NHS
Vale of York
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

19 September 2017, 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 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; this will start at 9.30am.

1. 9.40	Verbal	Welcome and Introductions		
2.	Verbal	Apologies		
3.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
4. 9.45	Pages 3 to 12	Minutes of the meeting held on 25 July 2017	To Approve	Keith Ramsay
5. 9.50	Verbal	Matters Arising • Proposal for sponsorship of John Lethem annual essay competition • Primary Care Dashboard Development	 To Agree To Note	All Phil Mettam Michelle Carrington
6. 10.05	Pages 13 to 16	Primary Care Commissioning Financial Report	To Receive	Tracey Preece
7. 10.30	Pages 17 to 41	General Practice Visits and Engagement: Briefing Summary	To Receive	Andrew Phillips
8. 10.50	Presentation	Nuffield Trust Primary Care Home Report	To Receive	Phil Mettam

9. 11.10	Pages 43 to 46	NHS England Primary Care Update	To Receive	Heather Marsh
10. 11.25	Verbal	Key Messages to the Governing Body	To Agree	All
11. 11.30	Verbal	Next meeting: 9.30am, 22 November 2017 at West Offices	To Note	All

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

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Item 4

Minutes of the Primary Care Co-Commissioning Committee held on 25 July 2017 at West Offices, York

Present

Keith Ramsay (KR) - Chair	CCG Lay Chair
David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Heather Marsh (HM)	Head of Locality Programmes, NHS England (Yorkshire and the Humber)
Phil Mettam (PM)	Accountable Officer
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Tracey Preece (TP)	Chief Finance Officer

In Attendance (Non Voting)

Caroline Alexander (CA) – for item 7	Assistant Director of Delivery and Performance
Dr Lorraine Boyd (LB)	GP, Council of Representatives Member
Dr Jan Hewitson (JH)	GP, Council of Representatives Member
Shaun Macey (SM)	Head of Transformation and Delivery
Dr Shaun O'Connell (SOC)	Joint Medical Director
Dr Andrew Phillips (AP)	Joint Medical Director
Michèle Saidman (MS)	Executive Assistant

Apologies

Kathleen Briers (KB)	Healthwatch York Representative
Dr John Lethem (JL)	Local Medical Committee Liaison Officer, Selby and York
Sharon Stolz (SS)	Director of Public Health, City of York Council.

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

There was one member of the public in attendance and no questions had been submitted by members of the public.

The agenda was considered in the following order.

1. Welcome and Introductions

KR welcomed everyone to the meeting He particularly welcomed JH and HM. KR advised that HM had replaced Chris Clarke on the Committee and expressed appreciation for his contribution during his membership.

KR advised that JL, who was unable to attend the meeting, was retiring from medical practice on 2 September. KR highlighted JL's significant contribution to the CCG during his time as Local Medical Committee Liaison Officer and expressed appreciation for his involvement. PM added his gratitude and noted that a formal record of appreciation would be arranged.

2. Apologies

As noted above.

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

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

4. Minutes of the meeting held on 30 May 2017

The minutes of the meeting held on 30 May were agreed.

The Committee

Approved the minutes of the meeting held on 30 May 2017.

5. Matters Arising

PCC6 Primary Care Commissioning Committee Terms of Reference – Role of the Committee in the context of the Accountable Care Partnership Board: KR advised that this was still ongoing.

PCC12 South Milford Surgery and Tadcaster Proposals to move to Leeds North CCG: SM reported NHS Leeds North CCG had stated that at the present time they did not wish to further progress discussion with South Milford Surgery and Tadcaster Medical Centre. These Practices would therefore remain with NHS Vale of York CCG.

The remaining matters were noted as agenda items or would be included in discussion of items.

The Committee:

Noted the updates.

7. Primary Care Dashboard Development

In presenting the initial 'proof of concept' of a Primary Care Dashboard MC advised that the ongoing work included further development of prescribing indicators and ambition of primary care. She commended the team involved in bringing together the data for the first time and reported on discussion with Dr Paula Evans, Chair of the Council of Representatives who had also commended the progress and requested inclusion of locality work and Quality and Outcomes Framework. MC confirmed that consideration had also taken place in the context of the CCG's other reporting mechanisms and the NHS England CCG Improvement and Assessment Framework.

SP referred to a Limited Assurance Primary Care Commissioning Audit Report and, whilst recognising progress, expressed concern at the delay in development of the dashboard, also noting loss of previous historic dashboards. MC responded that the main delay had been due to prioritisation of Business Intelligence capacity for the amount of available data and the fact that the indicators required discussion with primary care before being published. She noted data from Public Health and the GP Survey were already in the public domain and could be presented at the next meeting, also advising that a decision was needed in terms of timescale as some data was annual and other data may be up to two years out of date.

Members welcomed the progress to date and discussed a number of aspects of further development, including how the dashboard would be used; incorporation of Public Health expected prevalence data; process issues such as patient access, fulfilling prescriptions and skill mix in Practices; comparison with NHS costs; expansion of immunisation beyond flu; and the context of collaborative working which required a system approach to the information. PM emphasised the need to prioritise creation of a transformation plan to address the significant financial deficit. He noted that General Practice was key to development of locality based out of hospital care, the Care Quality Commission assessment of 'Good' for all 26 Practices in the CCG and the strategic need to incentivise out of hospital providers. The dashboard would provide intelligence that helped inform development of new models of care to manage population health.

HM highlighted complexity due to the need to triangulate many sources of data, including relating to General Practice, other primary care providers, Public Health disease prevalence registers and the Quality and Outcomes Framework.

CA referred to the integrated performance report and proposed development of the primary care dashboard be incorporated in this work to inform prioritisation of business intelligence resources. MC additionally noted areas that needed improvement, such as Learning Disabilities Registers for which information was not routinely captured therefore annual health checks were not always provided.

MC referred to the next steps detailed which members supported. It was also agreed that a small group be established to progress this work comprising representatives from across the CCG teams, also including Lay Member(s) and NHS England Primary Care representation, and that available information be shared as soon as practicable.

The Committee:

1. Endorsed the draft dashboard and supported the next steps outlined.
2. Agreed that a small group be established to progress this work comprising representatives from across the CCG teams, also including Lay Member(s) and NHS England Primary Care representation, and that available information be shared as soon as practicable.

CA left the meeting

6. Primary Care Commissioning Financial Report

TP presented the report which provided information on financial performance of primary care commissioning as at month 3 of 2017/18. She noted that both the year to date position and the forecast outturn were almost in line with the CCG's 2017/18 financial plan which had been updated for the capped expenditure process.

TP explained that the forecast spend offsetting the £56k variance on Personal Medical Services funding was reported under Primary Care in the CCG dashboard and agreed to also include this clarification in the financial report to the Committee. She also noted the year to date overspend of £38k, due mainly to increased costs within administration for new retainers and ongoing sickness claims, and that detailed Quality and Outcomes Framework information was not presented in accordance with discussion at the previous meeting.

In respect of the Personal Medical Services monies TP referred to discussion at the previous meeting of the Committee and highlighted the indicative costs pertaining to the three parts:

i) Costs to support GP attendance at Locality meetings, Unplanned Care Steering Group meetings and Accountable Care System Partnership Board.

ii) Funding to support a GP lead in each of the localities who will work across their locality to develop the programme of work and secure engagement with each locality's constituent Practices to develop their sustainability and manage demand.

iii) Any remaining funding should be offered through localities to support constituent Practices in the management of demand.

TP advised that the indicative costs had been discussed with the Council of Representatives and that a process for submission of a 'plan on a page' for the uncommitted funding under (iii) would be expedited. She also confirmed that backdated requests for reimbursement for meeting attendance would be paid.

Discussion ensued regarding flexibility for the uncommitted funding, including in the context of the GP Forward View. LB noted the need for support to Practices to progress a locality approach.

The Committee:

1. Noted the financial position of primary care commissioning as at month 3.
2. Noted the suggested split for Personal Medical Services monies.
3. Requested that subsequent reports include identification of variance on Personal Medical Services funding.

8. Practice Visits: Update

KR noted that this item arose from discussion at the previous Committee meeting and it would become a standing agenda item.

AP reported that Practice visits and engagement took place in many ways, including individually, on a locality basis, and via the Council of Representatives where ongoing discussion included extended access. AP also noted the requirements of the General Practice Forward View. He advised that a plan was currently being developed for working with Practices based on feedback from the initial visits, as per the report presented at the last Committee meeting.

In respect of the request at the previous meeting for a matrix SM explained that a paper was being developed for strategic support to General Practice in the context of demand management and system transformation. A further paper was being developed regarding the practicalities and resource requirements of working with Practices for a longer term system approach.

SOC highlighted the various approaches for Practice visits, both formal and informal, emphasising their importance in terms of relationship building and gaining an understanding of varying issues. A flexible approach enabled Practices to raise concerns. LB supported the value of the visits.

PM welcomed the additional capacity and expertise that HM and her team were providing in terms of supporting Practices on specific issues and endorsed HM's view that Executive Directors also undertake visits to support resilience. PM requested that, in addition to SOC and AP regularly visiting Practices, Executive Team members should make three to five visits per year.

Further discussion recognised the need to ensure resources for development of the localities, a priority to achieving change; the management role of improving patient outcomes; and the intention that Practice visits would become part of "business as usual". KR added that all Governing Body members could be utilised for Practice visits.

The Committee:

1. Noted the update.
2. Agreed that Practice Visits become a standing agenda item.

9. Enhanced Services Review

TP presented the report which provided an update on current Enhanced Services commissioned by the CCG, the financial position pertaining to this area of spend, next steps on the review of all Enhanced Services, Enhanced Services contract uplift, Near Patient Testing – Amber Drugs, moving drug bandings, new drugs and continuation of drugs. A number recommendations required consideration.

In respect of Near Patient Testing – Amber Drugs SOC, as Joint Medical Director, expressed the view that the proposed uplift should be backdated to 1 April 2017 as some Practices had taken on this responsibility prior to that date. He also explained that one of the roles of the Medicines Management Committee was to agree standard shared care guidelines; these were circulated to Practices who were expected to comply. SOC also noted Practice medico-legal responsibilities highlighting that if Practices declined to provide these services there would be a cost

to the CCG through outpatient attendances. TP, however, advised that there was currently no contractual or monitoring requirement for Practices to provide evidence to support backdating the payment and provide assurance from a financial governance perspective. LB noted that even the 1 August timescale would pose difficulty for Practices to provide correct and consistent data and JH expressed concern both about the cost to Practices to provide the information and the content of the specification. In regard to the latter she received confirmation that thyroid function and diabetes testing were included.

Members sought clarification on a number of aspects of the report and discussed in detail the Near Patient Testing – Amber Drugs proposal, including the funding implications. TP referred to the £93,420 earmarked for the Local Enhanced Services review advising that a further c£5k would be required for a full year effect on a recurrent basis, also noting JL's email support for this option. She highlighted that this option would mean there would be no funding available in 2017/18 to support other priority schemes.

HM and SM referred to the wider transformation agenda, progression of out of hospital care, and the need to agree a baseline for core General Practice services and consistency of Enhanced Services. MC also noted the planned systematic strategic review for 2018/19.

TP confirmed her recommendation for the 1 August 2017 implementation for Near Patient Testing – Amber Drugs advising that, if approved, Practices would be informed and support would be provided in terms of data submission from that date. TP agreed to liaise with LB outside the meeting in respect of data collation.

The Committee:

1. Supported the development of a working group to review the priority Enhanced Services as part of reviewing all in the coming months with a view to implementing any agreed service changes from the start of next financial year, 1 April 2018.
2. Supported the uplift of all Enhanced Service agreements by 1% effective 1 April 2017 (with the exception of Near Patient Testing) to support primary care.
3. Approved the YORLMC request to update the Near Patient Testing – Amber Drugs Service Specification, through a contract variation, by including the monitoring of anti-psychotic drugs, and additional drugs included in the NHS Harrogate and Rural District CCG model, with effect from 1 August 2017 whilst the wider Enhanced Service review was undertaken.
4. Confirmed the preferred funding arrangements for 2017/18 with a further proposal to come to resolve this recurrently in 2018/19 as part of the wider review.

10. Notional Rents

TP referred to the report which sought approval for notional rent adjustments as notified by the NHS England Primary Care Finance Team in respect of: Gale Farm

Surgery, Millfield Surgery, MyHealth, Drs Jones and McPherson, Front Street Surgery, Terrington Surgery and Beech Tree Surgery.

LB explained that the Millfield Surgery increase was substantially more than the other Practices due to expiry of funding from Hull York Medical School.

The Committee:

Approved the notional rent adjustments for Gale Farm Surgery, Millfield Surgery, MyHealth, Drs Jones and McPherson, Front Street Surgery, Terrington Surgery and Beech Tree Surgery.

11. Quality and Outcomes Framework

HM advised that a quality review, rather than the financial perspective, of the Quality and Outcomes Framework was currently taking place. In the meantime an overview of the aims and principles of the Quality and Outcomes Framework was presented to provide members with a better understanding. HM advised that the Quality and Outcomes Framework had supported systemised care and LB emphasised that the payments were integral to the survival of General Practice.

The Committee:

Supported the recommendations to:

1. Utilise the national annual report which provided a systematic review
2. Establish a small team (clinician, commissioning manager and data analyst) which would also be linked to the Primary Care Dashboard development
3. Review disease register size compared to expected prevalence as evidenced by population demographics, RightCare information and Public Health data
4. Compare exception reporting levels
5. Carry out Practice review visits to outliers to discuss the potential reasons for this and provide support to Practices where appropriate

12. NHS England Primary Care Update

HM referred to the report which provided updates in respect of the Estates and Technology Transformation Fund, Dispensing Services Quality Scheme, GP Clinical Waste, Resilience Funding, Practice Based Pharmacist Scheme and rent reviews. In respect of the latter HM highlighted that NHS England was working with the small number of Practices where rent reviews were outstanding and requested that return of the required paper work be expedited.

The Committee:

Noted the updates.

13. Key Messages to the Governing Body

- The Committee welcomed the development of the Primary Care Dashboard noting that the ongoing work included increasing relevance of information
- The Committee noted the all members of the Executive Team and Governing Body would be asked to undertake Practice visits
- The Committee approved recommendations relating to Enhanced Services

The Committee:

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

14. Next meeting

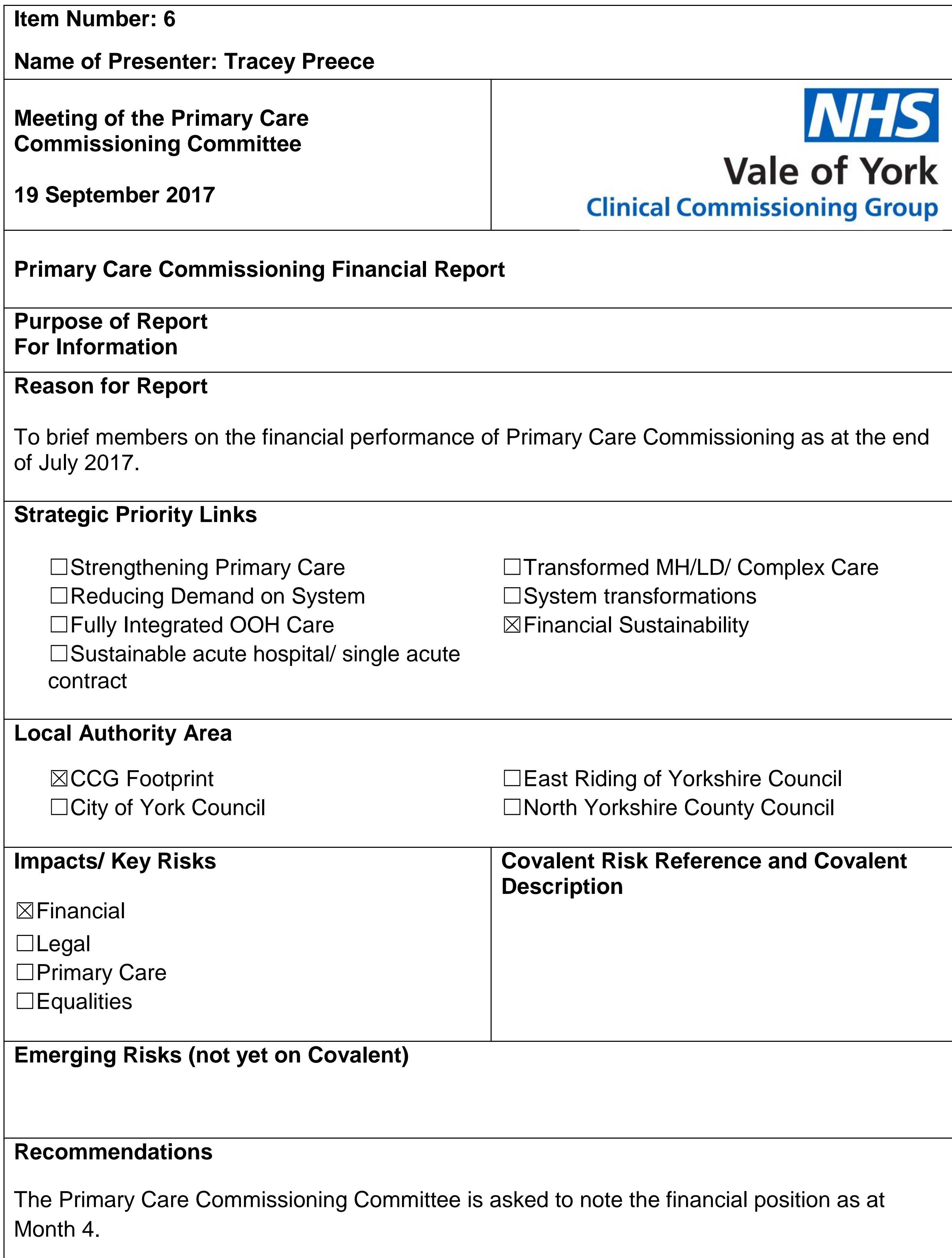
9.30am on 19 September 2017 at West Offices.

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE

SCHEDULE OF MATTERS ARISING FROM THE MEETING HELD ON 25 JULY 2017 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCC6	28 February 2017 28 March 2017	Primary Care Commissioning Committee Terms of Reference	• Discussion to take place of the role of the Committee in the context of the Accountable Care Partnership Board with the Executive Director of Planning and Governance • KR to discuss with PM	SM KR/PM	 Ongoing
PCC21	30 May 2017 25 July 2017	General Practice Visits – Summary to April 2017	• Further report to include a matrix of the issues, proposed next steps, resource implications and expected outcomes • To become a standing agenda item	SM	25 July 2017 With effect from 19 September 2017
PCC22	25 July 2017	Financial Performance Report	• Variance on Personal Medical Services funding to be included in the financial report	TP	With effect from 19 September 2017

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCC23	25 July 2017	Primary Care Dashboard Development	• A small group to be established to progress the work comprising representatives from across the CCG teams, also including Lay Member(s) and NHS England Primary Care representation	MC	
PCC24	25 July 2017	Quality and Outcomes Framework	• A small team (clinician, commissioning manager and data analyst), also be linked to the Primary Care Dashboard development, to be established	HM	



Item Number: 6

Name of Presenter: Tracey Preece

Meeting of the Primary Care Commissioning Committee

19 September 2017

NHS
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Clinical Commissioning Group

Primary Care Commissioning Financial Report

Purpose of Report
For Information

Reason for Report

To brief members on the financial performance of Primary Care Commissioning as at the end of July 2017.

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	**Covalent Risk Reference and Covalent Description**
☒Financial ☐Legal ☐Primary Care ☐Equalities	

Emerging Risks (not yet on Covalent)

Recommendations

The Primary Care Commissioning Committee is asked to note the financial position as at Month 4.

Responsible Executive Director and Title	**Report Author and Title**
Tracey Preece, Chief Finance Officer	Michael Ash-McMahon, Deputy Chief Finance Officer

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

Report produced: August 2017

Financial Period: April 2017 to July 2017

Introduction

This report details the financial position of the CCG's Primary Care Commissioning areas at year to date and at forecast outturn (FOT) level.

Financial position – Month 4

The table below sets out the year to date and outturn position as at Month 4.

Area	Cumulative To Date				Forecast Outturn		
	Budget £000	Actual £000	Variance £000		Budget £000	Actual £000	Variance £000
Primary Care - GMS	6,919	6,881	38		20,758	20,758	0
Primary Care - PMS	2,865	2,782	83		8,594	8,594	0
Primary Care - Enhanced Services	370	370	(0)		1,110	1,110	0
Primary Care - Other GP services	949	994	(46)		2,988	2,988	0
Primary Care - Premises Costs	1,416	1,414	2		4,248	4,248	0
Primary Care - QOF	1,366	1,413	(47)		4,099	4,099	0
Sub Total	**13,885**	**13,855**	**30**		**41,797**	**41,797**	**0**

The total FOT figure of £41,797k remains in line with the 2017/18 CCG financial plan for the capped expenditure process submitted on the 12th June.

GMS has been calculated based upon current list size, resulting in a year to date under spend of £38k.

The PMS contract is on budget, which assumes Scott Road sign up to the NHS England calculated contract. This has been formally agreed and sign-up is in progress presently. The budget for CCG premium reinvestment funding is showing as slippage (£74k YTD), spend against this funding is reported under primary care in the main CCG dashboard. The list size adjustment and Out of Hours deduction are £9k under as per the current list size

The year to date position on other GP services is showing an overspend of £46k, due in the main part to increased costs within admin for new retainers and on-going sickness claims.

Premises Costs are based on current expected costs with an assumption on rent revaluations due. However, rates are accrued to budget pending confirmation of the 2017/18 actual cost.

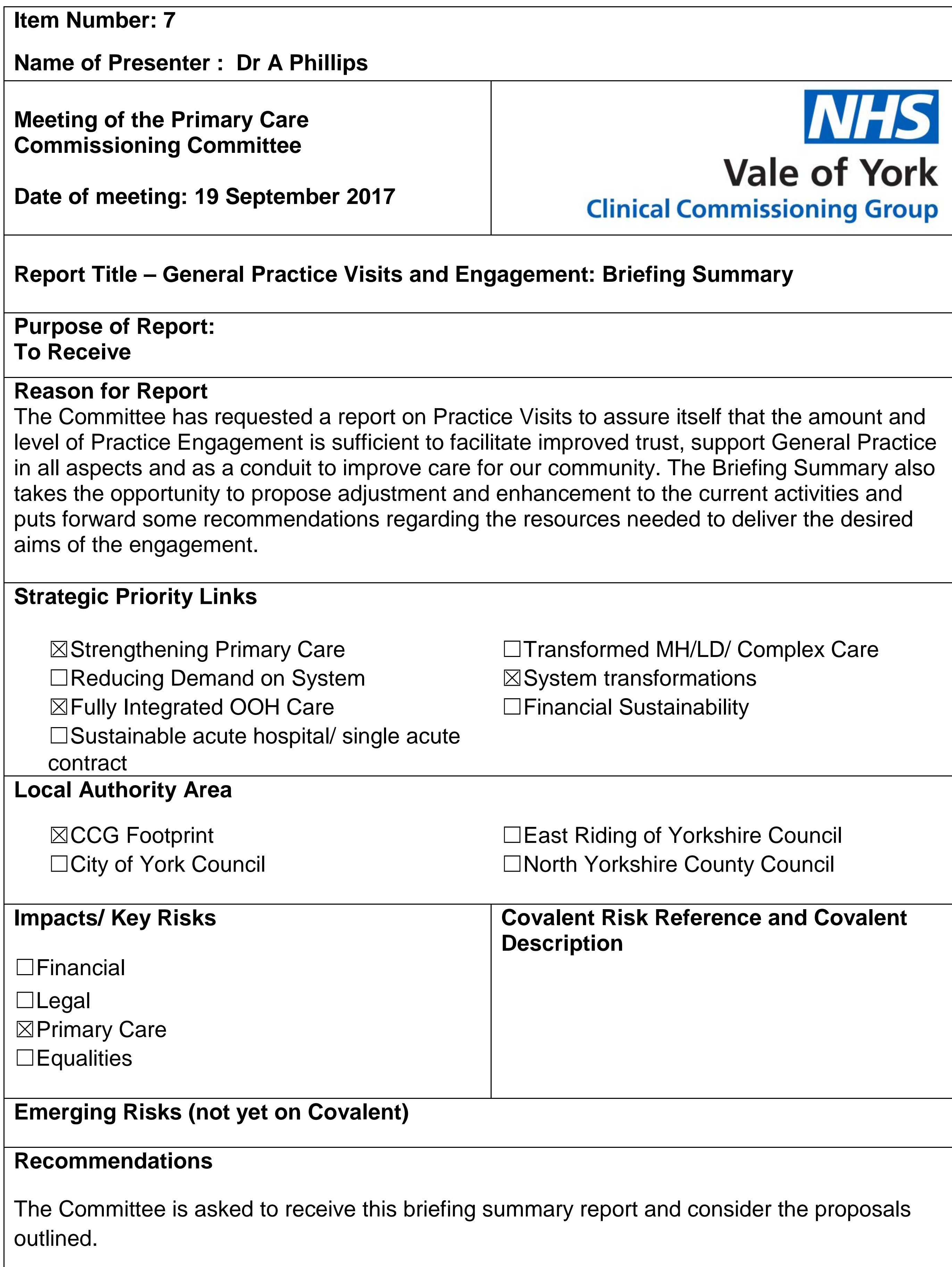
QOF has been accrued based upon 2016/17 points and prevalence at 2017/18 prices with an increase of 0.7% for estimated demographic growth. This has resulted in a £47k YTD adverse variance.

As we have not been advised of a legacy cost centre to use we have currently accrued out prior year variances to budget pending finalisation of all 2016/17 costs. However, we are aware of a number of emerging issues listed below to date:

QOF - £121k under accrual against 2016/17 actual claims
Dispensing Doctors - £11k over accrual against 2016/17 costs

Recommendation

The Primary Care Commissioning Committee are asked note the financial position of the Primary Care Commissioning budgets as at Month 4.



Item Number: 7

Name of Presenter : Dr A Phillips

Meeting of the Primary Care Commissioning Committee

Date of meeting: 19 September 2017

NHS
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Report Title – General Practice Visits and Engagement: Briefing Summary

Purpose of Report:
To Receive

Reason for Report
The Committee has requested a report on Practice Visits to assure itself that the amount and level of Practice Engagement is sufficient to facilitate improved trust, support General Practice in all aspects and as a conduit to improve care for our community. The Briefing Summary also takes the opportunity to propose adjustment and enhancement to the current activities and puts forward some recommendations regarding the resources needed to deliver the desired aims of the engagement.

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 Committee is asked to receive this briefing summary report and consider the proposals outlined.

Responsible Executive Director and Title	**Report Author and Title**
Dr A Phillips Joint Medical Director	Dr A Phillips Joint Medical Director

Vale of York Clinical Commissioning Group: Engagement with General Practice Briefing Summary

The purpose of this briefing summary is to describe current Practice visits and engagement arrangements and to propose a Practice Visits and Engagement Plan to the Primary Care Commissioning Committee for their consideration.

Practice Engagement is a vital element of the functioning of the CCG. It crucially facilitates trust between the CCG Practices as both commissioners and providers. Central to this engagement is visiting Practices and their staff to achieve multiple aims; most notably to build trusting collaborative relationships that support service transformation and the development of sustainable services. Predominantly these visits are based on the GPs and their Practices as providers. These activities comprise a complex interaction requiring clear communication, reliable data and analysis, and transparent objectives. As such, they require skilled and effective delivery that is flexible and responsive to individual Practice needs.

In the last 12 months, every Practice has had at least one visit. Several Practices have had follow-up meetings to resolve specific issues regarding estate, service delivery, IT and specific pilots or projects. These visits have taken the feedback and, where required, have been actioned as far as possible. Examples include, estate challenges presented by significant projected population increases and the increased workload experienced by General Practice because of the transition of patient management between secondary and primary care. The latter has been informed the work undertaken by the CCG with York Teaching Hospital NHS Foundation Trust in relation to the adherence to the Six Hospital Standards guidance that was promulgated earlier in 2017.

Other feedback has come in the form of the Practice Manager feedback (refer to the General Practice Improvement Programme Meetings Summary attached).

The Aims of Practice Engagement

- To build trust with the Practices and their Localities
- To share and agree the Vison and Strategy of the CCG to meet the health and care needs of patients
- To take opportunities to incentivise and influence
- To listen and understand Practices' concerns and issues and act on them
- To support Practices to be resilient and sustainable
- To support Practices to transform their service models to align with other providers
- To support transformation of services in localities
- To support the overall objectives for high quality General Practice

    - Improved access to primary care and the integrated wider out of hospital services with more services closer to home ('Place-based Care')
    - High quality Out of Hospital Care based around our three Localities
    - Improved health outcomes, equity of access, reduced inequalities

- A better patient experience through joined up services and coordinated care both in and out of hours

Types of Practice Engagement and Agendas

There are several types of meetings held by the CCG which GPs attend. These tend to be at West Offices. The GPs who attend these provide input, insights and ideas which are vital to the development of projects and improved service delivery. However, there is a requirement for visits to Practice sites to speak to a wider Practice audience and to discuss Practice specific items. One of the problems is that we tend to see the same GPs at the CCG meetings and the Council of Representatives and do not have a wider discussion with the younger Partners (who will be taking on the transformational elements in the coming years) and the salaried GPs who have a valuable voice in how services should be commissioned. Practice visits give us some access to them and the wider Practice staff including Practice Nurses and Practice Managers.

Individual Practice visits demand our own staff resource and need to be co-ordinated properly. In the past visits could have been better prepared and supported to make the meetings more effective, and this is a lesson that we have noted. However, the meetings that have gone ahead have been fruitful for both sides and have led to further discussions to enable issues to be resolved or plans developed. In the future, this prior preparation should be an integral part of any Practice visit plan.

Practice engagement activities are varied and arise from differing agendas and functions. There is a high degree of complexity reflecting the various stages of programmes and their progress. Some of the Practice meeting agendas have been complicated and confused by Practices having different involvement in projects and different levels of understanding. It would help to have a more sophisticated and co-ordinated approach to these visits to make the process more efficient and objective. We should note that the CCG staff who visit the Practice should be determined by the agenda and should not always include the same people, however there should be some consistency.

Individual Practice meetings tend to occur around lunchtimes to increase the likelihood of GP attendance. Other Practice meetings (see below) require more time and formality and therefore the issue of backfill often crops up as a challenge to GPs' attendance. This is recognised in other CCGs who provide specific funding for GP backfill. For example, for a rate of £0.50 per patient, a fund could be provided that would include all GP attendances at planned events over a year. This could align with the current proposals to support GP attendance using money already identified to support Locality development this year; a prior agreement with the Practices would be needed.

There are several types of visit/engagement for Primary Care which include formal visiting of various types.

Practice Visits by type:

A. **Individual Practices Visits (Operational)** – to discuss performance, estate issues, Quality and Outcomes Framework, telephony, IT, staff training, enhanced services, variation. General Practice Forward View, feedback on specific service issues (Hospital Standards, allocation versus need). Financial considerations. Enhanced Services involvement. Education eg sepsis pathway.
B. **Individual GP meetings** – These are as required meetings where issues have been identified and there is a need for additional engagement with GP influencers and leaders. Typically, this will be to build on trust (intimacy, benevolence, credibility), brokerage, facilitation of process and transformation.
C. **Locality (Transformation) visits/meetings** – Strategic and tactical aspects of service development and delivery, QIPP, financial considerations.
D. **GP Practice Improvement Programme** – selection of modules to improve all aspects of Primary Care delivery.

Additional Engagement Opportunities:

E. **Locality Delivery Events** covered by Out of Hours locally, suggested 4 per year for each locality – this then means that the discussion is with all of the GPs and not just the partner leaders. Two afternoons for locality events (locality to determine the scope and what they want to achieve in that time – trajectory of delivery needs to be agreed). Two practice meetings for General Practice Forward View/access/operational resilience – could these be hosted that at the CCG offices – they can then meet the wider team.
F. **Practice Manager Forum**
G. **Practice Nurse Forum**
H. **CCG Transformational Agenda Forum** – Project Initiation Documents review, Frailty, IT, access, enablers
I. **Federated Groups** – These tend to be ad hoc meetings for specific issues at the federation's request, NIMBUS, CAVA, SHIELD, non-federated
J. **Council of Representatives** – commissioning forum. These meetings are already planned in.
K. **Additional Meetings** – facilitated networking between Practices and federations and collaboration with organisations (Clinical Summit), individual visits by Accountable Officer/Medical Directors,
L. **Local Medical Committee Meetings -** (regional and Local). These are booked well ahead and are usually attended by the Joint Medical Director/Head of Transformation and Delivery.
M. **Project Support in General Practice –** this should include CCG staff time to support transformational work where a Practice or Locality feel they have no capacity. This is therefore an option when financial resource is not available. It may help to build trust through benevolent action.
N. **Project Specific Meetings –** examples include Alternative Medical Services negotiations in preparation for a potential procurement.

Locality Visits are already planned in for the next three months (see unplanned care meetings - overview), the topics of consultation are:

- North: Same Day Urgent Access, Multi Disciplinary Team/Intermediate Care
- Central: Same day Urgent Access, Self-care Project, Frailty Project
- South: Same Day Urgent Access, Intermediate Care/Integrated Teams, (Prevention).

These unplanned care meetings are supported by the Unplanned Care Programme Board/Steering Group, and Delivery, Assurance and Support meetings.

Proposed Practice Visit Format and Plan

The first principle is that the current avenues of engagement should continue. Where there are specific objectives (General Practice Improvement Programme, Practice Nurse Forum, etc) there is no perceived need to change their format.

Each Individual Practice will get at least one visit every 6 months with additional follow-up meetings as required. The agenda will determine the information and data resources made available beforehand and the people attending the meeting.

1. Bi-annual Operational visit: to discuss the core agenda items

   Variation Referral Support Service data
   Care activity data (including allocation vs need)
   Care process data
   Quality and Outcomes Framework
   Feedback of workforce and skill mix data

   These meetings will also cover additional items from the following list:

   Premises
   Workforce
   GMS/PMS reviews
   Core, enhanced and locally commissioned services
   Performance and Quality Development
   Information Technology
   Information Sharing
   Operational Resilience
   Service Development

2. One Transformational Programme Visit

   Frailty/Elderly
   Project Initiation Document Programmes
   Integration of Services
   Locality Progress and enablers
   QIPP
   Educational elements to support programmes such as sepsis or Referral Support Service pathways

Practice Visits Plans to be led by (and not necessarily attended by):

Primary Care Director
Joint Medical Director for Out of Hospital Care
Locality Managers
Finance representation
NHS England support

Other potential avenues of engagement when Practice Visits are not achievable should be considered to make it easier for the CCG to achieve its aims. These could include:

- Skype/Video Teleconference Meetings
- Webinars
- Social Media facilitated Practice/Locality Networks

Risks

- There is insufficient CCG Practice Visits Team Capacity to be able to fulfil the commitments to engagement.
- General Practice Forward View and Practice focussed funding sources – There is a high degree of complexity to these arrangements that can lead to misunderstanding and therefore difficulties in getting agreement across all Practices, Alliances and Localities.
- Workforce – especially the GPs ability to attend meetings.
- Funding pressure on CCG and lack of Practices understanding on the access to funds and just what is available and to whom.
- Oversubscribed Estates Transformation and Technology Fund – decisions could be seen as divisive by individual Practices which can undermine their trust.
- Practice visits do not have a clear narrative to refer to, which creates confusion and misunderstanding and could undermine trust and involvement in transformation.
- The Practice visits do not refer and link back to the Patient Participation Group (PPG) feedback and risk the loss of trust in the process.
- Appropriate Practice Activity Data is not available (or credible) and therefore a lack of evidence renders discussions ineffective.

Proposed Actions to Support a Practice Visits and Engagement Plan

1. Publish a programme of Individual Biannual Practice (operational) visits booked and prepared for over the next 12 – 18 months.
2. Prepare a process of collating relevant evidence and data prior to the meeting and agree the aims of individual Practice visits. This information should comprise a Practice data pack that should be standardised to maintain equity. This data should inform and enable agreements for any service changes and should range from Public Health assessments through to immunisation uptake, non-elective activity, referral activity, PPG feedback, prescribing and Mental Health access.

3. The outputs of these visits should support a co-produced vision and strategy for General Practice. The next set of visits could inform the development of Practice packs.
4. The CCG should aim to publish a Programme of Locality Meetings for the next 12 months aligned to key delivery milestones with the requirement to ensure high levels of GP involvement.
5. Establish a process to agree any financial support to GPs to attend any type of meeting/visit. The issue of backfilling GPs' time has been raised on numerous occasions.
6. Agree to provide an annual Practice Visit and Engagement report to the Primary Care Commissioning Committee.
7. The core team to meet to scope other avenues of engagement/involvement such as skype/video teleconference.
8. The CCG Executive will need to agree the provision of staff and time to allow the Practice Visit Plan to proceed effectively.
9. The CCG should articulate our Practice engagement and visits offer to General Practice.

Andrew Phillips

September 2017

General
Practice
Improvement
Programme

Fast
Practical
Improvement

Vale of York CCG – Practice Manager meetings summary

KM&T
OUR KNOWLEDGE YOUR POTENTIAL

wdid

A joint development by KM&T and wdid

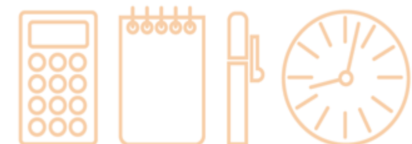
Overview

General Practice Improvement Programme

As part of the ongoing commitment to the Vale of York Practices and their development, our plan was to contact and engage with the 4 original development practices and the 12 “second wave” practices. It’s purpose being to understand where each practice was following the completion of the programme and to what level the work areas had embedded. Additionally we would look to understand their thoughts around the programme and what if anything they would want to undertake next or where they required further support.

All 16 practices were contacted via e-mail and with follow up phone calls to arrange a meeting at the practice. 9 practices were able to meet within the timescale whilst 2 practices provided a high level (brief) phone call. 4 practices are unable to discuss prior to Christmas and have asked if we can arrange for the New Year. We have been unable to make contact to arrange a meeting or a call with one practice.

It has been very pleasing to note that every Practice Manager who took part were able to outline many successes even if some areas had not embedded as deeply as others or that they had struggled to implement. Additionally in all discussions the Practice Managers expressed the benefit of going through the Programme and were pleased to have been part of it.



The Practices

General
Practice
Improvement
Programme

Practices met with

York Medical Group
Old School
Tadcaster
Tollerton
Millfield
Elvington
Unity Health
Pickering
Sherburn

Practices with telephone appointment

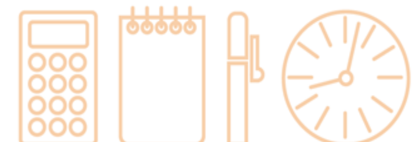
Posterngate 16/12/15 (vey brief, requires follow up visit)
Helmsley – 21/12/15

Practices unavailable until 2016

My health - Stensall
Clifton
Pocklington Group
South Milford

Unable to contact

Stillington



Old School Medical Practice

General Practice Improvement Programme

General

The Practice undertook 4 modules for which the Practice Manager felt the communication and delivery was excellent. On reflection he thinks the logistics of gathering the required staff to the sessions could have been better and would have helped improve the implementation particularly if there could have some way in providing backfill to cover the key staff on the day. *"Overall very pleased to have been involved and would recommend it to anyone"*

Workplace Organisation

The module started in the clinical rooms and has been maintained, additionally has progressed into admin and the Nurses rooms which have been standardised. Stock control systems have improved along with emergency kits & out of date drug control. Responsibilities & auditing has been improved

Consistency of Approach

Original focus was prescription management which developed a number of good actions that will support the implementation of the paperless prescription system. They have identified inconsistencies in the reception team which they want to address next but hasn't started to date

Chasing the Tail

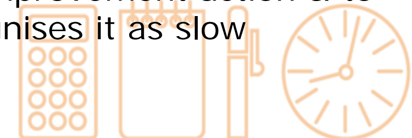
They identified that CTT has stalled a little due to the appropriate meeting structure not being put in place. When they have run the meetings they've been happy with it but its's been inconsistent. They have agreed and set up a regular report run to view the patients & focus is being placed on agreeing the meeting structure to allow reintroduction.

Minimum Job Requirement

The T-card board was set up for the reception area and after the original focus there was a period where it wasn't used to full potential. Since then the leader of the area has recognised the benefit and now ensures all tasks are completed.

Further GPIP support

The practice manager indicated he would like to undertake the E-mails & meetings module with a view to linking it to Chasing the Tail to further develop the CTT meeting structure.
Additionally he would like to revisit the Consistency of approach both for the original improvement action & to resolve a new issue. Overall the PM is confident with the direction in general and recognises it as slow progress but would also welcome refresher sessions to maintain and improve skills



Tadcaster

General Practice Improvement Programme

General

The Practice undertook 4 modules during the development stage, the main elements are still the same but there are a few improvements to the interventions that the practice would benefit from. The practice manager felt that the time *"commitment was very challenging but the benefits of what was implemented has made it a worthwhile experience"*

Chasing the Tail

The practice felt was their big "eye opener" and has subsequently completely changed their MDT meeting. All clinicians bring CTT ideas and are more challenging with regular push back asking "what can we do". Also now run peer review sessions of consultations, the report is run regularly and can now spot increased attendances of patients at an early stage.

Workplace Organisation

The upstairs office was the original focus and was greatly improved, more importantly the thinking of the staff has also changed for the better. There has been no further group activity of the roll out but individually many of the staff have applied the learning to their individual areas

Consistency of Approach

A successful module that improved their handling process for incoming mail. The practice is currently looking at Hypertension with a view to review their Warfarin & Travel processes

Minimum Job Requirement

This was the least effective modules which didn't "get off the ground" for a number of reasons. The T-card rack was not fit for purpose and fell apart. Additionally the skill matrix wasn't developed at this stage

Further GPIP support

Following a discussion around MJR and what options for boards there are now available and the addition of the skill matrix the PM felt they would like to revisit this module. Additionally the PM asked if there could be further support to help with the CoA module

Sherburn

General Practice Improvement Programme

General

The Practice Manager felt that *"GPIP has a fantastic ethos behind it with great practicalities for implementation"* The practice undertook 5 modules. Time was felt to be the biggest constraint the PM felt that they could have achieved better results if they could have provided backfill options

Workplace Organisation

Some really good results have been achieved, started in the admin. area and have since moved on to Nursing room stock control. The PM reflected that they would have liked to have measured the improvement more but they were unsure how to. Additionally stationary costs are now tracked, GP rooms have been improved also which was commented on in the CQC audit

Workforce Planning

This area provided more of an assurance to the practice that they were in already using a solid and sound method. It did however highlight a few surprises in their perception of busy periods.

Chasing the Tail

The original perception was that they felt they were not doing everything they could for the patient review. The intervention largely reinforced the GP's opinion, they now bring patients to review using the new method at the weekly MDT meeting.

Minimum Job Requirement

Implemented in the reception team originally, since then the PM has also adopted the system in her office and the Nursing team are also now using it. Still to implement the skill matrix.

E-mails & Meeting Management

E-mail improvements have worked well internally with protocols being developed to improve how and what is written and reduced the volume of traffic. Additionally they are focusing on a single point of contact. The intervention also highlighted the meetings improvements to make and also identified there was no meeting with the full staff group which has now been implemented. The Partners meeting has been improved with just small tweaks required, all practice meetings now have agendas, start and finish on time with topics timed. The behavioural change has been difficult but has been worthwhile

Pickering

General Practice Improvement Programme

General

It is felt that the programme has been a huge success in many ways and is recognised that the financial savings are without question the general benefits are harder to quantify. *"There's nothing it doesn't help, you can apply what you've learned anywhere, its all been invaluable". "This programme has the full respect of the Partners – which doesn't happen easily!"*

Workplace Organisation

Reception was the original development area, at times still need to keep on top of staff as audits aren't fully implemented but the area's are much better than before. Nursing has been completed since but they want to revisit, Admin & Secretarial are the next areas to go live

Chasing the Tail

There have been a number of significant improvements which include focus on long term & palliative care, Diabetic management, at every 3 months review need for visits (potential 400 appointment reduction) Social want V's clinical need.

Minimum Job Requirement

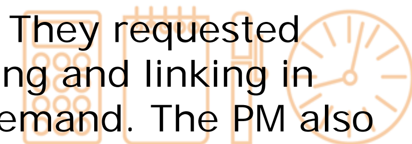
Began in reception area, understood and embraced by staff, Nurses have been identified as the next area and the IT area has also requested involvement. It has also been used to begin to help address staffing issues. The practice has identified a very high overtime issue and by managing workloads this will reduce significantly. Also beginning to look at the right patient matched to the right clinician to ensure effectiveness & value for money.

Capacity & Demand

This isn't part of the standard gpip delivery but was agreed to include as a development option. Some useful activities and understanding came from this but the practice feel that there is still more needed and would like to continue with this further.

Further GPIP support

The PM is very keen to continue and would welcome support immediately. They requested that they would like to continue pre Christmas looking at Workforce planning and linking in the skill matrix in MJR. They also would like to continue with Capacity & Demand. The PM also would like support in working through E-mails & Meetings and Consistency of Approach



Unity Health

General Practice Improvement Programme

General

The practice as a whole have been pleased to have been part of the development phase and have learned a lot form the programme, the Clinicians in particular have enthused about the programme. The practice undertook 5 modules with E-mails & meetings felt not to be needed

Workplace Organisation

Nursing rooms was the original focus and has since moved to their consulting rooms and also Admin cupboards. The PM feels that this has been most useful prior to the new build as they have been able to discuss ideas with the architects.

Minimum Job Requirement

This area has been focused with the Duty Doctor at each of the Surgeries, the practice are looking at ways to "make global" They have had 2 trials to date and used "5 Whys" etc. to tweak in preparation for the upcoming third trial.

Chasing the Tail

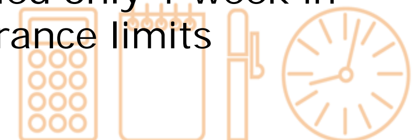
It is felt that this has absolutely been embedded with quarterly reviews of "frequent flyers and their commonality. Also they review the variation of GP recall, they run the report and produce the graph regularly. Now focusing on pre- frequent flyers, overseas student attendances & e-consultations

Consistency of Approach

Linked to CTT for the GP recall process, they have identified that they next want to review the university student mental health processes with focus on diagnosis, their journey, the inconsistencies and self help/ownership and post diagnosis pathway. Also they have identified for the future to review the diabetic process.

Workforce Planning

This has been a general review around clinical timings etc. as they identified only 1 week in 52 they had sufficient capacity. Rolled out to Nursing upper and lower tolerance limits additionally taking into account seasonal and university time.



Elvington

General

"GPIP has had a very positive impact upon the Practice as a whole and it's staff", it has been received well and is clearly being used every day. The practice undertook 4 modules

Workplace Organisation

WO commenced in the Admin office and has since been adopted in almost every room in the practice including the GP rooms(varying levels of success but all have seen an improvement) Ordering & restocking processes have been addressed & the next main project is to be the main office layout, all the staff are involved in redesigning the area.

Workforce Planning

Initially focused on the Dispensary, a very good level of engagement was achieved with the staff and everyone getting involved. The team focused on holiday entitlement rules, breaks and created a list of "golden rules". GP availability is the next focus area planned.

Consistency of Approach

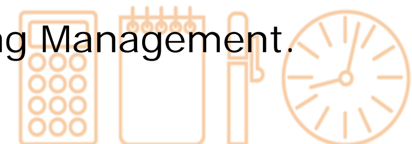
The incoming mail workflow was initially investigated, the focus has now moved slightly to coding. It is planned to begin to look at the internal IT systems early in the New Year. A driver diagram for the Nursing dressing pathway has been developed.

Chasing the Tail

In its wider sense this intervention hasn't been fully embraced. Prior to the intervention the clinicians felt that held regular well run MDT meetings and the opinion hasn't changed. However the meeting review itself was of some value and has changed the way the meeting is run slightly, also the team look to try to establish groups or themes within the patient profile

Further GPIP support

The practice have identified that they would like to look at E-mail & Meeting Management.



Millfield

General

As one of the four development practices, the PM remains committed to the programme and is still very much focused on continuing the implementation of the methods and skills of gpip.
4 intervention areas originally implemented

Chasing the Tail

CTT was well received, with the new way of working still very much in use. The practice have now looked numerous areas including Hypertension, blood pressure monitors, high end users or the practice and are currently working back to the lower appointment patients. Reports are run and MDT meetings review patients regularly in the new format

Workforce Planning

The intervention originally focussed on Admin, has since looked at GP's, Dispensing and Nursing. The practice have identified a shortfall in staff as they were able to quantify the true need. With WP and in conjunction with MJR they have given the supervisor confidence to instruct and challenge, staff now think differently and Team Leader positions have been created to support.

Minimum Job Requirement

Since implementation the staff have gone on to identify tasks that are no longer needed (birth book) ring fence time in areas that has saved time overall (2hours / month in reception) and change ways in which they operate, message book & notifications on EMIS, also Nursing now use an electronic version of the Visual board located on Intradoc.

Workplace Organisation

This intervention was initially started in the general reception area but has since been developed in the admin areas, stationary cupboards and the GP files.

Consistency of Approach

This intervention fell towards the end and had only a high level review of the GP consistency and hasn't really embedded

Further GPIP support

The practice have identified that they would like revisit Workforce Planning & Consistency of Approach plus additional collaboration events. They also are going through a potential new build and would like Project Management support training

York Medical Group

General Practice Improvement Programme

General

GPIP was well received and has had a very positive impact upon the Practice as a whole, it is clearly being used every day. The practice undertook 4 modules *"GPIP helped us to develop ourselves directly and through for what CAVA needs"* The focus of the programme was at the Acomb practice but with representatives from the other sites

Minimum Job Requirement

The initial Visual board has been a success at the practice and has since been rolled out to Monkgate practice. It is felt that some of the other practices are too small for this same method to be used there however the skill matrix is to be rolled out group wide.

Chasing the Tail

Whilst the Practice Manager feels that this area hasn't embedded fully there have been a number of significant improvements because of it, the practice are using the methodology to look at high users with unplanned admissions. The action list has been adopted and is used in the MDT meetings and the review style is still used to look at access for patients. The practice also has extended the MDT meeting to include appropriate skills in the assessment process .

Workforce Planning

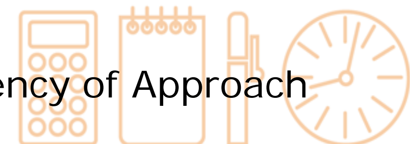
This module was adapted at implementation and proved very effective in forward planning for GP's (also reduced Locum spend). Since implementation it now helps the team recruit staff with specific skill sets not previously identified and helps understand and plan improvements for clinical triaging at the reception booking to match the appropriate clinician to patients.

E-mails & Meeting Management

A number of meetings have greatly improved including the Partners & Nurses meetings. Exception reporting now in place and timely agenda's. Now reviewing the numbers with a view to reducing meetings across the group

Further GPIP support

More co-production workshops would be beneficial and undertake Consistency of Approach



Tollerton

General Practice Improvement Programme

General

The practice looks "in control" and the Practice Manager felt it had been a good experience. *"GPIP went well, even after the gpip team left we all agreed it had been good for us".* The practice worked through four of the modules.

Workplace Organisation

Initially the team looked at the Reception and Admin areas which embraced the change and proved good for the area. They have since looked at the Dispensary. A number of the staff have continued individually in their own areas but as a practice they have not been able to release staff to look at areas as a team.

Consistency of Approach

The work carried out on specimen samples has proved to be very effective and have since applied the approach on reception triage. The learning has helped them to understand in more detail the process, in particularly non-clinical elements.

Chasing the Tail

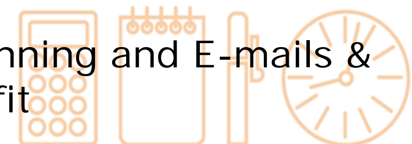
The Practice found this a very interesting module and challenged them to look inwardly at the way they reviewed patients. Since they started they have now started to look at zero attendees and invited a few selected patients in. They now include the QOF report in identifying patients to review. They have also looked to standardise the GP's call back procedure which is having mixed success (one GP has bought in but difficulty with another).

Minimum Job Requirement

The Dispensary team implemented initially and is now working, the team identified some small issues but have since rectified them. The next area has been agreed to put into reception but freeing off the staff is proving difficult.

Further GPIP support

The practice have identified that they would like go through Workforce Planning and E-mails & Meetings. Additionally a refresher of the earlier modules would be of benefit



Telephone Reviews

General Practice Improvement Programme

Posterngate

General

The Practice Manager didn't have the time available to go through the work areas in detail but gave a very high level overview and identified opportunities they would like to be included in, should there be any provision made available. Very happy to meet & discuss in the New Year

Intervention areas

CTT – A vey useful module that they have adapted slightly but feel they could get more from
MJR – This has proved very helpful in reception
WP – A module they struggled with but would like to understand further and look at reception/admin
EM&MM – Another good module but have not implemented everything they wanted.

Further GPIP support

They would like to revisit Chasing the Tail and Workforce Planning, also they have identified they would like support with Consistency of Approach.

Helmsley

General

The Practice Manager didn't have the time available to go through the work areas but was able to provide some indication of what they may benefit from if there is support available and suggestions for activities in general She has also indicated that she is happy to meet & discuss in the New Year

It would be useful to have a follow on the triaging project (COA) as this is a big piece of work and is on-going, good to have a check on our progress
A visit to Terrington to see how we have implemented the same standards there (Workplace organisation and Minimum Job Requirement

Observed Capability Gap

General Practice Improvement Programme

All practices

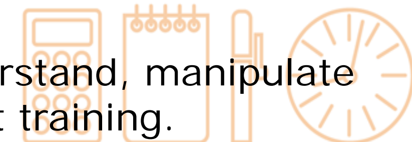
Throughout the discussions and in every practice there was a notable gap evident with regard to data identification, collection, manipulation and visualisation in measuring improvements.

When discussed the common theme from the Practice Managers was that, as they were going through the interventions with the coaches, everything made sense in what to look for and how to use it. However the common feeling is that when on their own particularly when looking at new areas of improvement the practices didn't really know what to measure or how.

For example in the case of Consistency of Approach what needs to be measured is driven by the actions they generate at the driver diagram development stage and these can be very different actions to those they have looked at previously. Therefore they have "reverted to type" to just "get on and do it"!

Secondly where data is captured or they understand what data to capture, often there is insufficient skills in the practice to put into pivot tables for example and manipulate it into something meaningful or to create simple graphs to visualise it. This is usually as a lack of skill base in using Excel etc.
In most cases the practices recognise that these are limiting factors but do want to address them.

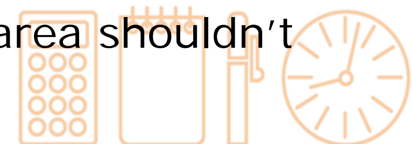
In order to resolve this we would advise two steps in approach
1: A combination of group and 1-2-1 sessions to provide the ability on how to look at a problem, define it and understand baselining the data. Incorporated would be how to take the data and understand what to do with it
2: Specific and targeted training with key staff within the practices to understand, manipulate and visualise data, this may need to include some basic Excel or equivalent training.



Themes & Practice Requests

General Practice Improvement Programme

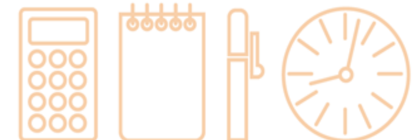
- GPIP refresher sessions
- Career development training for staff to provide potential PM's with middle management training prior to being in post, (qualification) training also useful for PM's in post
- Word & Excel skills training for nominated staff
- Front of house & customer service training
- System 1 training
- The CTT data report adding to universal search section of System 1 to simplify the process. (there are a number of universal searches already imbedded in system 1)
- Standardised templates across all practices
- Improved or better use of intranet for communications (Intradoc)
- Develop federation / collaboration further /Shared processes / Cross practice skill matrix
- Further collaboration sessions
- Larger scale collaboration
- Development of Capacity & Demand modelling
- Improved two way communication with Community Nursing, ensuring that all nursing is being effective i.e. During Flu campaign there are housebound patients, who should administer them with the costs agreed
- System1 & EMIS developed to be able to "talk" to each other
- Community Nursing divided up amongst practices (catchment area shouldn't sit with the Acute Trust)
- Practice manager collaborative sessions



Themes & Practice Requests

General Practice Improvement Programme

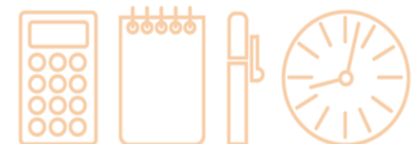
- Patient access to appointments
- Development of a standardised telephone triage system
- Web consultations
- Clinical systems – VoY practices able to see attendance data
- Project management training
- Communication flow & reduction of duplication of messaging from CCG & NHS England.
- Clarification of the committees, and what each one do and who they represent.
- A polite request for the CCG to undertake some of the key gpip modules.
- IT support for training and pulling of reports
- How to create and maintain and interpret KPI's
- Reducing emergency admissions
- Co-production to widen to more practices
- Re-structure of the Practice Managers (employed by CAVA?)
- Shared workloads within CAVA
- Facilitated away days (practice only)
- Review the process of how to send claims as there are different systems & quite clunky (e.g. CQRS) Streamline processes.
- Run a CCG finances training day
- Simplified enhanced services, currently have to search to understand new specs.



Themes & Practice Requests

General Practice Improvement Programme

- Locality managers allocated and employed by the CCG to improve two way communication and provide support.
- Commission of Community Nursing Structure that's driven (and resourced?)by CCG
- Access to primary care data
- Improving communications with community health Nursing teams
- Review rural practice links with the CCG (often in the shadow of city practices) including rural specific meetings (quarterly?)
- Patient experience & dementia training
- Specific project management training
- The role of Pharmacists and their employment
- Signposting & booking the patient to see the most appropriate clinician
- Shared learning
- Patient behaviours and child learned behaviours – breaking the cycle
- Assistance with Cava work-streams in line with the business plan and the vision to work towards merging some mngt functions. This is the next step on from the collaboration where there is now work-streams and work-stream leaders looking at how to progress with working across a CAVA wide group of practices and getting down into the detail.



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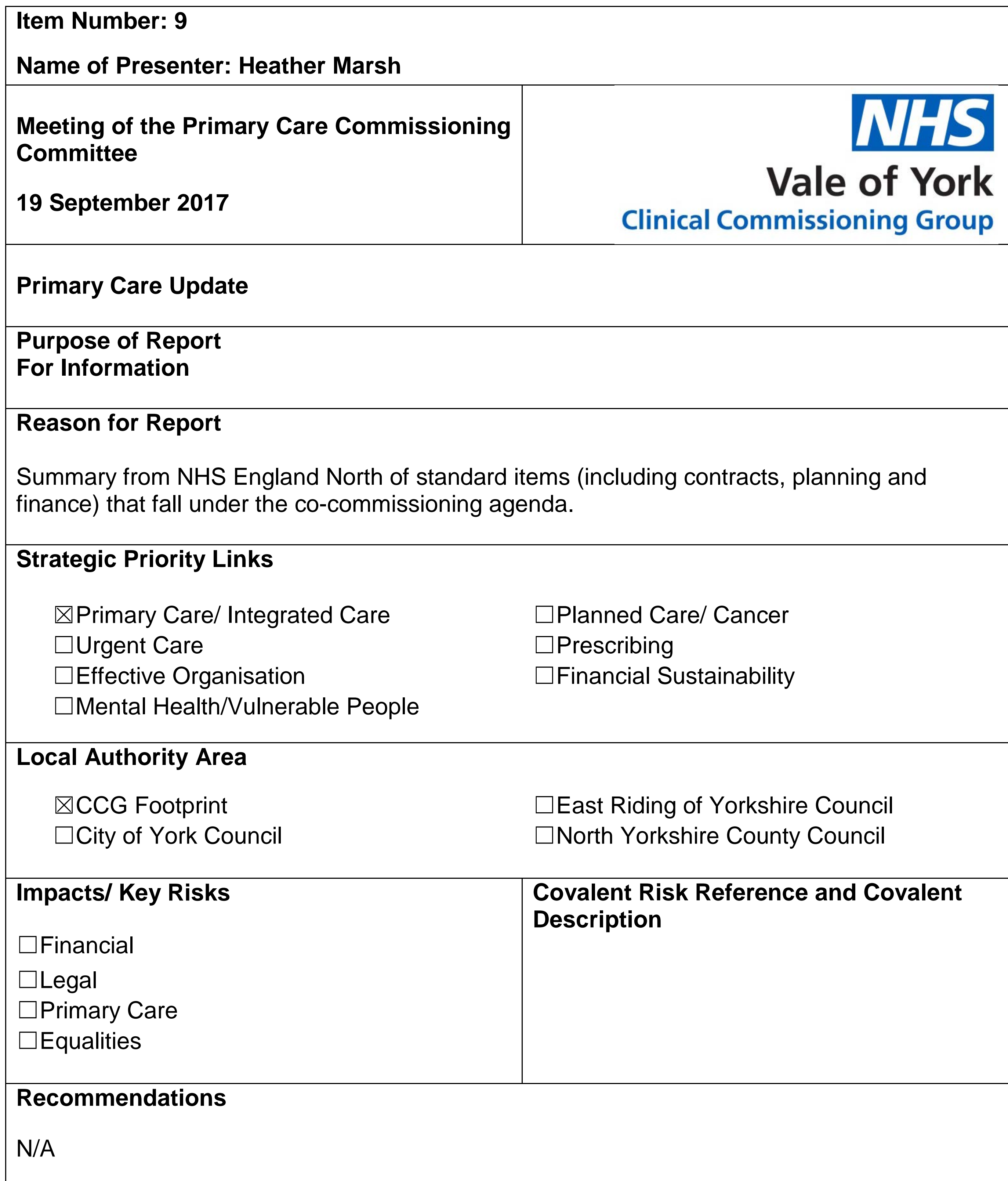

Item Number: 9

Name of Presenter: Heather Marsh

Meeting of the Primary Care Commissioning Committee

19 September 2017

NHS
Vale of York
Clinical Commissioning Group

Primary Care Update

Purpose of Report
For Information

Reason for Report

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

Strategic Priority Links

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

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	

Recommendations

N/A

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

NHS
England

Vale of York Update

Prepared by David Iley

Primary Care Assistant Contracts Manager

NHS ENGLAND – North (Yorkshire and The Humber)

12 September 2017

1. Resilience Funding

GP Practices were asked to submit applications for this year's resilience funding by 20th July 2017. Vale of York received 18 bids, 17 of which were supported by the CCG. All bids then went to a Humber, Coast & Vale STP panel for approval and consistency across the area.

2 schemes were approved

- Beech Tree - £6,000 - Organisational Development work in regard to the 3 Selby based Practices
- Sherburn - £9,000 – To support a merger with South Milford

Both schemes have been asked to produce a project plan which will be used as part of a Memorandum of Understanding (MOUs) to be agreed with NHS England. The deadline for MOUs to be agreed is 30th September 2017.

Funding in support of bids for nurse prescribing back fill or course fees is still being considered by NHS England.

The Committee is asked to note this update

2. Practice Based Pharmacist Scheme

The first waves of applications for the clinical pharmacy roll out programme have been assessed and over 730 sites, covering nearly 6 million patients, will benefit from the skill mix and knowledge that clinical pharmacists bring to general practice.

Applications through Wave 2 of the scheme have now been assessed by a local panel. 5 applications were received from the North Yorkshire and Humber locality, 3 of which were approved at a local level and were passed forward for further assessment by a regional and national panel. One of the 3 forwarded for further approval was an application from York CCG on behalf of Priory Medical Group, covering a total population of 213,478 patients. This scheme has now been approved by the regional and national panels.

Priory Medical Group were informed of the decision and a meeting between NHS England, the CCG and Practice Managers took place on Thursday 7th September to discuss the roll out of the scheme and the model for employing the clinical pharmacists. A further update will be provided at the next meeting.

The Committee is asked to note this update

3. 2017/18 Directed Enhanced Service (Extended Access Element)

The Primary Medical Services (Directed Enhanced Services) Directions 2017 have been amended as part of the 2017/2018 contract negotiations.

The amendments include the following provisions

> (9) The arrangements that the Board enters into with a GMS or PMS contractor for extended hour's access must, from 01 October 2017, also include—
>
> > (a) a requirement that the contractor's practice is not closed for half a day on a weekly basis unless by written prior agreement with the Board;
> >
> > (b) a requirement that patients must be able to access essential services which meet the reasonable needs of patients during core hours from the contractor's practice or from any person who is sub-contracted to provide such services to the contractor's patients during core hours.

In order to understand which GP Practices may be affected by this change the CCG wrote to any practice where their 2016/17 electronic Annual GP Practice self-declaration (eDec) indicated the practice closed for half a day on a weekly basis asking them to confirm their plans for the Extended Access DES from October 2017.

Of the 2 Practices identified in the Vale of York, Kirkbymoorside confirmed this was due to an error on the eDec submission made by the Practice; they do open all core hours and therefore will continue to provide extended access. At the time of the report the CCG had yet to receive a response from Terrington Surgery.

The Committee is asked to note this update