Vale of York
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

1 March 2019, 9.30am to 11.30am

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

AGENDA

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

1. 9.40am	Verbal	Welcome and Introductions		
2.	Verbal	Apologies		
3.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
4.	Pages 3 to 13	Minutes of the meeting held on 24 January 2019	To Approve	Keith Ramsay Committee Chair
5.	Verbal	Matters Arising		All
6. 9.50am	Pages 15 to 18	North Locality £3/head Report: North Integrated Care Team Review	To Receive	Dr Kevin Smith Executive Director of Primary Care and Population Health
7. 10.05am	Pages 19 to 21 Verbal Verbal Verbal	Central locality £3/head Reports: 1) Development of a Learning Disability Support Team (as part of Complex Care and Vulnerable Adults Programme of Care) 2) Supporting complex older patients in their home (including Care Homes) 3) Improving quality of services to patients with mental health conditions 4) Complex older patients at risk of hospital admission due to falls	To Receive	Dr Kevin Smith Executive Director of Primary Care and Population Health

8. 10.35am	Pages 23 to 27	Primary Care Commissioning Financial Report Month 10	To Receive	Simon Bell Chief Finance Officer
9. 10.45am	Pages 29 to 41	Five-year Framework for GP Contract Reform - Summary	To Receive	Dr Kevin Smith Executive Director of Primary Care and Population Health
10. 11.05am	To Follow	Amber Drugs Monitoring Local Enhanced Service	To Approve	Dr Kevin Smith Executive Director of Primary Care and Population Health
11. 11.20	Pages 43 to 57	NHS England Primary Care Update	To Receive	David Iley Primary Care Assistant Contracts Manager, NHS England North Region (Yorkshire and the Humber)
12.	Verbal	Key Messages to the Governing Body	To Agree	All
13.	Verbal	Next meeting: 2.00pm, 9 May 2019 at West Offices	To Note	All

EXCLUSION OF PRESS AND PUBLIC

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

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

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

Vale of York
Clinical Commissioning Group

Item 4

Minutes of the Primary Care Commissioning Committee held on 24 January 2019 at West Offices, York

Present

Keith Ramsay (KR) - Chair	Lay Member and Chair of the Quality and Patient Experience Committee and Remuneration Committee in addition to the Primary Care Commissioning Committee
Simon Bell (SB)	Chief Finance Officer
David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Phil Goatley (PG)	Lay Member and Audit Committee Chair
Heather Marsh (HM)	Acting Head of Primary Care
Dr Kevin Smith (KS)	Executive Director of Director of Primary Care and Population Health

In attendance (Non Voting)

Laura Angus (LA) – item 12	Strategic Lead Pharmacist
Dr Aaron Brown (AB)	York and Selby Division Officer, Local Medical Committee
Dr Paula Evans (PE)	North Locality GP Representative
Lesley Pratt (LP)	Healthwatch York Representative
Shaun Macey (SM)	Head of Transformation and Delivery
Michèle Saidman (MS)	Executive Assistant
Sharon Stoltz (SS)	Director of Public Health, City of York Council

Apologies

Kathleen Briers (KB)	Healthwatch York Representative
Phil Mettam (PM)	Accountable Officer

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

There were two members of the public in attendance.

The following matter was raised in the public questions allotted time.

Bill McPate

The substantial efforts being made to implement quality assurance monitoring measures in primary care, including the CQC Ready Programme, are acknowledged and appreciated. What are the latest prospects for a "Primary Care Dashboard" which is a long standing commitment by the CCG for monitoring practice performance?

KS responded that he did not support the principle of a primary care dashboard as the data flow from Practices was neither comprehensive nor timely; however work was taking place towards routine information being available. He referred to discussion at the previous meeting at the item 'Update on General Practice Intelligence Process' noting this approach had been successful. KS also explained that, as previously reported to the Committee, the CCG was working with Practices to provide support, including in respect of the Care Quality Commission approach, and to additionally identify common issues which may only emanate from "soft" data. The ambition was to progress such as digital opportunities and encourage improved use by Practices of e-dec (self declaration by Practices). KS assured members that available routine data was continually reviewed but not in the context of a dashboard. DB and AB, who had been involved in discussions about potential development of a dashboard, supported KS's view.

In response to Bill McPate enquiring about availability of information from Patient Participation Group meetings KS advised that the CCG did not hold this as it was not a requirement of the national GP contract. KS noted that the CCG could access information from the national GP database and emphasised there was no other information that was not being shared. He added that the most up to date information was via the Public Health England 'Fingertips' search engine at https://fingertips.phe.org.uk/ and that the CCG was working with Practices in terms of information on capacity.

HM referred to the information in the General Practice Forward View annex to item 11 relating to the Edenbridge Workforce Tool which was being rolled out nationally and would enable easier data access. She noted that the latest workforce data submission from Practices was being reviewed with a view to standardisation but such changes would take time to implement. In response to PE noting the need for training on the Edenbridge tool, KS advised that this would be included in a future Protected Learning Time event.

Prior to commencing the agenda KR expressed appreciation to HM who was retiring that day. He commended her contribution both from the NHS England perspective and as the CCG's Acting Head of Primary Care. Members wished HM well for the future.

Agenda

The agenda was discussed in the following order.

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

AB declared an interest in items 9 and 11; PE declared an interest in item 9. They did not take part in the discussion at item 9 and AB left the meeting for aspects of item 11 relating to his Practice, York Medical Group. All other declarations were as per the Register of Interests.

4. Minutes of the meeting held on 22 November 2018

The minutes of the meeting held on 22 November were agreed.

The Committee

Approved the minutes of the meeting held on 22 November 2018.

5. Matters Arising

The matters arising were included on the agenda.

6. Primary Care Commissioning Financial Report Month 9

SB presented the report which detailed the financial outturn of the CCG's delegated primary care commissioning areas at month 9 of 2018/19. The year to date position was an underspend of £121k and the forecast outturn spend remained at £43.4m, a forecast underspend of £29k. SB noted that in month 9 the CCG had received non-recurrent allocation of £343k to offset the additional 1% pay award.

In highlighting the £956k year to date overspend in the prescribing budget SB referred to the report at item 12 which was part of the reason for the deterioration. SB advised that, following assurance from NHS England that the No Cheaper Stock Obtainable issue experienced in 2017/18 was not expected to re-emerge, allowance had not been included in the 2018/19 plan however this did now appear to be re-emerging as an issue this year. He also noted the potential connection to the uncertainty around Brexit but advised that an improvement in the prescribing budget spend was expected in the last three months of the financial year.

KR sought and received assurance that there was no expectation of pressures emanating from estates reimbursements and associated costs. KS added that discussions were on going with the Local Authorities and other sectors regarding potential estates solutions to address additional costs arising from the need for growth to accommodate clinical services.

The Committee:

Received the month 9 Primary Care Commissioning Financial Report.

7. Update on General Practice Intelligence: Care Quality Commission Ready Programme – Supporting Quality across Primary Care

KS referred to the report which described the programme of support for Practices established by the CCG in response to Unity Health's 'Inadequate' rating by the Care Quality Commission in 2018. He commended Lynn Lewendon, Senior Manager Practitioner Performance, NHS England, and Sarah Goode, the CCG's Quality Lead for Primary Care in this regard.

KS explained that the full information was not appropriate for sharing but referred to the summary of 10 emerging themes. He highlighted those relating to Practices establishing Significant Event Audits and inclusion of unexpected deaths in these audits, utilisation of the Carers Trust Professionals GP Toolkit, consideration of identifying patients with poor mental health who failed to attend or failed to collect their medication and liaison with local pharmacies to identify a list of 'top ten' medications they would want to be notified of not being collected. The themes were proposed as priorities for the localities.

KS advised that the programme had received positive feedback from Practices and noted many common experiences. Consideration was now taking place for further work to be shared between Practices.

SS referred to the unexpected deaths theme and advised that there was a programme across North Yorkshire and York to review drug related deaths. She also noted that York was an outlier for suicides and that a real time surveillance process had been established through working with North Yorkshire Police and the Coroner's office in this regard. SS enquired whether there was an opportunity for GPs to be included in this process in the event of drug related death or suspected suicide. Following detailed discussion about such information collected by Practices and the Significant Event Audits, SS agreed to write to Practices offering support. In response to KS noting the need for consideration in terms of information sharing, SS highlighted that associated legal processes would be through the Coroner's Office. PE noted this as an opportunity both for collaborative working and for a future Protected Learning Time event.

The Committee:

1. Received the update on General Practice Intelligence: Care Quality Commission Ready Programme – Supporting Quality across Primary Care.
2. Agreed the findings be published through the GP Practice Communications bulletin with each practice being given a unique identifier code to enable them to identify how they benchmark against their peers for each domain and/or criterion.
3. Agreed the 10 emerging themes from the findings become the priorities for Practices and localities noting this would inform a CCG plan to offer support to continue to improve the quality of service provision in primary care.

8. The NHS Long Term Plan - Summary of Key Implications for General Practice

In introducing this item KS highlighted that the recently published NHS Long Term Plan aimed to support primary care and community services to move to an approach of

prevention, management of care and reduction in pressure on secondary care. He noted that guidance was awaited.

SM presented the report that highlighted key aspects of the Plan that would impact on General Practice noting that some areas were inter related. Information was awaited in respect of access to the increased investment.

SM explained key areas of the Plan described under headings of: investment in primary medical and community health services; a new NHS offer of urgent community response and recovery support; Primary Care Networks of local GP Practices and community teams; fully integrated community based health care; changes to the GP Quality and Outcomes Framework; a new Primary Care Networks 'shared savings' scheme; guaranteed NHS support to people living in care homes; supporting people to age well; social prescribing; digital-first primary care; increase the number of doctors working in General Practice; a new state-backed GP indemnity scheme; and increasing digital options.

Members sought and received clarification on aspects of the Plan. With regard to the digital developments KS confirmed that Practices had been asked to provide assurance that telephone access would be maintained in addition to online.

The Committee:

Received the report summarising key implications for General Practice in the NHS Long Term Plan.

9. Local Enhanced Services Review 2019/20

AB and PE did not take part in the discussion due to their conflict of interest.

HM presented the report which provided an update on the review of Local Enhanced Services and made recommendations for their amendment or continuation in 2019/20. She noted that review of the schemes through the appropriate clinical processes had been completed to different degrees for various reasons but highlighted that overall issues of complexity about the data requirements had been identified. Any changes to fees paid had been reviewed by the Finance Team and were within current existing budgets.

Bone Protection Service

HM explained that the Bone Protection Service guidelines, pathway and service specification had been updated to reflect the issues detailed. Guidelines and simplification of the payment process enabled Practices to be paid for work done in two pay points within six months instead of four over 12 months; clinical system templates were more user friendly; and links had been included to printable patient advice on diet, calcium, lifestyle, how to take medications and falls prevention.

The Committee noted the outcomes of the review of the Bone Protection Service.

Diabetes

HM noted that, although the CCG had a good diabetes model, nationally the number of patients achieving the three NICE recommended treatment targets and attendance at a structured education course within a year of diagnosis was still below average. These had been added to the Key Performance Indicators together with a number of additional aspects of information. Payment of £10.10 per registered patient would be made in accordance with achievement of the Key Performance Indicator requirements outlined in the Service Specification and Quality Requirements, detailed in Schedule 7, and was dependent on achievement of a number of Key Performance Indicators. If a Key Performance Indicator was not met a percentage of the total payment would be deducted in line with the percentage value stipulated in Schedule 7.

The Committee noted the aim of the revised service was to encourage and support Practices to improve upon their achievement of a number of indictors for both the Quality and Outcomes Framework and Improvement and Assessment Framework to bring the CCG in line with the national average.

Care of the Homeless

HM referred to the highly valued service provided by York Medical Group, provided mainly through a clinic at Changing Lives in Union Terrace, and noted the holistic approach being delivered through collaboration.

The Committee agreed the proposed new contract of a block payment of £40k per annum which would include core clinic services as currently provided with the addition of a fortnightly would care clinic and an outreach programme, inclusive of vaccination clinics, to extend the services beyond residents of Changing Lives. The staff at Changing Lives would support and facilitate engagement of other support services for their clients.

Amber Drugs / Shared Care

HM noted that this service had been updated in 2017/18 but that a clinical review had ensured clinical guidelines were in line with current standards. No changes were required to the specification.

PSA

HM advised that this review was ongoing with a completion date of the end of March 2019 due to the recent allocation of the Macmillan clinical lead.

Neonatal Care New Baby Check

HM reported that the current specification was in line with clinical guidelines but the Quality Team was currently reviewing Practice concerns about advice to new parents that they should return to hospital for the Neonatal Care New Baby Check. SS noted that this was a routine screening assessment to identify any potential health issues and agreed to discuss a solution with Michelle Carrington, the CCG's Executive Director of Quality and Nursing / Chief Nurse and report back to the next meeting.

The Committee noted that the service would continue to be made available to Practices.

Locality Reviews

HM referred to the information pertaining to services identified for locality review noting that the recommendations for these services were linked to simplifying and clarifying payment systems and data collection processes.

With regard to allocation of resources to the local networks KS explained that there would be a mixed model approach with funding based on need.

HM agreed to provide clarification to PE after the meeting regarding recent communications from the Finance Team about minor injuries capitation and activity.

The Committee:

1. Approved the planned changes to the Bone Protection, Diabetes and Care of the Homeless services as described.
2. Agreed that, as the Macmillan clinical lead had only recently been allocated, recommendations for the PSA enhanced service should be brought to the Committee after completion of the review at the end of March.
3. Agreed that the primary care local enhanced services be included within the wider Community and Primary Care Networks transformation programmes to align with guidance in the NHS England Long Term Plan.
4. Agreed simplification of the data collection process and payment mechanisms.
5. Agreed the current clinical specifications for minor injuries, wound care and phlebotomy be rolled over for a further six months.
6. Noted payments for all the remaining enhanced services would be made on a quarterly basis with a corresponding requirement for quarterly data returns. The specifications would include specific Read Codes that Practices would be required to use to easily identify activity.
7. Noted the specification would require Practices to submit a description of how their access systems promoted and facilitated access to these services where payment was on a capitation basis (simple post operative wound care, phlebotomy and minor injuries.)
8. Noted complex wound care and phlebotomy would be included in the community review
9. Noted that minor injuries would be reviewed by the primary care networks as a priority early in 2019/20

LA joined the meeting

12. Emerging Pressures on Prescribing Budgets

KS commended LA for having highlighted the emerging No Cheaper Stock Obtainable issues to the Executive Committee in advance of the national reporting. He emphasised that in addition to causing issues for GPs and Community Pharmacies, there was the human factor of concern for patients requesting their medication.

LA referred to discussion about the No Cheaper Stock Obtainable issue at the Committee in November 2017 reiterating this meant generic drugs were not available therefore more expensive alternatives had to be prescribed. She advised that the No Cheaper Stock Obtainable levels had returned to expected levels in April 2018 but was now becoming an issue. LA noted It was unclear as to whether there was any impact from Brexit emphasising the need to focus on the No Cheaper Stock Obtainable position.

LA highlighted that the CCG was trending below the national and North Yorkshire CCGs position in respect of No Cheaper Stock Obtainable. She also noted that NHS Vale of York CCG had the lowest prescribing costs across the Yorkshire and Humber CCGs and was 9% below the national average spend. She referred to the examples of products affected by the issue and the associated pressures.

LA reported that a range of medicines optimisation projects were continuing and that further opportunities were being sought, including identification of “quick wins”. She noted that information from NHS England was being shared on receipt and that further communications were being circulated collaboratively across the North Yorkshire CCGs and Sustainability and Transformation Partnership to ensure GPs, Community Pharmacists and patients were kept informed.

In terms of the financial position SB explained that such an issue late in the financial year reduced the number of opportunities for reduction in managing spend.

AB and PE noted that there was no evidence of patients stock piling drugs and that there were ways of identifying this in clinical systems.

KS explained that in the event of a No Deal Brexit outcome there must be adherence to the national position with no stockpiling of drugs by GPs and Pharmacies. Planned stockpiling was taking place, namely a further six weeks supply on top of regular stock. KS emphasised the need to heighten consistent messages to this effect across the Sustainability and Transformation Partnership and to reduce anxiety. The current issue appeared to be one of flow.

The Committee:

Noted the emerging pressures on prescribing budgets.

LA left the meeting

10. Improving Access to General Practice Services at Evenings and Weekends

The Committee:

Noted the update on the CCG’s progress against the national programme to commission Improving Access to GP Services at evenings and weekends.

11. NHS England Primary Care Update

HM presented the report which sought approval for a number of contractual and estates matters and provided updates on the Estates and Technology Transformation Fund

relating to Pickering Medical Practice, the General Practice Forward View and NHS England Clinical Pharmacist in General Practice Programme; three appendices comprised respectively York Medical Group's application to the CCG to sub-contract the provision of services to Push Doctor, a proposed process to agree rent increases and details of the General Practice Forward View transformation programme.

Approval was sought in respect of:

- Temporary reduction in service provision at Posterngate Surgery and Jorvik Gillygate Practice respectively for delivery of staff training and to support the delivery of all staff meetings.

AB left the room during discussion of matters relating to York Medical Group.

- York Medical Group use of Push Doctor, a virtual GP consultation provider. HM reported that this was already being used in the North Locality for improving access to services and confirmed that there were no governance issues.

- York Medical Group's proposal to take up the option of 100 square metres in two buildings adjoining the 32 Clifton surgery which would enable them to complete the consolidation of back office functions to this site and in so doing free up 145.1square metres for additional clinical space at the Acomb site. HM explained that this request had been considered in the context of future estates planning and noted the timescale also provided a potential opportunity for a capital grant from the Sustainability and Transformation Partnership. She added that a Business as Usual Grant would also be sought and advised that the maximum risk to the CCG was £13k. Members additionally discussed the need for a CCG Estates Strategy and noted the expected increase in population in the Acomb area.

AB returned to the meeting

- Estates and Technology Transformation Fund improvement grant for the Carlton branch of Beech Tree Surgery following formal review of the scheme by the District Valuer. HM explained that there had been a change in costs associated with this development and the notional rent had increased from £4k to £8k.

KR left the meeting and DB took over the role of Chair

- Heads of Terms for a proposed new lease for Front Street Surgery, 14 Front Street, York, with a proposed 20 year lease term and rental of £86,500 per annum against the current £87,190 per annum. Members did not support this as an estates review was planned for 2019.

- Rent reimbursement for Tollerton Surgery, 5-7 Hambleton View, Tollerton, York.

- Process for approving notional rent increases. HM explained the proposal to simplify the standard three yearly cycle of rent reviews that were less than £5k or less than 5% was for approval by NHS England and CCG officers with decisions reported to the Committee for information. Committee approval would only be sought by exception for reviews of these levels. KS requested that advice be sought from the Head of Legal and Governance regarding the approval levels.

In respect of the General Practice Forward View update HM highlighted support through resilience funding and noted increasing online consultation activity.

The Committee:

1. Approved the temporary reduction in service provision at Posterngate Surgery and Jorvik Gillygate Practice respectively for delivery of staff training and to support the delivery of all staff meetings.
2. Approved the sub-contracting arrangements between York Medical Group and Push Doctor.
3. Supported in principle York Medical Group's proposal regarding the premises development at 32 Clifton subject to the Heads of Terms confirming an increase in rent of not more than £13k and no increase in the current lease term, noting a capital bid could still be made but agreeing the scheme would not be subject to this being successful.
4. Approved the revised increase in notional rent to support the Estates and Technology Transformation Fund improvement grant for the Carlton branch of Beech Tree Surgery noting that the original approval was in line with the abated figure as per the District Valuer's evaluation.
5. Rejected the proposed Heads of Terms for a new lease for Front Street Surgery, 14 Front Street, York
6. Approved the increase in notional rent from £17,500 per annum to £18,200 per annum for Tollerton Surgery.
7. Supported the proposal for delegated approval of small scale notional rent increases to the Executive Director of Primary Care and Population Health subject to review of the proposed £5k delegated amount; update to be provided to the next meeting.
8. Noted the updates.

13. Key Messages to the Governing Body

The Committee**:**

- Noted the actions being taken in respect of prescribing budgets.
- Noted the importance of aligning community services with primary care in the NHS Long Term Plan.
- Agreed changes in GP contract payments.

The Committee:

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

14. Next meeting

9.30am on 1 March 2019 at West Offices.

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE

SCHEDULE OF MATTERS ARISING FROM THE MEETING HELD ON 24 JANUARY 2019 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCCC35	24 January 2019	Local Enhanced Services Review 2019/20	• Report on PSA review • SS to discuss with Michelle Carrington concerns about neonatal checks in hospital instead of the community	Head of Primary Care SS	9 May 2019 1 March 2019

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Item Number: 6

Name of Presenter: Shaun Macey

Meeting of the Primary Care Commissioning Committee **Date of meeting: 1 March 2019**	NHS Vale of York Clinical Commissioning Group

North Locality £3/head – North Integrated Care Team Review

Purpose of Report
For Information

Reason for Report
To update the CCG's Primary Care Commissioning Committee on progress around the North locality's £3/head project, the North Integrated Care Team (NICT).

Strategic Priority Links

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

Local Authority Area

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

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

Emerging Risks (not yet on Covalent)

Recommendations

n/a

Responsible Executive Director and Title	**Report Author and Title**
Dr Kevin Smith Executive Director of Primary Care and Population Health	Becky Case Head of Transformation & Delivery

North Locality Integrated Care Team

1st Year review 2018

1. Background

The North Locality group is formed from all General Practices within the North of the NHS Vale of York CCG area in two groups; South Hambleton (encompassing Millfield, Stillington and Tollerton Practices) and North Ryedale (encompassing Pickering, Kirkbymoorside, Helmsley and Terrington Practices). A coproduction workshop was held in June 2017 for all partners to agree a way forward; the outcomes of this highlighted a need for more flexible and integrated working, appropriate and standardised referral, reduction in duplication, better trusting relationships and the outputs of higher patient satisfaction whilst managing expectations.

The proposal was to roll out a 'North Integrated Care Team' (NICT) which has oversight of each practice's palliative care and frailty registers, and all the admissions and discharges to York Teaching Hospitals NHS Trust (YTHFT) on a daily basis, and can effectively assess, manage and refer on as appropriate. The dedicated team then reviews and identifies patients who are on those registers and have been in or out of hospital or social care recently, or who are at first presentation to the health and care system but may need support. The patients will be identified via case finding mechanisms on the Primary Care systems and the daily admission/discharge lists provided by YTHFT, or by recommendation from any other related partner who has a concern, eg. volunteer services, housing support, the Fire Service etc.

The NICT will review each patient to understand what intervention is required and use an MDT approach to develop care plans or signpost the patient to the most appropriate option.

Strategic aims:

- To put service users at the centre of hub delivery
- To improve defined population-based health and care outcomes
- To reduce population-based healthcare costs, social care costs and associated costs
- To improve the quality and equity of health and care services for the hub population as measured through defined information/outcomes
- To provide proactive and preventative healthcare and health promotion through, for example, self-care and measures of patient independence

2. Challenges around mobilisation

- Data streams needed to be set up quickly to best use available resource – there were benefits in having an existing care coordinator role, but HCA recruitment was slow
- Information sharing and suitable governance between partners using different IT systems whilst ensuring patient confidentiality

- IT support and availability of equipment for the team
- Geography of area means large distances to travel between practices and patients
- Finance agreements around centralized funding ‘pot’, access and invoicing
- Small amounts of available funding meant careful stewardship and shared planning
- Sharing the vision to all, including existing community and social care services

It was clear that these challenges would need to be rapidly addressed if significant progress was to be made in the first year, and hence evidence the effectiveness of the investment made; both to locality partners and to the CCG.

3. Describe the progress that has been made, benefits/outcomes, and the status of the service/project at the end of 2018/19

As of January 2019 the following key changes have occurred in the system:

- NICT has been established for a year with a 0.4wte Care Coordinator lead (focus on frailty) in post
- The same staff member has maintained their other 0.5wte (based on 20 hours pw) complementary role funded by Macmillan
- Additional admin support has been available to the Care Coordinator in all practices since June ‘18
- B3 HCA’s have been in place to support the locality since November ‘18
- Metrics have been agreed and a monthly highlight report is produced and shared showing activity as well as qualitative outcomes, ongoing actions and any emerging risks
- Outcomes have been agreed and shared
- The Improving Access bid has been won by the same group of GPs – offering opportunities to work more flexibly and provide different types of medical support to the locality patient group
- The group have described priorities for the 19/20 financial year, which include more focus on dementia and cognitive impairment and the use of a virtual ward to embed the role of Community Geriatrician, mental health support for children and young people, and more preventative support.
- A Phase 2 strategic plan has been drafted to describe the next steps and expansion of the NICT in more detail.

4. Outcomes and metrics

Outcomes have been outlined with the input and approval of the North Locality Steering Group. These were agreed to have a balance of activity metrics, patient quality metrics, attendance and admission avoidance metrics and staff and patient satisfaction metrics. These will support the reporting on the following outcomes.

1) a) we can identify our patients at highest risk
   b) we can improve the sharing of information across health and social care providers

2) a) we have identified our severe and moderately frail cohort and benchmark well

b) we have obtained the consent of our high risk cohort to share their aSCR
c) we have improved the quality of shared information; including partner information
d) we have developed and enhanced the level of engagement with other partners and bridged the gap between health and social care to effect the seamless delivery of services to patients
e) we have reduced the need for our high risk cohort ' to tell their story twice'

3) a) we did achieve a reduction in the average time our frail patients spent in A/E
b) we did achieve a reduction in the average length of stay for our frail cohort
c) we did achieve an increase in the average time spent at home in the Last Year of Life.

5. Current status

Bids for further care coordination around dementia and cognitive impairment, and DWP Mental Health in work support are currently being completed. A bid for funding from the Alzheimer's Society was unsuccessful but provided the opportunity to examine the detail of such a proposal; this will be recycled.

The next phase of the project being agreed; with discussions about Primary Care Networks taking place in mid-March 2019, and a presentation from YTHFT describing their proposed changes to Community Services taking place at the North Locality Steering Group towards the end of March.

Item Number: 7

Name of Presenter: Shaun Macey

Meeting of the Primary Care Commissioning Committee **Date of meeting: 1 March 2019**	NHS Vale of York Clinical Commissioning Group

Central Locality £3/head – Learning Disabilities Team Review

Purpose of Report
For Information

Reason for Report
To update the CCG's Primary Care Commissioning Committee on progress around the Central locality's £3/head project, the Learning Disabilities Team.

Strategic Priority Links

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

Local Authority Area

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

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

Emerging Risks (not yet on Covalent)

Recommendations

n/a

Responsible Executive Director and Title	**Report Author and Title**
Dr Kevin Smith Executive Director of Primary Care and Population Health	Sarah Blades Haxby Group Practice

Central Locality £3/head - Learning Disabilities Project

Yorkshire Integrated Learning Disabilities (LD) Team

1. The original aims of the project

- Improve numbers of LD patient checks in the city
- Improve the quality of these checks
- Develop a team to act to signpost resources for LD patients and carers
- Improve patient screening
- Run clinician and carer training events annually

2. Challenges around mobilisation

- One practice had to take ownership to run all the employment contracts and this was at some risk.
- With only getting funding 1 year at a time it's hard to employ a team and get the right people on board.
- As the computer systems used across the city are different we need to develop a clinical template for both systems the clinicians can use to do the health check
- The team will need to develop systems to audit the work across practice sites so we can adapt if needed to improve the service.
- We had to get practices to sign up to the enhanced service and develop frameworks for them to achieve the health checks. Everyone is now signed up.
- Getting contacts and links developed with the local authority LD team has been difficult but we now have good links now and they have verified the template and will check patient registers.

3. Progress that has been made

- We just really started the project late 2018 but have made lots of progress!
- We currently have recruited one of the nurses and are interviewing a second soon and we have recruited the Care Navigator.
- We have a room at Haxby fitted out for the team and an action plan for when they all start so we can quickly start doing health checks across the city.
- We have a clinician training event on the 7th March for all practices and will be running a carer event alongside the LD forum over Summer.
- We have developed a new template for the annual health check and will be rolling this as well as easy read invite documents across the practices. This will help practices run a good quality health check and help patients attend for the check.
- The team will also advise practices on clinical coding and registers can be checked centrally to ensure we are not missing any patients with LD.
- We have encouraged screening via the template with easy links to information leaflets and In will be promoting screening at the training

events. Patients can take home written care plans and information about screening procedures.

4. Summary

- We have achieved or are well on the way to achieving our goals. We will soon have a team in place and hope that by the end of the year we can show improvements in health check numbers, patients on the register and training events.
- Over time we hope to show improvements in screening. In the short term we will be promoting screening and improving information provided to patients and carers about screening.
- LD is an area previously overlooked, even patients with mild LD die on average 10 years before patients without LD. We need to change the health equalities for this group.
- Seeing patients can help us support them and their carers, spot health problems early and start preventing lifestyle issues. We can educate patients and help them overcome fears about screening.
- Please support this project going forward as we need to continue training events, keep the team running and support local practices to engage with LD patients and improve their access to health checks and health advice.

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Item Number: 8

Name of Presenter: Simon Bell

Meeting of the Primary Care Commissioning Committee

Date of meeting: 1 March 2019

NHS
Vale of York
Clinical Commissioning Group

Primary Care Commissioning Financial Report

Purpose of Report
For Information

Reason for Report

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

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

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

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

The Primary Care Commissioning Committee is asked to note the financial position of Primary Care Commissioning as at Month 10.

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

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

Report produced: February 2019

Financial Period: April 2018 to January 2019

Introduction

This report details the year to date financial position as at Month 10 and the forecast outturn position of the CCG's Primary Care Commissioning areas for 2018/19.

Delegated Commissioning Financial Position – Month 10

The table below sets out the year to date and forecast outturn position for 2018/19.

Area	Month 10 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Primary Care - GMS	18,073	18,024	49	21,688	21,649	39
Primary Care - PMS	7,147	7,252	(105)	8,576	8,699	(123)
Primary Care - Enhanced Services	971	986	(15)	1,166	1,176	(11)
Primary Care - Other GP services	2,982	2,754	228	3,553	3,348	205
Primary Care - Premises Costs	3,706	3,480	225	4,447	4,204	244
Primary Care - QOF	3,573	3,601	(28)	4,288	4,320	(32)
Sub total	**36,452**	**36,097**	**355**	**43,718**	**43,396**	**321**
Memo: exclude non-recurrent allocation	*(250)*	*0*	*(250)*	*(300)*	*0*	*(300)*
Revised sub total	***36,202***	***36,097***	***105***	***43,418***	***43,396***	***21***

- The underlying overall year to date position is a £105k under spend, excluding the non-recurrent allocation received from NHS England.
- The forecast outturn remains at £43.4m at Month 10, but is showing as an under spend of £21k, after the non-recurrent allocation of £300k received in Month 7.
- **GMS** is based upon current list size and includes the additional 1% pay award. The YTD variance of £49k relates to list size growth budget phasing. MPIG is per actual costs for current contracts.
- The **PMS** contract in the plan had a shortfall of £117k full year due to material list growth during 2017/18 on several of the PMS practices, resulting in a YTD adverse variance of £98k. There is an under spend on the list size adjustment and out of hours of £8.5k, offset against a variance of £15k on PMS delivery relating to Tadcaster Medical Centre.

- **Enhanced Services** have been accrued based upon claims received to date pro-rated. There is a small over spend due to a prior year claim made by a practice for learning disabilities in 2017/18.

- Year to date there is an under spend on **Other GP services** of £228k. This includes an accrual for £116k for the reimbursement of Unity legal fees in relation to their new property and £104k due to increased tariff of 6.9% for Dispensing Doctor fees from October plus seasonal variation due to flu season. This is offset by unused contingency of £180k and £250k of additional non-recurrent allocation which was received in Month 7.

- The forecast outturn for Other GP services shows an under spend of £205k. This is made up of the Unity legal fees of £116k, a £136k overspend on dispensing doctors' fees due to tariff increase set nationally of 6.9% from October and a forecast overspend on PCO Administrator (which includes Maternity & Sickness, CQC and Seniority) of £78k. This is offset by the release of the 0.5% contingency of £219k and the additional non-recurrent allocation of £300k.

- **Premises** are based on current expected costs with an assumption on rent revaluations due. Business rates are per the forecast from GL Hearn where claims are yet to be submitted. Prior year accruals of £136k have now been released as a benefit into the position. This includes a benefit against a number of Priory Medical Group properties that have had recent valuations, having missed their three yearly review periods. In Month 10, a prior year accrual of £11k has been released (included within the £136k) relating to Jorvik practice following backdated rental arrears which were lower than had been estimated.

- **QOF** achievement is based on 2017/18 actual points and prevalence. In Month 10, the accruals and forecast values have been updated to reflect the latest list size as at 1st January 2019. This has resulted in a YTD overspend of £28k and forecast variance of £32k. Prior to this, demographic growth had been estimated at 0.7% in the position, however actual growth as per the latest list size is 1.2%.

Other Primary Care *(information only)*

Primary Care within the core CCG budget is included in this paper for information only, to ensure the Committee has awareness of the wider spend in primary care.

Primary Care	Month 10 Year To Date Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Primary Care Prescribing	39,668	40,804	(1,135)	47,272	48,417	(1,145)
Other Prescribing	1,351	2,107	(756)	2,026	2,306	(281)
Local Enhanced Services	1,677	1,714	(37)	2,013	2,060	(47)
Oxygen	265	310	(46)	318	372	(55)
Primary Care IT	786	737	50	957	881	76
Out of Hours	2,661	2,680	(20)	3,193	3,243	(50)
Other Primary Care	2,284	968	1,317	3,118	1,868	1,250
Sub Total	**48,692**	**49,319**	**(627)**	**58,896**	**59,148**	**(251)**

As reported previously to this Committee, the £1.2m underspend on Other Primary Care is the impact of maintaining the currently anticipated underspends within primary care over the remainder of the year. No Cheaper Stock Obtainable (NCSO) adjustments continued to increase prescribing costs with a further increase in November 2018. This is expected to continue for the remainder of the year and the CCG is working with NHS England to understand how this can be managed.

Recommendation

The Primary Care Commissioning Committee is asked to note the financial position of the Primary Care Commissioning budgets as at Month 10.

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Item Number: 9

Name of Presenter: Shaun Macey

Meeting of the Primary Care Commissioning Committee

Date of meeting: 1 March 2019

NHS
Vale of York
Clinical Commissioning Group

Five-year Framework for GP Contract Reform - Summary

Purpose of Report
For Information

Reason for Report
To update the CCG's Primary Care Commissioning Committee on the key, new areas of work and associated funding that the contract reform introduces through Primary Care Networks (PCN's) and associated contracts.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☐Financial
☐Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

n/a

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

Five-year Framework for GP Contract Reform - Summary

1. Background

On 31 January 2019, "**Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan**[1]" was published.

This agreement between NHS England and the BMA General Practitioners Committee (GPC) in England, and supported by Government, translates commitments in The NHS Long Term Plan[2] into a five-year framework for the GP services contract.

The purpose of this paper is to update the CCG's Primary Care Commissioning Committee on the key, new areas of work and associated funding that the contract reform introduces through Primary Care Networks (PCN's) and associated contracts.

In broad terms, the contract reform covers the following areas:

- seeks to address workload issues resulting from workforce shortfall
- brings a permanent solution to indemnity costs and coverage
- improves the Quality and Outcomes Framework
- introduces automatic entitlement to a new Primary Care Network Contract
- helps join-up urgent care services
- enables Practices and patients to benefit from digital technologies
- delivers new services to achieve NHS Long Term Plan commitments
- gives five-year funding clarity and certainty for Practices
- tests future contract changes prior to introduction

This report is not intended to cover every aspect of the contract reform document, but will summarise the key requirements and opportunities for Vale of York Practices and the CCG to strengthen primary care and improve services for our population.

2. The Primary Care Network Directed Enhanced Service (DES) Contract

In The NHS Long Term Plan, Primary Care Networks (PCN's) become an essential building block of every Integrated Care System, and under the Network Contract DES, general practice takes the leading role in every Primary Care Network. This will mean much closer working between PCN's and their Integrated Care System, not just their Clinical Commissioning Group.

The GP Contract Reform document focuses primarily on the Network Contract DES for general practice, but the Primary Care Network concept is wider. It is intended to dissolve the historic divide between primary and community health services. PCN's are about provision not commissioning.

[1] https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf
[2] https://www.longtermplan.nhs.uk/

The Network Contract DES goes live from 1 July 2019, and as a Directed Enhanced Service, it is an extension of the core GP contract. This compels CCG's (through delegated functions from NHS England) or NHS England to offer the Network Contract DES to all Practices. The commissioner of the Network Contract DES is therefore the CCG in nearly all instances.

The Network Contract DES has three main parts:

- First, the national Network Service Specifications. These sections set out what all networks have to deliver. National investment and services grow in tandem.

- Second, the national schedule of Network Financial Entitlements, akin to the existing Statement of Financial Entitlements for the Practice contract.

- Third, the Supplementary Network Services. CCG's and Primary Care Networks may develop local schemes, and add these as an agreed supplement to the Network Contract, supported by additional local resources.

GPC England and NHS England are committed to 100% geographical coverage of the Network Contract DES by the Monday 1 July 2019 'go live' date.

To be eligible for the Network Contract DES, **a Primary Care Network needs to submit a completed registration form to its CCG by no later than 15 May 2019, and have all member practices signed-up to the DES**. At this stage, six pieces of information will be required:

1. the names and the ODS codes of the member Practices
2. the Network list size, i.e. the sum of its member Practices' registered lists as of 1 January 2019
3. a map clearly marking the agreed Network area
4. the initial Network Agreement signed by all member Practices
5. the single Practice or Provider that will receive funding on behalf of the PCN
6. the named accountable Clinical Director

CCGs are responsible for confirming that the registration requirements have been met by no later than Friday 31 May 2019.

Rather than approve each Network Contract one at a time, all the Network Contracts within a single CCG will be confirmed at the same time. This is to ensure that both: (a) every constituent practice of a CCG, and (b) 100% of its geographical area, are included with Primary Care Networks. Taken together, the Network boundaries within a CCG must always fully cover the CCG's own boundary.

Once the registration requirements are met and GMS/PMS/APMS contracts have been varied to include the DES, the Primary Care Network can start receiving national investment from 1 July 2019.

The key dates for introducing the Network Contract DES are set out below.

Date	Action
Jan-Apr 2019	PCN's prepare to meet the Network Contract DES registration requirements
By 29 Mar 2019	NHS England and GPC England jointly issue the Network Agreement and 2019/20 Network Contract DES
By 15 May 2019	All Primary Care Networks submit registration information to their CCG
By 31 May 2019	CCGs confirm network coverage and approve variation to GMS, PMS and APMS contracts
Early Jun	NHS England and GPC England jointly work with CCG's and LMC's to resolve any issues
1 Jul 2019	Network Contract DES goes live across 100% of the country
Jul 2019-Mar 2020	National entitlements under the 2019/20 Network Contract start: • year 1 of the additional workforce reimbursement scheme • ongoing support funding for the Clinical Director • ongoing £1.50/head **from CCG allocations**
Apr 2020 onwards	National Network Services start under the 2020/21 Network Contract DES

Every practice will have the right to join a Primary Care Network in its CCG and have a right to participate in the Network Contract DES. Akin to an additional service, a Network Participation Practice Payment will start in 2019 and will be a Practice entitlement. A typical Practice will receive over £14,000 each year from April 2019, in return for their initial and then continued active participation in a Primary Care Network as demonstrated by signing up to the Network Contract DES by 1 July 2019 and their subsequent participation. CCG's, working with LMC's, must ensure all Practice lists are covered by a Primary Care Network in their area for the provision of network services.

In the event that a Practice doesn't want to sign-up to the Network Contract DES, its patient list will nonetheless need to be added into one of its local Primary Care Networks. That PCN then takes on the responsibility of the Network Contract DES for the patients of the non-participating Practice through a locally commissioned agreement. For those patients, it receives all the Network Financial Entitlements, and it delivers the Network Service Specifications as well as Supplementary Network Services. Although this is a necessary backstop, NHS England would not wish to see it widely used.

2.1 Network List Size

A Primary Care Network will typically serve a population of at least 30,000 people. It needs critical mass to do its job. Low population density across a large

rural and remote area could be a legitimate reason for a slightly smaller network list size. That is likely to be the only permissible exception to the 30,000 population rule.

A Primary Care Network will not tend to exceed 50,000 people. Operating on a small-enough scale to make relationships work is an essential facet of the 'Primary Care Home' sites, whose experiences have informed these plans. 50,000 is a suggested upper level, not a strict requirement. Some individual Practices, or existing networks operating as super-Practices, are already bigger.

2.2 Primary Care Network Areas

Each Primary Care Network must have a boundary that makes sense to: (a) its constituent Practices; (b) to other community-based providers, who configure their teams accordingly; and (c) to its local community, given it marks the extent of PCN accountability for the health and wellbeing of a defined place. While it is possible that a single geography could be served by more than one PCN (building on current multi-practice arrangements) most areas are likely to have a single PCN.

Normally a practice will only join one network. It is likely that most network areas will not overlap, but this is not an absolute rule: **for example a large town of 100,000 population could have two different 50,000 networks operating on exactly the same footprint. They would have to collaborate together on wider place-based goals**. And a practice's catchment area may continue to span more than one network, just as it can currently span across more than one CCG (or across into Wales or Scotland

2.3 The Network Agreement

The Network Agreement must be signed by all constituent GP Practices. A national template version will be mandated to reduce avoidable legal and transaction costs. Jointly developed by GPC England and NHS England, it will be available by March 2019. **It will include a patient data-sharing requirement**, in order to support safe and effective delivery of patient care. The network will also be required to share its non-clinical data within the network and its CCG, to support network analysis or assessment of compliance of the requirements of the contract.

2.4 The Network Clinical Director

A Primary Care Network must appoint a Clinical Director as its named, accountable leader, responsible for delivery.

Together, the Clinical Directors will play a critical role in shaping and supporting their Integrated Care System. They will help ensure the full engagement of primary care in developing and implementing local system plans to implement the NHS Long Term Plan. These local plans will go much further than the national parts of the Network Contract DES in addressing how each ICS will achieve the triple integration.

In recognition of the importance of this role and as a contribution to the costs, NHS England has agreed that **each Network will receive an additional ongoing entitlement to the equivalent of 0.25 FTE funding per 50,000 population size**.

2.5 Network Funding

The Network DES comprises four different funding components:

1. the new Additional Roles Reimbursement Scheme. Whether or not the whole £891 million of national funding is spent will depend on the extent to which networks draw down their entitlement

2. network support, through a combination of an extension of the existing recurrent £1.50/head (as originally set out in the December 2018 NHS planning guidance - CCG's will continue to fund this out of their general CCG allocations) and the new 0.25 WTE contribution for the Clinical Director, which equates to £2.01/head in 2019/20 (£2.19/head thereafter). From July 2019 these will be are minimum funding requirements. Many CCGs provide additional financial support, as well as support in kind from CCG staff.

3. access, through a combination of the transferred Extended Hours Access DES and the £6/head CCG-commissioned enhanced (improving) access arrangements. These become a combined legal entitlement in 2021/22 in return for implementing the revised and more joined-up access requirements that will arise from the access review

4. the new Investment and Impact Fund. If agreed with GPC England, access to the fund becomes an entitlement, in line with national rules. The level of funding will relate to the level of achievement.

2.6 Local Enhanced Services

The national agreement covers national contract funding. It does not cover additional CCG funding for primary medical care. CCGs in discussion with LMC's, will need to review their local enhanced services in the light of the new Network Contract DES, so that their additional local funding for general practice secures services that go beyond national contractual requirements. **Most local contracts for enhanced services will normally be added to the Network Contract DES**.

2.7 Centrally Funded Programmes

The agreement also commits NHS England to new centrally-funded support:

1. the new framework to offer digital-first platforms to all Primary Care Networks, on top of the existing GP IT futures programme which replaces GP Systems of Choice
2. a significant national Primary Care Network development and support programme
3. the new primary care fellowship programme and training hubs
4. provision for expected indemnity costs
5. support for the new testbeds programme

3. Addressing the Workforce Shortfall

3.1 Additional Roles Reimbursement

In the absence of sufficient levels of GP and nurse supply, Practices have been creating other roles faster than anticipated. Expansion of the multi-disciplinary team within Practices will now be given a major boost, through the Additional Roles Reimbursement mechanism within the Network Contract DES which will start from 1 July 2019.

The reimbursement will be recurrent and not subject to any reduction over subsequent years. For each of the next five years, the total funding under the scheme will rise substantially to pay for workforce expansion. The scale of that increase will be confirmed through annual contract changes, and is subject to agreeing the seven new national service specifications to support different facets of The NHS Long Term Plan. The available funding for additional role reimbursement that can be drawn down by PCN's is shown in the following table. Note that these figures are indicative and are dependent on the final network sizes – and illustrate what could potentially be drawn down for reimbursement of staff that have been successfully recruited into posts.

	2019/20 (from July)	2020/21	2021/22	2022/23	2023/24
Average maximum reimbursement per 50,000 size typical Primary Care Network (NHSE figures)	£92,000	£213,000	£342,000	£519,000	£726,000
Approx maximum reimbursement for VoY at circa 350,000 population	£644,000	£1,491,000	£2,394,000	£3,633,000	£5,082,000

The funding for the scheme is intended to create additional posts in five specific different primary care roles. The scope of the scheme extends gradually:

Year reimbursement commences	Additional Role	Reimbursement level
From 2019	**social prescribing link workers**	reimbursed at 100% recurrently
From 2019	**clinical pharmacists**	Reimbursed at 70% recurrently
From 2020	**physician associates**	Reimbursed at 70% recurrently
From 2020	**first contact physiotherapists**	Reimbursed at 70% recurrently
From 2021	**first contact community paramedics**	Reimbursed at 70% recurrently

Model role specifications will be published by March 2019 as a guide for networks. Networks will decide the job descriptions of their own staff, and in so doing they will want to bear in mind the new service requirements in the Network Contract DES.

The intention of the scheme is to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage. It is not to fill existing vacancies or subsidise the costs of employing people who are already working in primary care, whether funded by a Practice, a CCG or a local NHS provider. **Reimbursement through this route will only be for demonstrably additional people** (or, in future years, replacement of those additional people as a result of staff turnover).

The only exception to the 'additionality' rule is existing clinical pharmacists reimbursed under either (i) the national Clinical Pharmacists in General Practice scheme, or (ii) the national Pharmacists in Care Homes scheme. Both schemes have tapered funding. Both will be subsumed into the new more generous arrangement.

These rules will be reinforced by explicit monitoring and assurance arrangements with payment clearly linked to additional staff recruited. **Funding will be released from 1 July 2019 onwards on an actual salary claims basis up to the maximum amount, at the point networks can demonstrate that the additional staff have been recruited**.

Each network will be able to decide which provider organisation employs the staff. This could be a single lead practice, a GP federation, or a community, mental health or an NHS trust (or voluntary sector organisation) if the network and that party agree.

Every network has a different local starting point and faces different circumstances. And so **NHS England is giving networks the flexibility to decide how many of each of the reimbursable staff they wish to engage**, within their Additional Roles Sum. This could mean, for example, that in 2020/21, one network chooses to employ more physician associates, but fewer clinical pharmacists. However, the national supply will be limited; and each network will need sufficient of each of the different groups in order to perform the associated national service specifications.

Each network's share will be based on weighted capitation. The basis for weighting will be confirmed in 2019.

3.2 Introductory Arrangements for 2019/20

2019/20 will be an introductory year, with simpler rules, prior to the full scheme taking effect. Rather than introduce a capitated sum, between 1 July 2019 until 31 March 2020, **every network of at least 30,000 population will be able to claim 70% funding as above for one additional whole-time equivalent (WTE) clinical pharmacist and 100% funding for one additional WTE social prescribing link worker**.

Beyond 100,000 network size, the 2019/20 reimbursement scheme doubles to two WTE clinical pharmacists and two social prescribers; with a further WTE of each, for every additional 50,000 network population size. Were a single 'super-practice', covering 200,000 patients, agreed as a network by its CCG in line with national rules, it would be eligible for four additional of each in 2019/20.

With agreement from the CCG, the 2019/2020 entitlement could be used to vary between numbers of clinical pharmacists and social prescribers, e.g. a typical network could hire two clinical pharmacists or two social prescribing link workers instead of one of each.

4. Improving the Quality and Outcomes Framework (QOF)

NHS England is implementing the findings of the QOF Review. 28 indicators, worth 175 points in total, are being retired from April 2019. 74 points will be used to create a new **Quality Improvement domain**.

The first two Quality Improvement Modules for 2019/20 are **prescribing safety** and **end-of-life care**.

101 points will be used for 15 more clinically appropriate indicators, mainly on diabetes, blood pressure control and cervical screening. The current system of exception reporting will be replaced by the more precise approach of the Personalised Care Adjustment. This will better reflect individual clinical situations and patients' wishes.

In 2019, NHS England will review the **heart failure, asthma and chronic obstructive pulmonary disease domains**.

In 2020, NHS England will review the **mental health domain** for change in 2021/22. Long term Quality Improvement module and indicator development will benefit from the new primary care testbed programme.

QOF implementation guidance will be issued by end March 2019, with full details about the 2019/20 changes. Associated changes to the Statement of Financial Entitlements will also be completed by end March 2019.

5. Delivering New Network Services

The increase in investment under the contract reform agreement includes the introduction of **seven specific national service specifications** under the Network Contract DES. These seven specifications give effect to most of the specific NHS Long Term Plan goals for primary care, not already covered through the improvements to QOF, access and digital.

The seven national service specifications are:

	Specification	Dates
1	**Structured Medications Review and Optimisation**	2020/21 in full
2	**Enhanced Health in Care Homes**, to implement the vanguard model	2020/21 in full
3	**Anticipatory Care requirements** for high need patients typically experiencing several long term conditions, joint with community services	2020/21 start
4	**Personalised Care,** to implement the NHS Comprehensive Model	2020/21 start
5	**Supporting Early Cancer Diagnosis**	2020/21 start
6	**CVD Prevention and Diagnosis**	2021/22 start
7	**Tackling Neighbourhood Inequalities**	2021/22 start

None of the formal contract specifications start in 2019/20.

A major new **national network Investment and Impact Fund will start in 2020** as a means of supporting Integrated Care System delivery of The NHS Long Term Plan.

The purpose of the Investment and Impact Fund is to help PCNs plan and achieve better performance against metrics in the network dashboard. NHS England will develop national rules and guidance. The Scheme will be overseen by Integrated Care Systems. **Networks will need to agree with their Integrated Care System how they spend any monies earned from the Fund**. These are intended to increase investment for workforce expansion and services, not boost pay.

Part of the Fund on wider NHS utilisation will be dedicated to The NHS Long Term Plan commitment to the principle of 'shared savings'. NHS England anticipates that this will eventually cover five elements:

1. **avoidable A&E attendances**, which Primary Care Networks will increasingly be able to impact through the changes around digital and access

2. **avoidable emergency admissions**, which will particularly be impacted through the Anticipatory Care Service and Enhanced Health in Care Homes

3. **timely hospital discharge**, helped by the development of integrated primary and community teams

4. **outpatient redesign**, this will be aided by the national ambition set out in the NHS Long Term Plan to redesign outpatients services using digital technology to avoid up to 30 million outpatient appointments a year. Primary Care Networks will have a critical role in supporting this ambition, whilst also increasing referrals for cancer, e.g. direct access diagnostics

5. **prescribing costs**, NHS England will review past and existing prescribing incentive schemes in 2019 to develop a standard national model

6. Digital and Joining Up Urgent Care Services

6.1 Specific digital improvements

NHS England and GPC England have agreed eight specific improvements, backed by agreed contract changes, in areas where it is realistic to make early progress, given available functionality:

1. all patients will have the right to **online and video consultation by April 2021**
2. all patients will have **online access to their full record, including the ability to add their own information, as the default position from April 2020**, with new registrants having full online access to prospective data from April 2019, subject to existing safeguards for vulnerable groups and third party confidentiality and system functionality
3. all Practices will be offering and promoting **electronic ordering of repeat prescriptions and using electronic repeat dispensing** for all patients for whom it is clinically appropriate, as a default **from April 2019**
4. all Practices will ensure **at least 25% of appointments are available for online booking by July 2019**. NHS England will launch a public campaign in 19/20 to raise awareness of the ability to book appointments online. Subject to systems capability, where patients wish, and as part of concluding the NHS 111 call, **NHS 111 could book into these appointments on their behalf where that is appropriate**, rather than requiring patients to do so in a separate process
5. whilst a Practice leaflet remains important, to recognise the changing habits of patients, **all practices will need by April 2020 to have an up-to-date and informative online presence**
6. all Practices will be giving **all patients access online to correspondence by April 2020**, as the system moves to digital by default (with patients required to opt-out rather than in)
7. **by April 2020, Practices will no longer use facsimile machines** for either NHS or patient communications
8. from October 2019, Practices will **register a practice email address with MHRA CAS alert system** and monitor the email account to act on CAS alerts where appropriate; notify the MHRA if the email address changes to ensure MHRA distribution list is updated; and register a mobile phone number (or several) to MHRA CAS to be used only as an emergency back up to email for text alerts when email systems are down.

With appropriate governance in place recognising patients' preferences, Practices will be expected to share data for digital services as outlined in the NHS Long Term Plan, like the NHS App and including contributing data to Local Health and Care Record initiatives as they come online to support information sharing with other services, in line with LHCR expectations for timeliness of data sharing.

6.2 Joining Up the Urgent Care System

In parallel with digital access, the emergence of Primary Care Networks provides an opportunity to bring more coherence to the way extended access is currently provided.

By April 2021 NHS England intends that the funding for the existing Extended Hours Access DES and for the wider CCG commissioned extended (improving) access service will fund a single, combined access offer as an integral part of the Network Contract DES, delivered to 100% of patients including through digital services like the NHS App.

Many of the enhanced access services are currently provided across more than one PCN. Their transfer into the Network Contract DES will need joint working across PCN's to deliver at the right scale.

Transition will begin on 1 July 2019. Instead of allowing the Extended Hours Access DES to draw to a close, removing £87m a year from general practice contract funding, NHS England has agreed to **transfer the Extended Hours Access DES requirements and existing funding to the Network Contract DES from July 2019** until it becomes part of the funding for the **combined access offer in April 2021**. The DES requirements will be delivered to 100% patients in every PCN, rather than those of the 75.7% of Practices currently participating so that an average network with a population of 50,000 would need to provide 25 hours extended access per week, shared between morning, evening and weekends. All extended hours slots would, as now, need to be delivered by the constituent Practices of the network.

To reflect the increased population coverage of the extended hours access requirements, funding will also increase accordingly via the Practice global sum, which also recognises the introduction of 111 direct booking.

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Item Number: 11

Name of Presenter: David Iley

Meeting of the Primary Care Commissioning Committee

Date of meeting: 1 March 2019

NHS
Vale of York
Clinical Commissioning Group

NHS England Primary Care Update

Purpose of Report
For Decision

Reason for Report

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

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☒Financial
☐Legal
☒Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Recommendations

- To approve the temporary reduction in service provision at York Medical Group

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

Vale of York
Delegated Commissioning
NHSE Primary Care Update
March 2019

Prepared by David Iley

Primary Care Assistant Contracts Manager

NHS ENGLAND – North (Yorkshire and The Humber)

2

1st March 2019

1. Items for Approval

1.1 Contractual

1.1.1 Temporary Reduction in Services – York Medical Group

York Medical Group has asked the CCG for approval in temporarily reducing their service provision to support the delivery of a staff training away day. This is an event the Practice arrange annually to support team building, staff training and quality improvement within the Practice. The proposed training day is the afternoon of Thursday 27th June 2019 which would result in a reduced service across all 8 Practice sites from 12:00 until 18:30.

The Practice would advertise the reduced service on their website and via social media channels, inform patients through the PPG as well as putting up posters in all their surgeries. To ensure patients still had access during this time telephone cover would be arranged with Vocare (Out of Hours provider) who would have the ability to respond to any urgent medical requests. The Practice will also increase their provision of urgent and same day appointments on 28th June to deal with any additional demand the reduction in service may create.

The Committee is asked to approve the temporary service reduction at York Medical Group

1.2 Estates

No items for approval

1.3 GPFV

No items for approval

1.4 Other

No items for approval

2. Items for Noting

2.1 Contractual

2.1.1 NHS Long Term Plan

The following documents have been released in relation to the future of the NHS and primary care.

- *The NHS Long Term Plan*

https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

- *Investment and Evolution: A 5year framework for GP contract reform to implement The NHS Long Term Plan*

This is the full five-year framework for GP services as agreed between NHS England and the BMA General Practitioners Committee (GPC) in England
https://www.england.nhs.uk/publication/gp-contract-five-year-framework/

2.1.2 Personal Medical Service (PMS) Agreement Review

In October 2018, the VoY CCG Executive Committee were presented with a proposal to align the price per patient of the GMS and PMS contracts as mandated by NHS England by 2020/21.

Nationally the expectation was that following the PMS reviews the price per patient would be the same for both GMS and PMS practices by 2020/21. It is now apparent that this is unlikely due to a variation in predicted reinvestment levels. After 2020/21 the MPIG will no longer exist so all future uplifts across PMS and GMS will be the same. However, unless the two contracts weighted patient values are aligned the gap between the two contract types will remain.

The committee were given 2 options for consideration:

1. Undertake a further “PMS premium” exercise post 2020/21 once the final position is known, with a pace of change over several years to erode the difference between PMS and GMS
2. Withhold or part pay the 2020/21 uplift for PMS practices so that they are immediately re-aligned with GMS practices

It was recommended that the Executive committee supported option 1. An update regarding this was provided at the November PCCC meeting.

Since the executive meeting in October, there have been further discussions with both the CCGs and LMC. A final letter was distributed to the PMS practices on 9th February 2019 (Appendix 1a and 1b) explaining that actions would need to be taken to ensure parity with the GMS contract payments from 1st April 2020 which will be managed through the issue of a formal contract variation.

2.2 Estates

No items for discussions

2.3 GPFV

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

2.4 Other

2.4.1 Changes to the Health Education England (HEE) GP Workforce Data Collection

HEE are changing the way primary care workforce data is collected. They have been working with the Department of Health and Social Care (DHSC), NHS England, NHS Digital as well as CCGs and local practices to ensure primary care workforce data is

fit for purpose going forward. Following consultation, HEE has decided to support the implementation of the National Workforce Reporting System (NWRS), which takes the form of a Data Entry and Reporting module within the Primary Care Workforce Tool (PCWT), as the only platform for primary care workforce data collection. Therefore, access to the current HEE GP Tool will be removed from 1 January 2019.

2.4.2 Pharmacy Campaigns

On 4 February, NHS England launched a 'Pharmacy Advice' campaign under the overarching brand 'Help Us Help You'. The aim of the campaign is to encourage the public to use their local pharmacy as their first choice of healthcare setting for clinical advice for minor health concerns such as coughs, colds, tummy troubles and aches and pains. The campaign will help to further build the public's trust and confidence in community pharmacists and the pharmacy team as providers of care, and ensure minor illnesses are effectively managed in the right place. The campaign materials which have also been distributed to GP Practices across England can found on the PHE Campaign Resource Centre.

2.4.3 NHS Urgent Medicine Supply Advanced Service (NUMSAS)

NHS England commission a national NHS Urgent Medicine Supply Advanced Service (NUMSAS) pilot, via referral from NHS 111 to reduce the burden on urgent and emergency care services of handling urgent medication requests.

The urgent repeat medication services allows a pharmacist to supply 'prescription only medicine' (POM) without a prescription to a patient who has previously been prescribed the requested POM. These 'emergency supplies' are made under the provisions and requirements of Regulations 225, 253 and Schedules 18 and 23 of the Human Medicines Regulations 2012 (HMR). They include a requirement that the pharmacist has interviewed the person requesting the POM and is satisfied that there is an immediate need for it to be supplied and that it is impracticable in the circumstances for the patient to obtain a prescription without undue delay.

VoY CCG have made the decision to remove the repeat prescription codes from GP Out of Hours profiles on the NHS Pathways Directory of Services (DoS) which will enable NHS 111 to refer patients to an urgent repeat medication community pharmacy service. This will save patients from attending a primary care appointment through GP Out of Hours which in turn will free up appointments for patients with a greater clinical need.

2.4.4 Dispensing Services Quality Scheme (DSQS)

DSQS is an annual scheme that rewards Practices for providing high quality services to their dispensing patients. 16 GP Practices signed up to the scheme in 2018/19 and all successfully met the criteria.

B82081	Elvington Medical Practice
B82026	Haxby Group Practice
B82073	South Milford Surgery
B82079	Stillington
B82041	Beech Tree Surgery
B82071	Old School Medical Practice
B82080	My Health Group
B82002	Millfield Surgery
B82018	Escrick Surgery
B82064	Tollerton
B81036	Pocklington Group Practice
B82074	Posterngate Surgery
B82033	Pickering Medical Practice
B82619	Terrington Surgery
B82031	Sherburn Group Practice
B82105	Tadcaster Medical Centre

The Committee is asked to note all updates in section 2 of the paper

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8th February 2019

Dear Practice Manager,

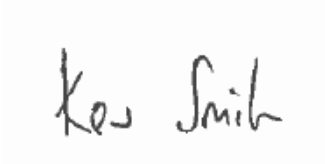
Equitable funding between GMS and PMS contracts

Enclosed is a letter from NHS England North – Yorkshire and the Humber, which is being sent to all PMS contract holders regarding the move to equitable funding across GMS and PMS contracts. The letter contains the background and next steps as to how the rate of payment for PMS and GMS Practices will be aligned by 1st April 2020.

NHS England North – Yorkshire and the Humber are intending to send out further communications in the next few weeks during which time we will start to understand the financial implications this will have on Practices. Representatives from the CCG are available to meet with you to discuss the impact of this review and support you through the process; we will be in touch soon to arrange a suitable time and date should this be something you'd find helpful.

If you have any queries please do not hesitate to contact me or the points of contact identified in the NHS England letter.

Yours sincerely,



Dr Kev Smith FFPH
GMC Number 4188269

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7th February 2019

Dear Colleague

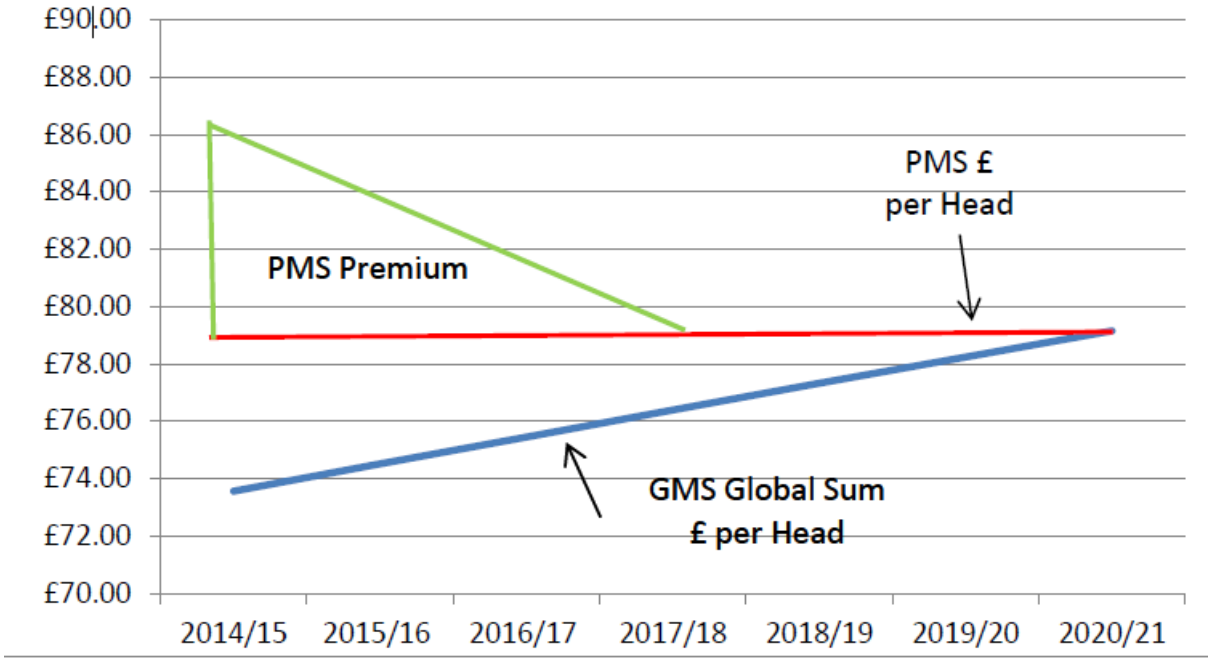
Equitable funding between GMS and PMS contracts

You may re-call that back in 2014 NHS England undertook a review of PMS contracts to determine the level of premium that was being paid when compared to GMS contracts. The approach that we took was aligned to the national guidance – Framework for PMS Contracts Review 2014 and based on our best estimations of growth on GMS contract funding. This approach was agreed locally with both LMCs and the CCGs, with the intention mitigating the immediate financial impact on the practices; managing the transition over time, rather than move practices straight to the GMS rate at the time and thereby increasing the practice PMS premiums that would be removed. Our assumptions at the time were predicated on differential increases being applied to GMS and PMS uplifts nationally. However as the level of the differentials applied to GMS payments have not been as high as we had been led to believe, it has been identified that, at current rates, GMS and PMS £ per patient are unlikely to be equitable as required by 31st March 2020.

We have been in discussions with both the local LMCs and the CCGs to make them aware of this issue and have started discussions with them around how we handle the matter. The purpose of this letter is to apprise you of the situation and set out our proposals to deliver parity from 1st April 2020.

The national requirements for the review was to extract the PMS Premium from contract payments and align PMS with GMS payments (£ per head for core services). Our local interpretation was to implement this through the *pace of change* arrangements with the PMS premium being removed by 31st March 2018 and for parity with GMS to be achieved from 1st April 2020. Our calculations were based on a predicted amount of £79.15 per head as a baseline.

To help illustrate this, I have included the original graph which was used within the review meetings to inform discussion.



NHS England- Yorkshire and Humber Finance team has recently completed a review of payments and are able to confirm that at the current rate, GMS will not achieve parity with PMS as planned. This was due largely to the impact of the application of the national contract uplifts to the PMS contracts as mandated by the national team.

Therefore, we will therefore need to act to ensure parity with the GMS contract payments from 1st April 2020. It is proposed that this will be managed through the issue of a formal contract variation (CV) to take effect from 1st April 2020. To help practices to plan and prepare for this, we will also be preparing a financial statement for the practice. The statement will schedule the estimated financial position for your practice. The CV and the statement will be finalised and sent out to you once the national contract agreement negotiations have been finalised and the financial settlement for 2019/20 is confirmed and received. This should help ensure that this statement is as accurate as possible albeit the 2020/21 uplift will still be estimated. A final statement will be issued as close as possible to April 2020 when the 2020/21 uplift is known and the financial gap can be calculated accurately.

I can confirm that in line with the earlier guidance issued under the Framework for PMS Contract Reviews, there is a clear understanding with both LMCs and CCGs, that the funding released from this review will be retained and reinvested in GP primary medical care services.

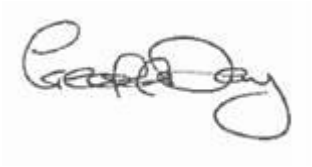
We recognise that this is not going to be welcome news to any practices and can ensure you that my team together with the CCG's will be happy to work with you to understand the impact this will have on the practice.

Given that the majority of CCG's now have delegated responsibility for the commissioning of primary care it will be for the individual committees to decide on how they manage the process. However it will not be possible for any CCG to continue to pay a differential rate to PMS practices from 1st April 2020.

I will be writing out to you again in the next few weeks to confirm the arrangements and the issue of the CV.

In the meantime, please do not hesitate to contact Chris Clarke: chris.clarke3@nhs.net or David Moore : david.moore7@nhs.net if you need further clarification.

Yours sincerely,



Geoff Day

Head of Co-Commissioning
NHS England – North (Yorkshire & Humber)

GPFV	High Impact Action (HIA)	Summary	Year	Funding	Deadline	Position February 2019
Improving Access in General Practice	5 Productive Workflows	Plan delivery of extended access as per the requirements in the refreshed Planning Guidance - access to General Practice services in evenings to 8pm, plus some weekend provision to 100 % of the population by October 2018. Reinforce links into locality programmes - and the wider agenda around the development of Urgent Treatment Centres. Planning guidance states procurement required.	2018/19	£6.00 per head	Oct-18	Providers working to secure more consistent coverage from the available workforce to cover the required clinical hours. Additional services are being brought on stream from Physiotherapists, Nurses, HCA's – with some testing of Skype type consultations. Utilisation rates are currently good, and Providers are working to increase the number of available appointments, whilst maintaining good utilisation rates. Some additional work required in individual Practices to ensure that evening and weekend appointments are being offered to all patients.
	7 Partnership Working		2019/20	£6.00 per head	Mar-19	
Reception & Clerical Training	1 Active Signposting	Funding for training of reception and clerical staff to undertake enhanced roles in active signposting and management of clinical correspondence. This innovation frees up GP time, releasing about 5 per cent of demand for GP consultations in most Practices.	2016/17		Mar-19	Funding has been confirmed of 61k for 18/19 - Federations have now provided plans on the update on the delivery for 17/18 and detailed plans for 18/19 funding, these have been approved and have been signed off with the federation leads.
	4 Develop The Team		2017/18	£ 61,000		
	6 Personal Productivity		2018/19	£ 61,000		
Clinical Pharmacists	4 Develop The Team	NHS England is inviting GP practices and other providers of general practice medical services to apply for funding to help recruit, train and develop more clinical pharmacists. Clinical pharmacists work as part of the general practice team to resolve day-to-day medicine issues and consult with and treat patients directly. This includes providing extra help to manage long-term conditions, advice for those on multiple medications and better access to health checks. The role is pivotal to improving the quality of care and ensuring patient safety.	2017/2018	£ -	Mar-20	4 Clinical Pharmacists in place covering a populattion of 127,46. Scheme not progressed within the South Locality looking at options available for Beech Tree Surgery to be able to contine within the Scheme there maybe an option in alinging with a new clinical Pharmacist scheme, awaiting further guidance from NHSE. 2 final waves are remaining for the Clinical Pharmacist scheme. NHSE will be contacting all practices for interest along with the application process - Wave 8 closes 22.2.19 & Wave 9 closes 31.5.19

ETTF	5 Productive Workflows	The Estates and Technology Transformation Fund (ETTF) is a multi-million pound programme to accelerate the development of GP premises and make greater use of technology. The aim is to improve facilities, increase flexibility to accommodate multi-disciplinary teams and develop the right infrastructure to enable better services for patients as well as increasing staff training facilities.	2017-2019	£ -	Mar-20	Sherburn and South Milford - Potential new build, 3PD project revenue neutral. PID to be developed. Beech Tree Surgery, Carlton branch - Improvement Grant - scheme cost approx £350k - scheme approved. Priory Medical Group Burnholme Health & Wellbeing Campus - Potential New Build - £10k feasibility study being undertaken by NHSE to look at local options Easingwold Health and Wellbeing Hub - New Build - Developing options paper for locality in partnership with York Foundation Trust. . Pickering - Improvement Grant to expand existing premises approved
Resillience Funding	5 Productive Workflows	Funding to support Practices to develop resilience in the following areas: Support for Practices having difficulties with recruitment Support for support Practice mergers Support for organisational development Support for the costs of a prescribing course for Practice nurses Support for an ANP to undertake a review / implement changes within the Practice that support the longer term plan / resilience of the Practice Organisational Development via a recognised programme following a CQC review that identifies improvements that need to be made	2016/17	£ 29,000		9 Schemes have been supported and approved with reimbursement to a value of £51,980. Awaiting confirmation from NHSE of the scheme going forward in 18/19 and the processes and requirements of assessing any future18/19 funding. NHSE has confirmed all funding available in 2018/19 has been committed in full.
	10 Develop of QI Expertise		2017/18	£ 49,740	Mar-18	
Patient Online	2 New Consultation Types	Work on uptake across Practices to meet national contractual targets. Most VoY Practices are achieving the targets, but there are a couple of outliers @ under 10% and 8 practices under 20%. 20% to be achieved by March 2018		£ -		Currently 6 practices remain below 20% expectation, the CCG is working with practices to see how they can best be supported.

Time For Care	4 Develop The Team 5 Productive Workflows	The programme focuses on spreading best practice, implementation support, and building improvement capability for the future. Support training and development opportunities are available for practice managers, reception and clerical staff, GPs and managers throughout the programme.		£ -	2020	CCG had initial phone call with Charlie Keeney from NHSE Sustainable Improvement Care Team to ascertain what is currently available for General Practice under the GPFV Time for Care Programme. Discussed the national programme available of support which includes: Primary Care Network Improvement Leader Programme Early Career GP development Programme Practice Nurse Development Programme Vision to deliver - 6 - 9 month action focused workshop collaborative. Further meeting to be scheduled locally to further understand involvement and timescales before engaging with Practices.
Wi-Fi Public Access	9 Support Selfcare	Patient access to Wifi from Practices https://digital.nhs.uk/nhs-wi-fi Funded by us and delivered by NHS Digital, NHS Wi-Fi is a response to patient feedback asking for free Wi-Fi services to be introduced in NHS locations. It provides an efficient, reliable and secure platform that enables GPs to offer and utilise the latest digital health and care services.	2017/18	£ 169,000	Mar-18	PA WIFI coverage is currently at 87% in the VoY area. Embed are working with the suppliers to establish dates of the final installations and any outstanding issues.
Online Consultation	2 New Consultation Types	Funding from NHSE allocated from 2017/18 to CCG's on a weighted capitation basis, once a plan for delivery by the CCG has been signed off by NHSE. With rapid development of a number of online consultation systems for patients to connect with their general practice. Using a mobile app or online portal, patients can tell the practice about their query or problem, and receive a reply, call back or other kind of appointment. They can also access information about symptoms and treatment, supporting greater use of self care.	2017/18	£ 88,962	Mar-20	Thirteen Practices have an expressed an interest in going live in 18/19, covering a potential population of 251,310. Of these four practices has since gone live with a further practice with a go live date scheduled before the end of February 2019.
	9 Support Selfcare		2018/19	£ 118,616		
	3 Reduce DNA's		2019/20	£ 59,308		
Practice Management	4 Develop The Team	Practice Management Development monies to upskill workforce	2016/17	£ 7,800	Mar-20	Allocation of £12,222.09 for 2018/19 - NHSE paid directly to YORLMC to develop PM Programme for VOY, SR and HRW including Appraisals and Coaching and mentoring.
			2017/18	£ 8,846		

Edenbridge Workforce Tool	5 Productive Workflows 10 Develop QI Expertise	Opportunity to become part of an early access programme to Edenbridge Apex - Business Intelligence tool that plugs into the Clinical System to enable Practices to better understand capacity and demand, and extract/report a range of operational/workforce/clinical data. Currently EMIS only - but SystmOne functionality in the pipeline.	2017/2018	£ -	Jan-18	12 Emis Practices have had Apex Software installed at Practice, 8 of which have had Apex configured to Practice data, with 1 of these having the Insight configured to Practice requirements. 4 SystmOne practices have indicated they wish to go live with the full Tool asap. NHSE are currently working with embed to resolve technical issues regarding the deployment of the Apex Insight Tool into SystmOne Practices which should be resolved by the 22.2.19. Further comms will be issued to
GP Retention Scheme	4 Develop the Team	The scheme is aimed at doctors who are seriously considering leaving or have left general practice due to personal reasons (caring responsibilities or personal illness), approaching retirement or requiring greater flexibility. The scheme supports both the retained GP (RGP) and the practice employing them by offering financial support in recognition of the fact that this role is different to a 'regular' part-time, salaried GP post, offering greater flexibility and educational support.		£ -		Currently 4 Retainers employed by practices across the CCG. Since the last Committee meeting a Retained GP has been approved for Gale Farm Surgery. The Retainer will be working 4 sessions a week and is entering their third year on the programme.