NHS
Vale of York
Clinical Clinical Commissioning Group

Item 15

Chair's Report: Primary Care Commissioning Committee

Date of Meeting	20 December 2016
Chair	Keith Ramsay

Areas of note from the Committee Discussion

- The Committee established revised membership and terms of reference, particularly noting membership from primary care.
- The Committee received an update on the GP Five Year Forward View.
- The Committee received a progress report on the Estates and Technology Transformation Fund.

Areas of escalation

Potential for linking together the Digital Roadmap, Estates Strategy and GP Five Year Forward View to strengthen primary care.

Urgent Decisions Required/ Changes to the Forward Plan

None

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Minutes of the Primary Care Co-Commissioning Committee held on 20 December 2016 at West Offices, York

Present

Mr Keith Ramsay (KR) - Chair	CCG Lay Chair
Mr David Booker (DB)	Lay Member
Mrs Michelle Carrington (MC)	Chief Nurse
Dr Arasu Kuppuswamy (AK) - part	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Governing Body Member
Mr Phil Mettam (PM)	Accountable Officer
Ms Helen Phillips (HP)	Primary Care Contracts Manager, NHS England – North (Yorkshire and the Humber)
Mrs Tracey Preece (TP)	Chief Finance Officer
Mrs Sheenagh Powell (SP)	Lay Member and Audit Committee Chair

In Attendance (Non Voting)

Dr Lorraine Boyd (LB)	GP, Council of Representatives Member
Mrs Kathleen Briers (KB)	Healthwatch York Representative
Dr John Lethem (JL)	Local Medical Committee Liaison Officer, Selby and York
Mr Shaun Macey (SM)	Senior Innovation and Improvement Manager
Dr Andrew Phillips (AP)	GP Governing Body Member, Lead for Urgent Care/Interim Deputy Chief Clinical Officer
Ms Michèle Saidman (MS)	Executive Assistant

Apologies

Mrs Constance Pillar (CP)	Assistant Head of Primary Care, NHS England – North (Yorkshire and the Humber)
Mrs Sharon Stoltz (SS)	Director of Public Health, City of York Council

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

Two members of the public in attendance; no questions had been submitted.

1. Welcome and Introductions

KR welcomed everyone to the meeting.

2. Apologies

As noted above.

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

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

4. Minutes of the meeting held on 2 June 2016

The minutes of the meeting held on 2 June were agreed.

The Committee

Approved the minutes of the meeting held on 2 June 2016.

5. Matters Arising

PCC2 – Terms of reference of the new arrangements between the CCG and the Vale of York Clinical Network: LB reported that in view of progress towards an accountable care system Vale of York Clinical Network was giving further consideration to these working arrangements, which may ultimately be through individuals or Practice alliances.

PCC4 – Development of a Primary Care Dashboard: MC reported that the Audit Committee had considered a Framework for Quality Assurance in Primary Care but this had not included indicators. The Primary Care Dashboard would be presented at the next meeting of the Committee following discussion of quality indicators at the January meeting of the Council of Representatives.

PCC5 – PMS Review: SM reported that work on PMS reinvestment had begun via the Vale of York Clinical Network. However this would be reviewed at the February Committee meeting in light of LB's update above.

The Committee:

Noted the updates.

6. Primary Care Commissioning Committee Terms of Reference

PM referred to the priorities in the CCG's Operating Plan, the key role of General Practice in their implementation, and the commitment to actively work with the Council of Representatives. As a membership organisation the CCG needed to work with General Practice in such a way that conflicts of interest were managed openly and transparently.

PM described the CCG's new governance arrangements. The Executive Committee, established in response to Legal Directions, would make decisions on behalf of the Governing Body on release of resources and the Clinical Executive would consider proposals from the patient perspective to ensure safety, quality and equity. The Primary Care Commissioning Committee would, in discussion with the Council of Representatives, determine deployment of resources. The Committee would hold regular meetings in public with continued attendance by representatives of the Local Medical Committee, Public Health, Health and Wellbeing Board and Healthwatch for the interests of the wider population. PM highlighted that, unlike with the other CCG committees, the Governing Body could not overturn decisions of the Primary Care Commissioning Committee.

PM reported on discussion with the Council of Representatives regarding membership of the Primary Care Commissioning Committee and referred to the proposed move to delivery of services through a locality structure. He explained that voting membership of the Primary Care Commissioning Committee would be the three Lay Members of the Governing Body, the Secondary Care Doctor Governing Body Member, the three statutory officers of the CCG – Accountable Officer, Chief Finance Officer and Chief Nurse – and a representative from NHS England. The non voting members would be two GPs from each of the localities , Chair of Clinical Executive, Director of Public Health, Healthwatch representative and Health and Wellbeing Board representative. PM explained that this approach would ensure clinical opinion from General Practice was sought but noted that there may be occasions when GPs could be asked to leave the meeting due to conflict of interest.

Members sought clarification on a number of areas in the draft terms of reference within the meeting papers, including acronyms. In this regard TP agreed to ensure explanation was included in the CCG's glossary.

Further discussion included: the need to ensure that the CCG's Scheme of Delegation was reviewed and updated in line with the new structure and incorporated primary care contracts; patient and public engagement in contract award processes; addition of a Practice Manager as a non voting member of the Committee; and potential consideration of other primary care representation.

In respect of patient and public engagement PM explained the CCG's commitment to become more effective. He noted that discussion was taking place with Siân Balsom, Director of Healthwatch York, and the Council of Representatives, and also the intention of improving engagement with Practice Participation Groups. MC additionally reported that the Quality and Patient Experience Committee Terms of Reference, to be considered at the first meeting later in the day, included quality assurance and safety.

KR requested that revised terms of reference be drafted for consideration at the February meeting of the Committee.

The Committee:

1. Requested that revised draft terms of reference be presented at the February meeting in line with the discussion.
2. Noted that TP would ensure acronyms were included within the CCG's glossary.
3. Agreed that the revised draft terms of reference include a Practice Manager as a non voting member.

7. Primary Care Commissioning Financial Report Month 8

In presenting this first report to the Committee TP sought members' views on content for future reporting.

TP reported that at month 8 the primary care commissioning underspend was c£300k with a forecast underspend of c£500k; this related to spend across all areas

with the exception of 'Other GP services'. In response to SP seeking clarification about potential use of the underspend TP advised that this was an area of delegated responsibility but the Committee had varying levels of control, citing enhanced services as a potential opportunity as part of the CCG's overall investment in primary care. She noted however that the underspend was part of the in-year allocation and could not be carried forward. PM added that, as referred to at item 6 above, the new Executive Committee would determine whether an underspend should remain in a specific area with the Primary Care Commissioning Committee considering its redeployment.

In respect of Primary Care – Other GP Services, the only area where there was an overspend, TP explained that the main pressure related to dispensing Practices where there was more volatility in volume of claims.

TP advised that the ongoing re-evaluation of premises costs would be reported through the new Executive Committee.

AP referred to concerns expressed by a number of Practices due to an increase in population from house building. TP explained that the 2017/18 primary care budget would include a level of expected population growth. SM added that Practices would receive an uplift of allocation for clinical staff based on list size, however expansion in terms of floor space was a challenge. He noted that the CCG was required to meet Practice notional rent but that this did not include revenue implications or wider developments; these required further consideration.

In response to LB seeking clarification about population increase allocation for Practices where the Minimum Practice Income Guarantee was still in place, JL explained that this was being reduced over a seven year period, currently around half way through the cycle. He noted that this was being reinvested in the global General Medical Services (GMS) sum therefore the expectation that GMS would increase.

Following discussion of Quality and Outcomes Framework payments, which LB explained were subject to performance management and linked to chronic disease activity, KR requested that information be provided in this regard to inform the Committee of variation between Practices. JL additionally noted complexity due to payment being a combination of achievement of target and prevalence of disease in the specific population. He supported discussion at the Committee based on the local NHS footprint.

With regard to future reports PM highlighted the role of the Committee in determining investment in General Practice to improve outcomes and ensure sustainability. Information was required in terms of providing an understanding of the pressures both within General Practice and the CCG as a whole to enable a patient centred focus for improvements. KR additionally proposed a development session for members to provide a greater understanding.

The Committee:

1. Noted the financial position of primary care commissioning.

2. Welcomed the report and requested inclusion of further detail to inform discussion.
3. Requested a report on Quality and Outcomes Framework performance.
4. Requested that a development session be arranged in advance of the February meeting.

8. General Practice Forward View Update

In presenting this report SM explained that the General Practice Forward View, an NHS England led programme of work complementing the Five Year Forward View, aimed to support Practices to develop resilient and sustainable services to meet future demand and be central in changes in the NHS. The funding from NHS England provided opportunities for Practices to collaborate, work at scale and develop innovation. SM emphasised that the CCG would engage with Practices to develop objectives and outcomes and ensure access to funding as it became available.

SM highlighted the information on key dates and summary of progress, information awaited and further opportunities in respect of the key programmes of workforce, workload, infrastructure and care redesign.

AK left the meeting

Discussion included the need for data in respect of activity and demand to develop strategic support for Practices and clarification about the new national contract for pharmacists. In respect of the latter HP explained that a new payment structure had come into effect on 1 December 2016 which included an additional payment in respect of opening hours. She noted that protection was initially for two years and there was the expectation of mergers, for example in locations where there were a number of pharmacies on a high street.

AP referred to the £171bn funding for collaborative working between Practices and sought clarification in this regard. HP advised that part of her new role within the Sustainability and Transformation Plan included gaining an understanding of this funding and how it could be used by CCGs.

In response to SP seeking clarification regarding alignment of the CCG's Primary Care Strategy with the General Practice Forward View, SM advised that a draft strategy was subject to discussion with member Practices. He noted that work was required in its development this via the Committee and the Council of Representatives.

SM highlighted the CCG's ambition that plans would be in place for Practices to work collaboratively in support of the out of hospital care agenda when the £6 per head became available recurrently from 2019/20 for commissioning additional capacity and improving patient access. In respect of the non recurrent £3 per head in 2016/17 PM reported that consideration was taking place via the Executive Committee in the context of the CCG's £24.1m financial deficit position; an update would be provided at the February meeting.

The Committee:

Agreed that the CCG should continue to actively support Practices in accessing any funding and training that became available through this programme, and proactively promote the General Practice Forward View transformation plans across member Practices.

9. Estates and Technology Transformation Fund Progress Report

SM presented the report which included bids submitted to the Estates and Technology Transformation Fund earlier in the year with to support Practices to meet future demand. Practices had been invited to submit applications for funding for expansion or new developments. The CCG had submitted 15 bids focused on premises developments and five smaller bids for technology focused schemes.

SM reported that to date no funding had been received from NHS England but all 15 premises applications were still being considered. They had been assessed as eligible for cohort 2, schemes to be delivered by 31 March 2019 and to proceed on an individual basis as and when funding was available, or cohort 3, unlikely to be delivered within the project timeframe but any possible funding routes would be shared with CCGs at a later date. SM noted the potential for a number of smaller schemes to progress in year. He also highlighted that when the funding came through further work would be required in terms of understanding capital or revenue implications for the CCG. The Committee would be asked to consider and prioritise the associated cost pressures.

SM referred to local population increases due to new housing developments of which the CCG was aware. He highlighted the need for these to be considered in the premises strategy.

In response to KR noting the need for the CCG to be able to align proposals from General Practice with planning timescales, SM advised that Stephanie Porter, Deputy Director - Estates and Capital Programmes at the Partnership Commissioning Unit, was undertaking work in this regard. He also referred to complex local authority technical funding mechanisms relating to Section 106 monies. Discussion ensued on Planning Department timescales and processes and the need for relationship building between health and local authorities to enable General Practice to be aware of expected population increases. Consideration of primary care estate was also required in the context of creative use of current premises across providers and the strategic context of support for small extensions against new build health centres. JL emphasised the urgent need for a realistic assessment of premises in terms of both estate and workforce requirements.

The Committee:

Noted that the recommendations in the report would be progressed via the Executive Committee. These were that the CCG should:

- Revisit the broader estates strategy to enable any of the Estates and Technology Transformation Fund schemes initial prioritisation to be revalidated – the estates

strategy and wider investment approach may need to be integrated into place-based out-of-hospital plans.
- Consider the option of creating an estates workstream / delivery group.

10. Protected Time for Learning

PM reported on discussion with the Council of Representatives regarding the feasibility of establishing an approach for protected time for learning. He noted many such examples that illustrated enhanced patient experience and outcomes, improved efficiency in General Practice and reduction in variation leading to better patient care.

PM advised that he would present a proposal to the February meeting of the Committee regarding the principle of establishing protected time for learning. Potential availability of resources would be considered by the Executive Committee.

The Committee:

Noted that a proposal for establishing protected time for learning would be presented at the February meeting.

11. NHS England Primary Care Update

HP presented the report which provided an update on: contract issues in relation to Personal Medical Services review in respect of Scott Road Medical Centre and a number of contract changes; General Practice Forward View in respect of GP indemnity proposals, General Practice Resilience Programme, General Practice National Development Programme, Retained doctor scheme – extra resources for GPs and Practices; Improving how hospitals work with General Practice – new requirements on hospitals in the NHS Standard Contract 2016-17; Estates and Technology Transformation Fund, Revised statutory guidance for CCGs on managing conflicts of interest; GP appraisal and revalidation; Vulnerable GP Practice Fund; Violent Patient Scheme – Yorkshire and the Humber; and Friends and Family Test.

PM referred to the General Practice Resilience Programme and discussion with Richard Armstrong, Regional Director of Public Health and Primary Care, NHS England North, regarding primary care transformation. He noted that the Council of Representatives was considering developing a proposal for General Practice at scale in this context. HP advised of the requirement for the funding to be allocated and spent in 2016/17 noting that for NHS Vale of York CCG this was expected to be £88k in-year and c£44k in 2017/18, and that the application submission date had been extended. In response to HP emphasising the need for an urgent submission JL and LB agreed to support a one page plan, including accountability, to ensure access to this funding.

MC confirmed that the Friends and Family Test requirements would be considered via the Quality and Patient Experience Committee. She also noted that the CCG did not receive information on quality functions relating to doctors, including performance and complaints; these were currently reported directly to NHS England. HP agreed to look into this and provide an update.

Discussion ensued on the late notification of funding availability from NHS England. PM advised that discussion at the CCG's quarterly meeting with NHS England had included a joint planning approach in this regard and that this was being followed up. He suggested that a proposal for an integrated operating model, including capacity, be presented at the February meeting of the Committee to ensure opportunities were maximised. HP additionally noted that her new role would include raising awareness of opportunities both with CCGs and the LMC.

Post meeting note: Appendix One 'NHS England North (Yorkshire and the Humber) Annual Assurance Report on Revalidation and the Responsible Officer Regulations 2015/16' and Appendix Two Letter template for submission of Friends and Family data, omitted in error, were subsequently circulated.

The Committee:

1. Received the NHS England report and noted the recommended actions.
2. Requested that an urgent submission be developed to ensure access to the General Practice Resilience Programme funding.
3. Noted that a proposal for an integrated operating model would be presented at the February meeting.

12. Updates

12.1 Update – Changes and Developments Across Member Practices

SM referred to the report which advised of: a merger between Front Street and Beech Grove Practices in Acomb; two branch site closures by Sherburn Group Practice; branch site relocation by Elvington Medical Practice; enquiries by Tadcaster Medical Centre and South Milford Practice about a potential move to Leeds North CCG; and the fact that Scott Road PMS Contract was still awaiting final approval and sign off from the Practice (as reported at item 11 above).

SM additionally reported that the developers of Unity Health's premises had explained that there would be an increase in notional rent of £20k from year 4. He advised that this still represented good value and was subject to review by the District Valuer, assuring members that this process would not cause delay. SM explained that all Practice premises were subject to a three year review cycle by the District Valuer.

12.2 'Improving how hospitals work with general practice – new requirements on hospitals in the NHS Standard Contract 2016/17'

AP reported that the NHS Standard Contract for 2016/17 included six standards for hospitals relating to the interface between hospitals and General Practice, namely: Local access policies, Discharge summaries, Clinic letters, Onward referral of patients, Medication on discharge, and Results and treatments. These were national standards that the CCG was required to implement.

AP advised that he and JL had met with York Teaching Hospital NHS Foundation Trust to discuss identification of departments and pathways that required attention relating to the six standards. A four week snapshot from General Practice had been proposed but, as agreement on its progression had not been reached to date, AP and JL had now co-signed a letter asking Practices which area they would be willing to sign up to. The CCG would thereafter work with York Teaching Hospital NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust in light of the results.

KB referred to a July 2016 Healthwatch publication *Local Voices: What are the public saying about health and care in Humber, Coast and Vale?* She noted that this included qualitative information relating to the standards.

MC emphasised that the CCG received letters relating to the standards not being met but needed local trend information to consider appropriate action. LB noted that providing this was not straightforward from the GP perspective.

JL highlighted co-operation from the Clinical Directors at York Teaching Hospital NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust and suggested that the resilience funding be used partly for organisational development as discussed earlier but also to fund a survey to fulfil the requirements of the six hospital standards in the NHS Standard Contract.

The Committee:

1. Noted the Front Street and Beech Grove Practice merger.
2. Noted that Sherburn Group Practice had closed two of its branch locations – Church Fenton and Ulleskelf – with effect from 5 December 2016.
3. Noted that Elvington Surgery had relocated its Dunnington branch surgery to space in Dunnington Pharmacy from 1 September 2016.
4. Noted that Tadcaster Medical Centre and South Milford Practice had made enquiries about a potential move to Leeds North CCG.
5. Noted an increase in Unity Health's notional rent of £20k from year four subject to review by the District Valuer.
6. Noted the update on the new requirements on hospitals in the NHS Standard Contract.

13. Next meeting

10am on 28 February 2017.

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE

SCHEDULE OF MATTERS ARISING FROM THE MEETING HELD ON 20 DECEMBER 2016 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCC2	29 March 2016 20 December 2016	Update on Primary Care Delivery Group	• Terms of reference of the new arrangements between the CCG and the Vale of York Clinical Network to be presented at the next meeting • Further update at next meeting	TM LB	12 July 2016 28 February 2017
PCC4	2 June 2016 20 December 2016	Development of a Primary Care Dashboard	• Draft dashboard to be presented at the July Committee meeting • Deferred to next meeting	MC/NL MC	12 July 2016 28 February 2017
PCC5	2 June 2016 20 December 2016	Additional Item – PMS Review	• PMS review to be an agenda item at the July Committee meeting • Further update at next meeting	SM SM	12 July 2016 28 February 2017
PCC6	20 December 2016	Primary Care Commissioning Committee Terms of Reference	• Revised draft terms of reference to be presented at the next meeting	PM	28 February 2017

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCC7	20 December 2016	Primary Care Commissioning Financial Report Month 8	• Report on Quality and Outcomes Framework performance • Development session be arranged in advance of the February meeting.	TP PM	28 February 2017 Before 28 February 2017
PCC8	20 December 2016	Protected Time for Learning	• Proposal for establishing protected time for learning	PM	28 February 2017
PCC9	20 December 2016	NHS England Primary Care Update	• Application to the General Practice Resilience Programme • Integrated operating model, including capacity, to be presented	SM, LB, JL PM	 28 February 2017