committee is responsible for reviewing the risk register and updating the Governing Body on key risks relating to Performance, Finance, Information Governance and Business Continuity/Emergency Planning Risks.

16.7 The Finance and Performance Committee has responsibility for oversight of the development of an annual financial plan for income and expenditure within an understood and accepted level of risk.

Quality and Patient Experience Committee

16.8 The Quality and Patient Experience Committee is responsible for reviewing the risk register and updating the Governing Body on key risks relating to

Quality Assurance, patient safety, patient outcomes and safeguarding issues. Quality and Patient Experience Committee is responsible for reviewing the risks relating to ALL commissioned services including but not limited too acute, mental health and primary care.

16.9 The Quality and Patient Experience Committee has responsible for oversight of the development of a Quality Assurance Strategy within an understood and accepted level of risk.

Executive Committee

16.10 The Executive Committee is responsible for reviewing the risk register and updating Governing Body on key risks relating to Corporate functions and HR. This will include estates issues, staffing issues and other HR matters.

16.11 The Executive Committee is responsible for monitoring risk sharing agreements between Commissioners or Commissioners and Providers where such agreements exist.

Audit Committee

16.12 The duties of the Committee are driven by the priorities by the CCG and the associated risks.

16.13 The Audit Committee is responsible for establishing and maintaining and effective system of integrated governance, risk management and internal control, across the whole of the Clinical Commissioning Group's activities that support the achievement of the Clinical Commissioning Group's objectives.

16.14 The Audit Committee is responsible for evaluating fitness for purpose of the CCG Board Assurance Framework

16.15 In particular the Committee will review underlying assurance processes; the adequacy and effectiveness of all risk and control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the CCG Governing Body.

16.16 The CCG Board Assurance Framework will be presented to the Audit Committee twice a year to be reviewed and monitored and a summary of all strategic risks will be presented at each meeting.

Governing Body

16.17 The Governing Body will be routinely briefed regarding all principal risks which the organisation faces, and which risks may lead to the noncompliance of the corporate objectives or failure to deliver statutory duties. The risk register will form the basis of the risk treatment plan and will be a living document, always changing to reflect the dynamic nature of risk and the organisations management of it.

17. MONITORING AND REVIEW PROCEDURES

17.1 The corporate risk register should be incorporated into the general management agenda. A Standard Operating Procedure will be maintained to ensure that the approach to managing and maintaining risk registers is consistent.

17.2 Identification – Identified risks should be specific in detail e.g. “Lifts are not level” is not adequate but must reflect the real risk, for example expanded to advise of the risks such as “Risk of manual handling injury to staff and slip/trip injury to staff, patients and visitors due to lifts not levelling”. The Summary Description of Risk will put the risk into context and adds detail to the issue and its impact in the CCG.

17.3 Assessment/Evaluation – Any risks identified should be added to the corporate risk register and graded using the CCG’s risk matrix. Responsibility for action and timescales should also be included. Only those risks which cannot be managed locally will be considered for escalation. Risk identification and risk management is a continuous process and should not be considered as a one off exercise. Evaluating the risks will assist the Governing Body in setting priorities.

17.4 Treatment – Once a decision has been made as to the treatment of a risk (eliminate, reduce or tolerate), the action taken must be documented appropriately on a risk treatment plan. This ensures an audit trail is kept of all risks and their treatment.

17.5 Both the risk register and the risk treatment plans need to be regularly reviewed, evaluated and monitored. It is good practice to review the corporate risk register quarterly and this will be undertaken by the Head of Legal and Governance with a paper prepared for Governing Body.

18. CONSULTATION, APPROVAL AND RATIFICATION PROCESS

18.1 The Committees reporting to the Governing Body will be involved in the development and maintenance of the strategy. The framework will be approved and ratified by the CCG Governing Body, in line with the CCGs Policy on Policies.

19. DOCUMENT CONTROL INCLUDING ARCHIVING ARRANGEMENTS

19.1 The previous version of this policy will be removed from the internet/intranet and will be available if required by contacting the author.

20. IMPLEMENTATION

20.1 This policy/strategy will be circulated to all teams to be cascaded to individual members of staff. The document will be made available for staff and users and other stakeholders through the CCG website.

20.2 The CCG has mechanisms in place in order to ensure that:

- Staff can raise issues of concern with their manager(s);
- Staff are consulted on proposed organisational or other significant changes;
- Managers keep staff informed of progress on relevant issues;
- Services users, their relatives, carers and advocates can identify pointes of concern or worry by using the complaints process or PALS service;
- The media are accurately advised of developments in the CCG through the CCG Communications Team or one of the Directors.

20.3 The CCG principles of risk management are communicated to service providers and support service organisations through commissioning mechanisms and contract requirements.

21. TRAINING AND AWARENESS

21.1 This policy/strategy will be published on the CCG's website and will be available to staff on the organisations' intranet.

21.2 The policy/strategy will be brought to the attention of all new employees as part of the induction process. Further advice and guidance is available from the Risk and Assurance Manager.

21.3 Training will be provided to staff bi annually on risk and assurance processes as well as being provided on an ad hoc basis as requested by staff.

22. MONITORING AND AUDIT

22.1 the CCG monitors and reviews its performance in relation to the management of risk, and the continuing suitability and effectiveness of the systems and processes in place to manage risk.

22.2 The Audit Committee is responsible for monitoring the effectiveness of this policy/strategy and for providing assurance to the Governing Body.

22.3 Monitoring of this policy/strategy may form part of the Internal Audit review of governance compliance.

23. REVIEW

23.1 This policy/strategy will be reviewed bi-annually. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

24. REFERENCES

- DOH 1999 – HSC 1999/123 Controls Assurance Statement 1999/2000: Risk Management & Organisational Control, DoH London
- DOH 2003 – Building the Assurance Framework, DOH, London
- Mayatt (Ed) (2004) Tolley's Managing Risk in Healthcare (UK) 2nd Edition 2004 Lexis Nexis

- NPSA (2008) A Risk Matrix for Risk Managers, NPSA
- Controls Assurance Support Unit (2002), Making It Happen, A Guide for Risk
- Taking it on Trust – Audit Commission, 2009
- ISO31000

25. ASSOCIATED POLICIES

- Serious Incident Policy
- Health and Safety Policy
- Emergency Preparedness Plan
- CCG Constitution (includes Standing Orders)
- Information Risk Management Strategy
- IMT Security Policy and associated procedures
- Complaints Policy
- Induction Policy

26. CONTACT DETAILS

Manager Name: Head of Legal and Governance
Telephone: 01904 555870
Email: voyccg.governance@nhs.net
Address: NHS Vale of York Clinical Commissioning Group, West Officers, Station Rise, York, YO1 6GA

27. LIST OF APPENDICES

- Appendix 1: Equality Assessment
- Appendix 2: Sustainability Assessment
- Appendix 3: Risk Assessment Tool

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APPENDIX 1: EQUALITY IMPACT ANALYSIS FORM

1.	**Title of policy/ programme/ service being analysed**
	Risk Management Strategy and Policy
2.	**Please state the aims and objectives of this work.**
	To define and document the CCG's approach to risk and risk management to ensure: • Risks within the organisation are identified, assessed, treated and monitored as part of the corporate governance of the CCG. • Robust risk assessment and monitoring mechanisms are in place for all elements of the commissioning process, including needs assessment, tendering, contract management and evaluation.
3.	**Who is likely to be affected? (e.g. staff, patients, service users)**
	CCG staff, partner organisations (where applicable), public, patients and member practices. CCG managers and staff (and other providers and partners where applicable). If Risk management arrangements are not effective patients and service providers may be impacted.
4.	**What sources of equality information have you used to inform your piece of work?**
	NHS England
5.	**What steps have been taken ensure that the organisation has paid due regard to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics**
	The analysis of equalities is embedded within the CCG's Committee Terms of Reference and project management framework.
6.	**Who have you involved in the development of this piece of work?**
	Internal involvement: Senior Management team **Stakeholder involvement**: Consultation with Senior Managers **Patient / carer / public involvement**: This is an Internal policy aimed at staff employed by the CCG and contractors working for the CCG. The focus is on compliance with statutory duties and NHS mandated principles and practice. There are no particular equality implications.

7.	**What evidence do you have of any potential adverse or positive impact on groups with protected characteristics? Do you have any gaps in information? Include any supporting evidence e.g. research, data or feedback from engagement activities** **(Refer to** Error! Reference source not found. if your piece of work relates to commissioning activity to gather the evidence during all stages of the commissioning cycle)	
Disability People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)		Consider building access, communication requirements, making reasonable adjustments for individuals etc.
N/A		
Sex Men and Women		Consider gender preference in key worker, single sex accommodation etc.
N/A		
Race or nationality People of different ethnic backgrounds, including Roma Gypsies and Travellers		Consider cultural traditions, food requirements, communication styles, language needs etc.
N/A		
Age This applies to all age groups. This can include safeguarding, consent and child welfare.		Consider access to services or employment based on need/merit not age, effective communication strategies etc.
N/A		
Trans People who have undergone gender reassignment (sex change) and those who identify as trans.		Consider privacy of data, harassment, access to unisex toilets & bathing areas etc.
N/A		
Sexual orientation This will include lesbian, gay and bi-sexual people as well as heterosexual people.		Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc.
N/A		

Religion or belief Includes religions, beliefs or no religion or belief.	Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc.
N/A	
Marriage and Civil Partnership Refers to legally recognised partnerships (employment policies only).	Consider whether civil partners are included in benefit and leave policies etc.
N/A	
Pregnancy and maternity Refers to the pregnancy period and the first year after birth.	Consider impact on working arrangements, part-time working, infant caring responsibilities etc.
N/A	
Carers This relates to general caring responsibilities for someone of any age.	Consider impact on part-time working, shift-patterns, options for flexi working etc.
N/A	
Other disadvantaged groups This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV.	Consider ease of access, location of service, historic take-up of service etc.
N/A	
8.	**Action planning for improvement** Please outline what mitigating actions have been considered to eliminate any adverse impact? Please state if there are any opportunities to advance equality of opportunity and/ foster good relationships between different groups of people? An Equality Action Plan template is appended to assist in meeting the requirements of the general duty

Sign off
Name and signature of person / team who carried out this analysis *Abigail Combes, Head of Legal and Governance*
Date analysis completed *December 2019*
Name and signature of responsible Director
Date analysis was approved by responsible Director

1. APPENDIX 2 : SUSTAINABILITY IMPACT ASSESSMENT

Staff preparing a policy, Governing Body (or Sub-Committee) report, service development plan or project are required to complete a Sustainability Impact Assessment (SIA). The purpose of this SIA is to record any positive or negative impacts that this is likely to have on sustainability.

Title of the document	Risk Management policy and Strategy
What is the main purpose of the document	To effective identify, manage and monitor risk within the organisation.
Date completed	December 2019
Completed by	Governance Team

Domain	**Objectives**	**Impact of activity** **Negative = -1** **Neutral = 0** **Positive = 1** **Unknown = ?** **Not applicable = n/a**	**Brief description of impact**	**If negative, how can it be mitigated?** **If positive, how can it be enhanced?**
Travel	Will it provide / improve / promote alternatives to car based transport?	0		
	Will it support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)?	0		
	Will it reduce 'care miles' (telecare, care closer) to home?	0		
	Will it promote active travel (cycling, walking)?	0		
	Will it improve access to opportunities and facilities for all groups?	0		
	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery?	0		
Procurement	Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives?	0		

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
	Will it promote ethical purchasing of goods or services?	0		
Procurement	Will it promote greater efficiency of resource use?	0		
	Will it obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)?	0		
	Will it support local or regional supply chains?	0		
	Will it promote access to local services (care closer to home)?	0		
	Will it make current activities more efficient or alter service delivery models	0		
Facilities Management	Will it reduce the amount of waste produced or increase the amount of waste recycled? Will it reduce water consumption?	0		
Workforce	Will it provide employment opportunities for local people?	0		
	Will it promote or support equal employment opportunities?	0		
	Will it promote healthy working lives (including health and safety at work, work-life/home-life balance and family friendly policies)?	0		
	Will it offer employment opportunities to disadvantaged groups?	0		
Community Engagement	Will it promote health and sustainable development?	0		
	Have you sought the views of our communities in relation to the impact on sustainable development for this activity?	N/A		
Buildings	Will it improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)?	0		

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
	Will it increase safety and security in new buildings and developments?	0		
	Will it reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)?	0		
	Will it provide sympathetic and appropriate landscaping around new development?	0		
	Will it improve access to the built environment?	0		
Adaptation to Climate Change	Will it support the plan for the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other weather extremes)?	0		
Models of Care	Will it minimise 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes?	0		
	Will it promote prevention and self-management?	0		
	Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available?	0		
	Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?	0		

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2. APPENDIX 3 : RISK ASSESSMENT TOOL (RISK MATRIX)

2.1. The CCG has adopted a risk assessment tool, which is based upon a 5 x 5 matrix. (Used by Risk Management AS/NZS 4360:1999) The Risk Matrix shown below is taken from the National Patient Safety Agency „A Risk Matrix for Risk Managers' guidance published in January 2008. Risk assessment involves assessing the possible consequences of a risk should it be realised, against the likelihood of the realisation (i.e. the possibility of an adverse event, incident or other element having the potential to damage or threaten the achievement of objectives or service delivery, occurring). Risks are measured according to the following formula:

Probability (Likelihood) x Impact (Consequences) = Risk

2.2. All risks need to be rated on 2 scales, probability and impact using the scales below.

2.3. For Probability and Impact scores please see the definitions below.

2.4. The scoring should determine at what level the risk is managed however the Governing Body have determined that those risks which score a specific level on the impact matrix will be reported to committee or Governing Body regardless of the likelihood scoring. This is set out at appendix four.

2.5. Based on the judgments in the matrices a risk assessment can be made of the potential future risk to stakeholders and the organisation as follows:

- Green – low risk
- Yellow – moderate risk
- Amber – high risk
- Red – extreme risk

Vale of York CCG Risk Matrix

Impact	Probability 1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

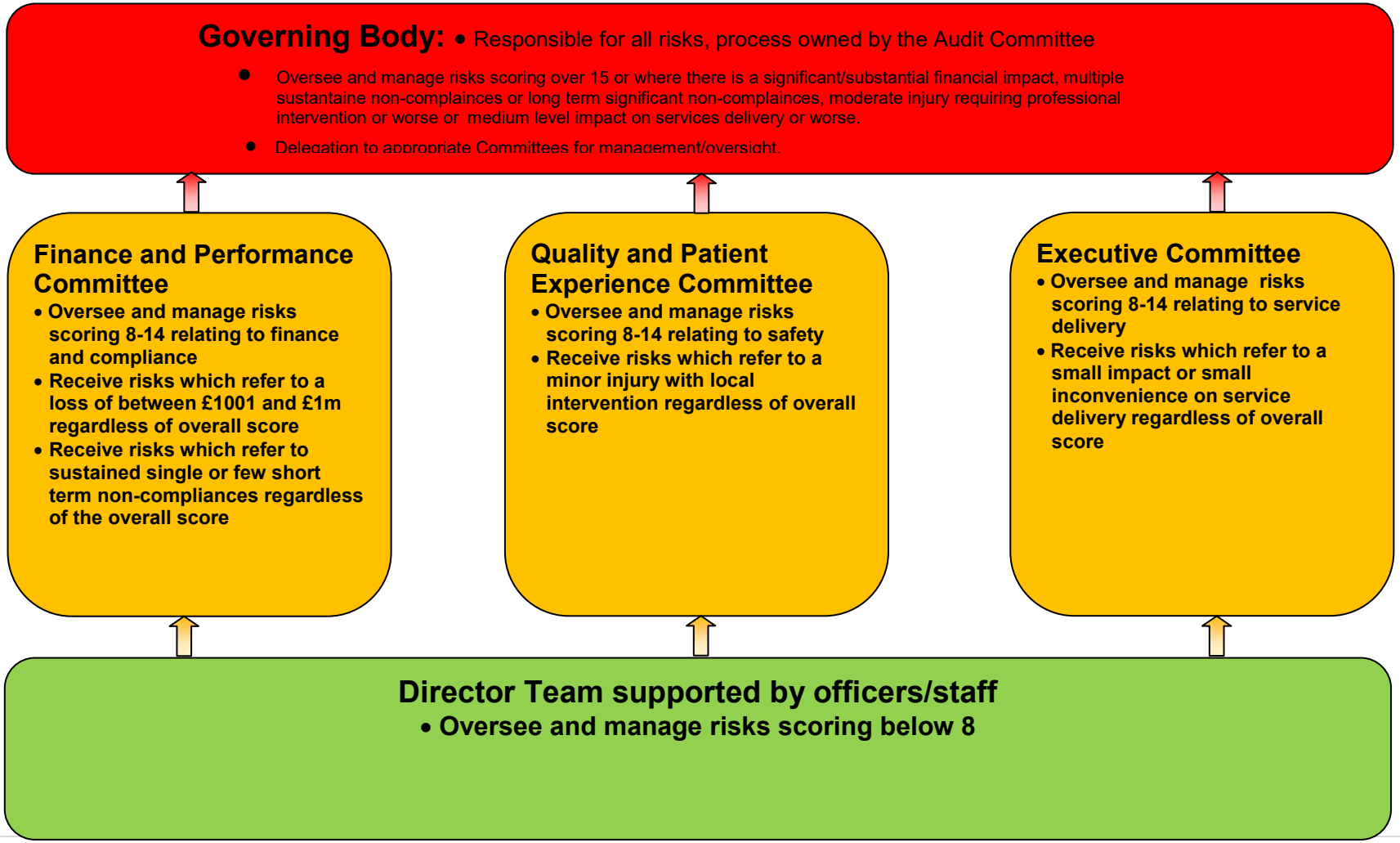
PROBABILITY DEFINITIONS

Rating	Classification	Broad descriptors of frequency	Time framed descriptors of frequency
1	Rare	This will probably never happen/recur	Not expected for years
2	Unlikely	Do not expect it to happen/recur but it is possible it may do so	Expected to occur at least annually
3	Possible	Might happen or recur occasionally	Expected to happen at least monthly
4	Likely	Will probably happen/recur but it is not a persisting issue	Expected to occur at least weekly

5	Almost Certain	Will undoubtedly happen/recur, possibly frequently	Expected to occur at least daily

IMPACT DEFINITIONS					
Rating	**Classification**	**Finance**	**Compliance**	**Safety**	**Service Delivery**
1	Adverse	Minor loss < £1000	Trivial, very short term single non-compliance	Insignificant injury (no intervention)	Negligible impact/unnoticed by service users
2	Cautious	Small loss £1,001-£10,000	Small, single short-term non compliance	Minor injury (local intervention)	Small impact/small inconvenience
3	Moderate	Moderate loss £10,001 - £100,000	Sustained single or a few short-term non-compliances	Moderate injury (professional intervention)	Medium level impact/moderate inconvenience
4	Open	Significant loss £100,001 - £1,000,000	Multiple sustained non-compliances	Major injury (hospital stay)	Significant impact/serious inconvenience
5	Hungry	Substantial loss > £1,000,000	Multiple, long-term, significant non-compliances	Fatal injury	Substantial/complete service failure

APPENDIX 4: RISK MANAGEMENT THROUGH THE COMMITTEE STRUCTURE



Item Number: 10

Name of Presenter: David Iley

Meeting of the Primary Care Commissioning Committee **Date of meeting: 26 November 2020**	NHS Vale of York Clinical Commissioning Group

Report Title – 2019/2020 Annual Chair's Report

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

Reason for Report

The purpose of this report is to update members with the progress of the work of the Primary Care Commissioning Committee for the period April 2019 - March 2020. This is a requirement of the CCG's Primary Care Commissioning Committee under fully delegated commissioning.

Strategic Priority Links

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

Local Authority Area

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

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

Emerging Risks

Impact Assessments

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

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

Risks/Issues identified from impact assessments:

N/A

Recommendations

For the Committee to approve the report.

Decision Requested (for Decision Log)

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

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

Primary Care Commissioning Committee
Chair's Annual Report
1 April 2019 to 31 March 2020

1. Introduction

1.1 The purpose of this report is to update Board members with the progress of the work of the Primary Care Commissioning Committee for the period April 2019 - March 2020. For the purposes of this report the term 'the Committee' will be used.

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

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

2. Role and Membership of the Primary Care Commissioning Committee

2.1 The role of the Committee includes the following:

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

2.2 The CCG Lay Member, who was also Chair of the Quality and Patient Experience Committee and the Remuneration Committee, acted as Chair until 31 May 2019 with the Vice Chair as the CCG Lay Member and Chair of the Finance and Performance Committee. The Vice Chair acted as Chair for the July meeting pending appointment of the new CCG Lay Member as Chair of both the Quality and Patient Experience Committee and the Primary Care Commissioning Committee. The full

membership is attached as Appendix 1. To note, the standing non-voting members changed on review of the terms of reference in September 2019.

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

Committee Member	Job Role	No of meetings attended	% of meetings attended
Keith Ramsay (Chair) *to 31 May 2019*	Lay Member and Chair of Quality and Patient Experience Committee and Remuneration Committee in addition to Primary Care Commissioning Committee	1/1	100
Julie Hastings (Chair) *from 2 September 2019*	Lay Member and Chair of Quality and Patient Experience Committee in addition to Primary Care Commissioning Committee	4/4	100
Simon Bell	Chief Finance Officer	5/6	83
David Booker	Lay Member and Chair of Finance and Performance Committee	4/6	66
Chris Clarke / David Iley	NHS England and NHS Improvement Representative	6/6	100
Phil Goatley	Lay Member and Chair of Audit Committee and Remuneration Committee	1/6	17
Dr Andrew Lee *from 1 May 2019*	Executive Director of Primary Care and Population Health	6/6	100
Phil Mettam	Accountable Officer	3/6	50

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

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

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

3.0 During 2019/20 the key areas of work and achievements of the Primary Care Co-Commissioning Committee were:

- Review of Committee terms of reference
- Formal approval for the registration of Primary Care Networks (PCNs), support for organisation development and oversight of recruitment and workforce plans through the Additional Roles Reimbursement Scheme
- Proposed bids for primary care estates investment and overview of the primary care estates strategy
- Enhanced Services reviews
- Primary Care Updates from NHS England including contractual changes
- Overseeing delivery of NHS England's General Practice Forward View Plan
- Overseeing delivery of improved access
- To manage the budget for commissioning of primary medical care services in the CCG
- Development of the Care Quality Commission Ready Programme
- Carry out the functions relating to the commissioning of primary medical services under Section 83 of the NHS Act
- Supporting practices mergers

4. Summary

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

APPENDIX 1

MEMBERSHIP OF PRIMARY CARE COMMISSIONING COMMITTEE

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

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

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

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

Voting Members
Lay Chair of Quality and Patient Experience Committee (Chair)
Lay Chair of Audit Committee
Lay Chair of Finance and Performance Committee
Accountable Officer
Chief Finance Officer
Director of Primary Care and Population Health
Representative of NHS England

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

Following review of the terms of reference at the September 2019 meeting:

Standing Non-Voting Members
A representative from each of the Primary Care Networks
LMC representative
Director of Public Health
Assistant Director, Primary Care
Healthwatch Representative
Health and Wellbeing Board Representative
Practice Manager

Item Number: 11

Name of Presenter: David Iley

Meeting of the Primary Care Commissioning Committee **Date of meeting: 26 November 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	☐Transformed MH/LD/ Complex Care
☐Reducing Demand on System	☒System transformations
☐Fully Integrated OOH Care	☐Financial Sustainability
☐Sustainable acute hospital/ single acute contract	

Local Authority Area

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

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

Emerging Risks

Impact Assessments

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

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

Risks/Issues identified from impact assessments:

N/A

Recommendations

For the Committee to receive the report.

Decision Requested (for Decision Log)

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

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

Vale of York CCG
Delegated Commissioning
Primary Care Update
November 2020

Prepared by David Iley

Primary Care Assistant Contracts Manager

NHS England and NHS Improvement – (NE and Yorkshire)

16th November 2020

1.0 Covid-19

1.1 COVID-19

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/

1.2 Urgent Preparing for General Practice to contribute to a potential Covid-19 Vaccination Programme

The following link provides details around the potential GP contribution to the Covid-19 vaccination programme.
https://www.england.nhs.uk/coronavirus/publication/preparedness-letters-for-general-practice/

1.3 Supporting General Practice – Additional £150 million of funding from NHS England

the following link provides details of a new General Practice Covid Capacity Expansion Fund. £150 million of revenue is being allocated through the ICS to CCGs for the purpose of supporting general practice capacity up until the end of March 2021.
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0828_GP-funding-letter-_second-wave_9novreb.pdf

2.0 Contract Changes

2.1 Changes to the GP Contracts from 1st October 2020

The following weblink provides details of changes to the GP contract.
https://www.england.nhs.uk/wp-content/uploads/2020/10/B0201_-GP-contract-letter-1-October-.pdf

Included is a new requirement for practices to participate in the Appointments in General Practice data collection in line with guidance jointly published with the BMA in August: https://www.england.nhs.uk/wp-content/uploads/2020/08/gpad-guidance.pdf . The Regulations have also been updated to include new and amended requirements in relation to: the NHS Digital Workforce Collection; list cleansing; removal of patients from a practice list because they have moved out of the practice area; removal of patients from a practice list who are violent; patient assignment where the relationship between a patient and a practice has broken down; out of area patient registration where patients have been assigned; subcontracting under the Network Contract DES; and amendments to termination rights where a practice registration with the CQC has been cancelled.

3.0 Workforce

3.1 Additional Roles Reimbursement Scheme (ARRS)

PCNs were required to complete a workforce planning template asking them to confirm their recruitment plans for this financial year as well as intentions for future years. Those submissions were made to the CCG who were

required to submit an aggregated CCG wide workforce plan to NHS England and NHS Improvement in early November.

The plan suggested that across Vale of York PCNs expect to have recruited an additional 88 Full Time Equivalent members of staff by 31st March 2021 under the ARRS utilising most of the funding available to them.

4.0 PCN Organisational Development (OD) Monies and GP Forward View (GPFV) Funding Update

Agreement has been secured to combine the remaining uncommitted GP Forward View monies along with the PCN Organisational Development funding for 20/21 to create a single pot of circa £2m. This will be allocated on a weighted capitation basis to all PCN's across the Humber Coast and Vale area and will be made available to the PCNs to develop local plans to support capacity and resilience for primary care throughout the winter, whilst providing the opportunity for learning and development of the PCN along the way.

The Committee is asked to note the updates in the paper