PRIMARY CARE COMMISSIONING COMMITTEE

30 May 2017 at 9.30am to 11.30am

Auden Room (GO47), 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.

9.40am	1.	Welcome and Introductions		Verbal	Keith Ramsay
	2.	Apologies		Verbal	Keith Ramsay
	3.	Declaration of members' interests in the business of the meeting		Verbal	All
9.45am Pages 3-13	4.	Minutes of the meeting held on 28 March 2017	To Approve	Enclosure	Keith Ramsay
	5.	Matters Arising		Verbal	All
9.55am Pages 15-22	6.	Primary Care Commissioning Financial Report	To Receive	Enclosure	Tracey Preece
10.15am Pages 23-27	7.	Personal Medical Services Monies 2017/18 Update	To Approve	Enclosure	Tracey Preece
10.35am Pages 29-33	8.	Primary Care Quality Dashboard: Update on Progress	To Receive	Enclosure	Michelle Carrington
11.00am	9.	CCG Support for General Practice in Development of New Models of Care	To Note	Verbal	Phil Mettam

11.10am Pages 35-39	10.	General Practice Visits – Summary to April 2017 *Dr Tim Maycock attending*	To Receive	Enclosure	Dr Andrew Phillips
11.20am Pages 41-60	11.	NHS England Primary Care Update	To Receive	Enclosure	Chris Clarke
11.30am	12.	Next meeting: 9.30am, 25 July 2017 at West Offices	To Note	Verbal	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

Item 4

Minutes of the Primary Care Co-Commissioning Committee held on 28 March 2017 at West Offices, York

Present

Keith Ramsay (KR) - Chair	CCG Lay Chair
David Booker (DB)	Lay Member
Michelle Carrington (MC)	Executive Director of Nursing and Quality
Chris Clarke (CC)	Senior Commissioning Manager Primary Care, NHS England
Phil Mettam (PM)	Accountable Officer
Tracey Preece (TP)	Chief Finance Officer

In Attendance (Non Voting)

Dr Andrew Phillips (AP)	Joint Medical Director
Stephanie Porter (SPo) - for item 12	Deputy Director – Estates and Capital Programme
Michèle Saidman (MS)	Executive Assistant

Apologies

Dr Lorraine Boyd (LB)	GP, Council of Representatives Member
Kathleen Briers (KB)	Healthwatch York Representative
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Governing Body Member
Dr John Lethem (JL)	Local Medical Committee Liaison Officer, Selby and York
Shaun Macey (SM)	Head of Transformation and Delivery
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair

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

One member of the public was in attendance.

No questions had been submitted by members of the public.

1. Welcome and Introductions

KR welcomed everyone to the meeting.

2. Apologies

As noted above.

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

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

4. Minutes of the meeting held on 28 February 2017

The minutes of the meeting held on 28 February were agreed.

The Committee

Approved the minutes of the meeting held on 28 February 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 he would discuss this with PM.

PCC8 – Protected Time for Learning: AP reported on discussion at the March meeting of the Council of Representatives advising that, other than for specific "one off" events, protected learning time had not been supported, noting that two Clinical Summits would take place during 2017/18. No formal proposal would therefore be presented to the Committee.

A number of matters were noted as agenda items.

The Committee:

Noted the updates.

6. Primary Care Commissioning Financial Report

TP presented the month 11 financial position on the CCG's primary care commissioning areas noting that the forecast underspend remained at £1.3m as reported at the previous meeting. The report also included Practice information on the Quality and Outcomes Framework which reflected January list sizes. TP noted that JL had requested inclusion of actual and weighted list sizes which she would provide in subsequent reports.

Members discussed the Practice variation in the Quality and Outcomes Framework information. TP noted that this was high level but more detail could be provided to explain variation and give assurance on equity. An error in the heading of the Quality and Outcomes Framework table was noted in that '£000' should not have been included.

TP explained the key assumptions for primary care in the 2017/18 and 2018/19 Financial Plan which were respectively £41.8m and £42.9m. KR expressed concern regarding the 0.7% list size growth applied to both years in view of discussion in other forums of planning developments.

TP advised that potential QIPP opportunities from the national business rates exercise had not been included in the Operating Plan emphasising the CCG's intent to invest in primary care. Budgets would be realigned in light of this exercise.

PM commented on the 2016/17 forecast underspend on the primary care budget in the context of the CCG's c£15m overspend on the acute sector. In response to clarification sought he advised that the underspend would be included in the CCG's 2017/18 bottom line figure.

PM highlighted the locality developments and work on new models of care with a focus on specific conditions in the localities, noting that CCG support would be required. He agreed to provide a report to the next meeting of the Committee to give assurance that there would be capacity for the detailed work required.

PM referred to the request from the Local Medical Committee for a new Local Enhanced Service included in agenda item 8. He noted that the CCG's two year Operational Plan did not include additional resource allocation to General Practice or Local Enhanced Services in 2017/18 and proposed an overall review of these services in the context of the variance between acute and primary care spend.

In response to DB referring to the forecast underspend, the identified need for capacity and the information needs of the developing accountable care system, PM advised that information on individual pressures and Practice needs from the CCG's programme of visits were recorded. He proposed that this be consolidated in to a report for consideration by the Committee to identify management and clinical capacity support in 2017/18; AP agreed to lead on this work.

CC noted that NHS England's view was that, although the year end Quality and Outcomes Framework information was not yet available, there were no major outliers in the CCG in this regard.

The Committee:

1. Received the primary care commissioning financial report.
2. Noted that a report would be provided for the next meeting on CCG support for General Practice in development of new models of care.
3. Requested a consolidated report from Practice visits to identify management and clinical support needs.

7. Update on CCG responsibility for Quality in primary care following full delegation of commissioning

MC referred to the report which described the RASCI matrix model - Responsible, Accountable, Supporting, Consulted and Informed - for quality in primary care and provided an update on various aspects of quality. She noted that complaints about performance of Doctors were made directly to NHS England.

In respect of professional development for Practice Nurses MC explained that the CCG's role was not one of direct line management but of support. She noted that assurance would be sought regarding such as revalidation and that, as with all

providers, the CCG would expect to be informed of any issues that would impact on commissioning or significant patient safety issues.

Regarding complaints to the CCG about primary care MC explained that a local resolution was sought unless escalation to NHS England was required. Complainants were encouraged to write directly to the GP Practice in question where appropriate.

DB additionally noted the role of the Audit Committee which received regular reports on areas including security, fraud and complaints.

The Committee:

Received the update on responsibilities for elements of quality following full delegation of primary care commissioning.

8. Personal Medical Services Monies 2017/18

TP referred to the principles for reinvestment of the Personal Medical Services (PMS) funding during 2017/18, agreed at the previous meeting of the Committee. She noted that the two proposals – General Practice engagement in the development of an accountable care system for the Vale of York population and use of PMS monies to sustain the amber drugs near patient testing shared care local enhanced service for NHS Vale of York CCG Practices – both met the principles. These had been discussed at the Council of Representatives and on a subsequent teleconference which had included representatives from each of the three localities and JL. The total available for investment from 1 April 2017 was £316,656.50 comprising £223,237 for 2017/18 plus £93,419.50 carried forward due to an underspend of PMS reinvestment monies in General Practice during 2016/17.

Discussion of the amber drugs near patient testing shared care local enhanced service included recognition that the £40k requested was an estimate; work was already taking place to address the shared care commissioning gap; and the potential for the CCG to be an outlier in other local enhanced services therefore requiring further investment. TP advised that the financial consequences of a review of local enhanced services were not in the Financial Plan and would be considered by the Executive Committee in the same way as all cost pressures.

Members noted that the NIMBUS group of Practices favoured the PMS monies being utililsed for General Practice engagement in development of an accountable care system. The need for CCG support in this regard for the North and South localities was also highlighted.

Following further discussion and clarification it was agreed that an amount between £90,000 and £100,000 of the £316,656.50, to be agreed by the Executive Committee, be ringfenced for an overall review of local enhanced services to be completed no later than the end of quarter one of 2017/18. The remainder would be allocated based on weighted Practice size to support General Practice engagement in the development of an accountable care system.

The Committee:

1. Agreed ringfencing of £90,000 and £100,000 of the £316,656.50 PMS monies, amount to be agreed by the Executive Committee, for an overall review of local enhanced services.
2. Agreed that the remaining monies be allocated based on weighted Practice size to support General Practice engagement in the development of an accountable care system.

9. Accountable Care System Update

PM reported that the Accountable Care System Partnership Board had held its first meeting and all three localities had been represented. Discussion had included pressures on Practices and the financial climate for General Practice. The representatives had confirmed they would continue to engage in the development of the accountable care system but had highlighted the limited capacity and resources for backfill. PM referred to the earlier discussion in this regard.

PM also referred to the Committee's terms of reference which included up to two GPs from each locality. He would discuss this with Rachel Potts (RP), Executive Director of Planning and Governance, noting that, even if attendance at the Committee was not possible, named representatives from each locality would be able to provide a view and therefore enhance engagement.

The Committee:

1. Noted the update.
2. Noted that PM would progress representation of up to two GPs from each locality on the Committee with RP.

10. Update on Proposal for Practices where there is variation between cost and need

AP referred to the information in the Medium Term Financial Strategy which compared Practice information in terms of acute need against spend per head highlighting Haxby Group Practice, York Medical Group and Unity Health as outliers. He explained that detailed work was taking place with York Medical Group to understand the data and inform future work.

TP reported on an internal CCG meeting to consider the York Medical Group data and advised that a Practice meeting was being arranged by early May to consider three main areas:

- Practice level spend on acute services
- Geography of the area covered by the Practice for which SM had a tool
- Age profiles of material difference

TP noted that the information gained would be shared with Practices and inform development of the out of hospital work programme.

Members welcomed the assurance that the work would be undertaken as a holistic approach, not purely for consideration of financial aspects, and that attendance at a regular York Medical Group Practice meeting was being sought to ensure maximum engagement.

The Committee:

Noted the update and approach to progress understanding of Practice variation.

SPo joined the meeting

11. Deployment of General Practice Forward View £3 per Head

TP referred to the report which sought approval of the proposed programme of work against the '£3 per head' funding in accordance with the requirements of the NHS Operational Planning and Contracting Guidance 2017/19 and General Practice Forward View. The proposal, which resulted from a number of discussions with the Council of Representatives, was for development of Primary Care Teams (potentially comprising GPs, advanced practitioners, care coordinators, clinical pharmacists and consultant outreach) to provide targeted support for the increasing population of elderly frail patients often with multiple morbidities. This would link with work around agreed locality footprints to develop population health management models.

AP explained the proposal in the context of the CCG's acute spend noting support in principle from General Practice. He also advised that a number of areas of evidence reinforced benefits of working with the frail elderly emphasising the need for a system approach. MC highlighted ongoing work in this area noting that clarity was required as to whether the proposal was a new model of care or supported existing schemes.

PM referred to the complex governance requirements in the context of the CCG's challenging financial position. He also referred to discussion, noting NHS England's attendance, at the Finance and Performance Committee where there was emphasis that any resources released were required to demonstrate return. DB, as Chair of that Committee, highlighted that the Finance and Performance Committee's paramount role was to oversee the financial recovery of the CCG operating under legal Directions. He also noted the expectation that investment of the £3 per head would require measurable quality and innovation.

Members supported in principle investment of the £3 per head in General Practice on the basis that the proposed scheme would help to manage demand in Practices, release time for clinicians to engage in care redesign and transformational programmes of work, and contribute towards a reduction in unplanned hospital activity and spend. They requested that the Executive Committee consider release of the resource for this investment within the context and constraints of the Financial

Plan and also noted the context of the Better Care Fund, requesting that the Committee be updated on the decision.

The Committee:

1. Supported investment of the £3 per head funding to support the development of Primary Care Teams - to work around agreed locality footprints to develop population health management models - to provide targeted support for the increasing population of elderly frail patients often with multiple morbidities.
2. Requested that the Executive Committee consider the release of resource, within the context and constraints of the Financial Plan, to fund this investment in General Practice which was in accordance with the NHS Operational Planning and Contracting Guidance 2017/2019, and the General Practice Forward View.

12. Estates Overview

SPo explained that 2017/18 was the third year of the four year Estates and Technology Transformation Fund. NHS England required a response as to whether the current 12 bids and the associated revenue impacts were still supported. She sought members' views on an alternative approach of considering estate requirements in the context of the CCG's strategic objectives and committing to support a smaller number of priority schemes. TP referred to the areas that required consideration highlighted in the report and emphasised the need for a transparent approach to decision making with full recognition of the impact of revenue consequences. She also referred to the earlier discussion of Practice list sizes and risk of closure.

Of the top prioritised bids, the top three had not received support from NHS England for early funds and two areas never submitted bids, so a strategic discussion about primary care infrastructure was required and the way in which available funding could be used within the constraints of affordability. Discussion ensued on the bids and respective issues relating to Tollerton Surgery and Millfield Surgery as an example. Tollerton had a bid against the Estates and Technology Transformation Fund, but Easingwold did not. The area as a whole would be subject to housing growth which would impact on the primary care provision. The CCG would need to determine if it continued with a small scale scheme at Tollerton only or if there was a wider strategic discussion to be had about a single transformational scheme for the area as a whole, with other health partners. CC advised that NHS England was more likely to support schemes which were ambitious and transformational.

SPo highlighted the Sherburn area as another example of known growth in an area where the Practice did not submit a bid, and referenced the developer proposal to keep the revenue figures for the Sherburn Group Practice and South Milford Surgery neutral for the abatement period of 15 years for a proposed new build, but this was dependent on a £1.5m capital grant. The CCG therefore needed to consider

discussing with NHS England a refresh of the Estates and Technology Transformation Fund bids and the prioritisation from the CCG alongside affordability. All schemes needed to be affordable and deliverable and, as always, the CCG needed to understand simple to deliver schemes, which helped capacity in the system but did little to affect major significant strategic change, against the more complex scheme, which would take greater internal resources to develop, but would affect the strategic change required to support the CCG's wider objectives.

In response to DB referring to capacity required to deliver schemes and the strategic locality approach TP referred to the uplift reported at item 6 above. She also reiterated that NHS England was more likely to support CCG submissions that were ambitious and transformational rather than smaller bids and noted that delivery would potentially enable access to future funding. The requirement for discussion with Practices who had submitted smaller bids was recognised.

SPo advised that, in order to access the Estates and Technology Transformation Fund, NHS England required bids within four weeks but with early indication that reprioritisation was taking place. CC confirmed that he would liaise with SPo.

PM highlighted a number of factors including population growth, development of localities, new models of care and transferring costs from hospital to the community. Following discussion, and in order to gain the best possible consensus from both the financial and strategic perspective in the timescale, it was agreed that further discussion should take place at the April meeting of the Executive Committee to which KR, DB and SP would be invited. It was also agreed that SM be asked to draft a set of principles to inform consideration and decision making.

KR requested that future estates reports include an additional column to denote financial responsibility on the part of the CCG, the relevant GP Practice, NHS England or the Local Authority.

Members requested an update on progress at the May meeting of the Primary Care Commissioning Committee.

The Committee:

1. Agreed that further consideration would be given to the CCG's approach to bids to the final two years of the Estates and Technology Transformation Fund at the April meeting of the Executive Committee with an update at the May Primary Care Commissioning Committee.
2. Requested that future estates reports include an additional column denoting organisational financial responsibility.

13. NHS England Update

CC referred to the report which provided an update on clinical pharmacists in General Practice; new GP contract for 2017/18; Estates and Technology Transformation Fund; and an Enhanced Service. The latter related to a financial settlement concerning patients being given an incorrect cardiovascular risk score due to software code mapping errors and was in recognition of the additional work this had caused GP Practices.

Members discussed clinical pharmacists in General Practice. DB additionally noted discussion at the Audit Committee relating to long term repeat prescriptions highlighting the potential for savings opportunities in this regard through working with pharmacists. This would be progressed via Dr Shaun O'Connell, Joint Medical Director, and Laura Angus, Lead Pharmacist.

The Committee:

1. Noted the updates.
2. Noted the changes to the GP Contract for 2017/18.

16. Next meeting

9.30am on 30 May 2017.

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE

SCHEDULE OF MATTERS ARISING FROM THE MEETING HELD ON 28 MARCH 2017 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCC4	2 June 2016 20 December 2016 28 February 2017 28 March 2017	Development of a Primary Care Dashboard	• Draft dashboard to be presented at the July Committee meeting • Deferred to next meeting • Deferred to next meeting • Example to be presented at the next meeting	MC/NL MC MC MC	12 July 2016 28 February 2017 28 March 2017 30 May 2017
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	

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCC12	28 February 2017	South Milford Surgery and Tadcaster Proposals to move to Leeds North CCG	• Discussion to take place with South Milford Surgery and Tadcaster Medical Centre regarding their expressions of interest to move to Leeds North CCG and the views of Leeds North CCG also to be sought	SM	30 April 2017
PCC14	28 March 2017	Primary Care Commissioning Financial Report	• Report on CCG support for General Practice in development of new models of care. • Report on management and clinical support for Practices	PM AP	30 May 2017 30 May 2017
PC15	28 March 2017	Accountable Care System Update	• Representation of up to two GPs from each locality to be progressed	PM	
PC16	28 March 2017	Estates Overview	• CCG's approach to bids to the final two years of the Estates and Technology Transformation Fund to be considered at the April meeting of the Executive Committee with an update at the May Primary Care Commissioning Committee.	PM/TP	19 April 2017 and 30 May 2017

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Item Number: 6

Name of Presenter: Tracey Preece

Meeting of the Primary Care Commissioning Committee

30 May 2017

NHS
Vale of York
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 March 2017 and provide details of the financial plans for 2017/18 and 2018/19.

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

The Primary Care Commissioning Committee is asked to note the financial position as at month 12 and financial plans for 2017/18 and 2018/19.

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

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

Report produced: May 2017

Financial Period: April 2016 to April 2017

Introduction

This report details the outturn financial position of the CCG's Primary Care commissioning for 2016/17. Detail on how the financial plans for 2017/18 and 2018/19 have been calculated has been included to give the Committee an overview of how they sit within the CCG's overall financial plans. The report also includes a more detailed section on QOF on a practice by practice basis.

Financial position – Month 12 Outturn

The table below sets out the outturn position as at month 12.

Area	Outturn		
	Budget	Actual	Variance
	£000	£000	£000
Primary Care - GMS	19,742	19,622	120
Primary Care - PMS	7,991	7,900	91
Primary Care - Enhanced Services	2,084	1,952	133
Primary Care - Other GP services	2,622	2,795	(174)
Primary Care - Premises Costs	4,799	3,671	1,128
Primary Care - QOF	4,173	4,071	102
Sub Total	**41,411**	**40,010**	**1,401**

GMS expenditure is based on the actual list sizes per Capita. Demographic growth for 2016/17 was less than originally forecast which is the main reason for the under spend in this area.

The PMS line includes the release of 15/16 premium accrual (£69k) and 16/17 premium slippage (£134k) for which the expenditure has been included in a non primary care commissioning code and is included under primary care in the CCG dashboard. This is offset by a shortfall in uplift funding (£86k) and also includes an accrual for Scott Road (£20k) to reflect the contract value calculated and notified by NHSE.

£108k of the enhanced services underspend is due to over accruals from 2015/16. The dementia enhanced service accounts for £93k of this with the remainder being avoiding unplanned admissions. York Medical Group did not sign up to the extended hours scheme until October 2016 which accounts for a further £20k underspend.

There is an over spend of £174k on other GP services at the end of the year. £111k of this is in relation to dispensing doctors as the tariff increased in October, more than originally forecast, and November to January's volume was high which has been assumed to

continue for February and March. PCO administered services account for a further over spend of £67k, of which £58k relates to maternity and £9k to the GP retainer scheme.

£1,070k of the under spend on premises costs relates to business rates rebates for GP surgeries. Business rates for the last 6 years have been reviewed and found to have been calculated wrongly. The remaining £58k is due to rent reviews which have come in at less than originally forecast.

The outturn position and movement on QOF is covered in more detail later in this report.

Financial Plan 2017/18 and 2018/19

The financial plan for 2017/18 has been prepared based upon the 2016/17 forecast outturn as at month 10. Any non-recurrent benefit in year has been added back to give a baseline recurrent expenditure figure. This has then been uplifted for estimated tariff increases and demographic growth. The resulting 2017/18 plan has then been uplifted for tariff increases and demographic growth to give the 2018/19 plan.

Area	16/17 Outturn £000	16/17 FOT as at M10 £000	Non-recurrent benefit £000	Recurrent 16/17 expenditure £000	Tariff uplift £000	Demographic growth (0.6%) £000	17/18 plan £000	Tariff uplift £000	Demographic growth (0.6%) £000	18/19 plan £000
GMS	19,622	19,609	0	19,609	392	120	**20,121**	543	124	**20,788**
PMS	7,900	7,861	203	8,064	161	49	**8,274**	223	51	**8,548**
Premises	3,671	4,682	0	4,682	94	0	**4,776**	96	0	**4,872**
Enhanced Services	1,952	1,987	108	2,095	21	13	**2,129**	21	13	**2,163**
QOF	4,071	4,088	19	4,107	41	25	**4,173**	42	25	**4,240**
Other GP services	2,795	1,745	504	2,249	22	14	**2,285**	23	14	**2,322**
Total	**40,010**	**39,972**	**834**	**40,806**	**731**	**221**	**41,758**	**948**	**227**	**42,933**

The amounts included in non-recurrent benefit are as follows:
PMS – this relates to the PMS premium which has been spent under a non primary care commissioning code and shows under primary care in the CCG dashboard.
Enhanced services – this is the release of 15/16 over and under accruals.
QOF – this is the release of a 15/16 over accrual.
Other GP services – this includes £550k for 15/16 rates rebates and £46k for the release of over and under accruals from 15/16.

Assumptions

The financial plans have been prepared using the following assumptions.

Tariff uplift	2017/18	2018/19
GMS	2.00%	2.70%
PMS	2.00%	2.70%
Premises	2.00%	2.00%
Enhanced Services	1.00%	1.00%
QOF	1.00%	1.00%
Other GP Services	1.00%	1.00%

Demographic growth has been assumed to be 0.6% year on year.

QIPP

No QIPP has been applied to Primary Care commissioning in 2017/18 or 2018/19. There are potential opportunities for QIPP as the business rates exercise concludes. Prudent estimates for outstanding rates reviews have been included in the 2016/17 accounts.

Quality and Outcomes Framework (QOF)

QOF is calculated based upon the achievement of a number of points which are given a price per point. This is then weighted by practice list size and disease prevalence.

QOF budgets are set based upon the expected prior year achievement inflated for the current year's price per point. Budgets are split into aspiration and achievement, with aspiration accounting for 70% and achievement accounting for 30%. Monthly payments are made to practices based upon twelfths of the aspiration budget. Achievement is then paid to practices in June for performance in the previous year. The forecast outturn during the year is then adjusted for actual prior year achievement (when this is known in June) and updates to list sizes. The forecast was updated in month 10 to reflect latest practice list sizes (as at 1 January 2017).

The table overleaf shows how the QOF achievement for 2015/16, how the budgets were set for 2016/17 and the QOF position by practice as at M12 and has been shared with the GP leads in advance of this committee. Note that the actual performance for 2016/17 will not be known until June 2017. Note also that there were some practice mergers during the year as follows:

Beech Grove Medical Practice merged into Front Street Surgery.
Clifton Medical Practice and Petergate Surgery merged into York Medical Group.

Practice	15/16 Points Achieved (out of 559)	15/16 % achievement	List Size as at January 2016	List Size as at January 2017	Movement in list size	15/16 Prevalence Factor	15/16 Outturn	16/17 Budget	16/17 Outturn
BEECH GROVE MEDICAL PRACTICE	510.85	91%	3,893	0	**-3,893**	0.9522	£45,398.86	**£46,173.82**	**£26,788.91**
BEECH TREE SURGERY	553.97	99%	15,768	15,827	**59**	1.0830	£205,046.91	**£208,547.06**	**£214,604.84**
CLIFTON MEDICAL PRACTICE	557.09	100%	5,125	0	**-5,125**	1.0787	£67,236.18	**£68,383.90**	**£17,347.84**
DALTON TERRACE SURGERY	559.00	100%	7,609	7,879	**270**	0.9262	£88,349.18	**£89,857.30**	**£89,191.64**
EAST PARADE MEDICAL PRACTICE	540.34	97%	2,091	2,101	**10**	1.0973	£26,396.49	**£26,847.07**	**£28,629.69**
ELVINGTON MEDICAL PRACTICE	556.94	100%	7,250	7,210	**-40**	1.0122	£88,253.53	**£89,760.02**	**£92,222.24**
ESCRICK SURGERY	547.80	98%	6,018	5,904	**-114**	0.9641	£66,532.49	**£67,668.20**	**£72,869.35**
FRONT STREET SURGERY	556.52	100%	4,302	8,116	**3,814**	1.0329	£55,161.58	**£56,103.19**	**£72,610.16**
HAXBY GROUP PRACTICE	546.11	98%	32,967	32,750	**-217**	1.1775	£469,545.47	**£477,560.61**	**£466,067.04**
HELMSLEY SURGERY	559.00	100%	3,184	3,278	**94**	1.2203	£50,714.07	**£51,579.76**	**£46,875.16**
JORVIK GILLYGATE PRACTICE	524.38	94%	19,835	19,465	**-370**	0.8069	£185,907.82	**£189,081.26**	**£182,259.76**
KIRKBYMOORSIDE SURGERY	559.00	100%	5,953	5,940	**-13**	1.2154	£86,673.86	**£88,153.38**	**£92,218.41**
MILLFIELD SURGERY	558.97	100%	7,284	7,330	**46**	1.0354	£86,454.32	**£87,930.10**	**£74,250.12**
MY HEALTH	545.40	98%	18,659	18,872	**213**	1.0367	£233,289.58	**£237,271.83**	**£236,522.43**
PETERGATE SURGERY	538.20	96%	6,360	0	**-6,360**	0.7810	£55,164.81	**£56,106.47**	**£39,622.28**
PICKERING MEDICAL PRACTICE	558.97	100%	10,518	10,505	**-13**	1.2628	£161,079.68	**£163,829.31**	**£167,466.55**
POCKLINGTON GROUP PRACTICE	520.51	93%	15,452	15,692	**240**	1.0249	£180,640.46	**£183,724.00**	**£187,199.46**
POSTERNGATE SURGERY	558.82	100%	16,181	16,485	**304**	1.0546	£214,515.49	**£218,177.27**	**£211,693.08**
PRIORY MEDICAL GROUP	559.00	100%	55,361	56,330	**969**	0.9450	£658,050.80	**£669,283.72**	**£648,170.55**
SCOTT ROAD MEDICAL CENTRE	556.77	100%	10,964	10,755	**-209**	0.8862	£119,938.98	**£121,986.34**	**£117,307.22**
SHERBURN GROUP PRACTICE	547.22	98%	8,950	9,104	**154**	0.9905	£104,902.85	**£106,693.54**	**£111,740.39**
SOUTH MILFORD SURGERY	553.64	99%	9,663	9,627	**-36**	1.0219	£127,192.78	**£129,363.96**	**£114,433.84**
STILLINGTON SURGERY	559.00	100%	3,221	3,237	**16**	1.0845	£44,985.56	**£45,753.46**	**£41,691.74**
TADCASTER MEDICAL CENTRE	557.74	100%	8,472	8,441	**-31**	1.1370	£118,663.29	**£120,688.87**	**£118,787.77**
TERRINGTON SURGERY	556.00	99%	1,096	1,163	**67**	1.0652	£13,220.69	**£13,446.37**	**£16,401.33**
THE OLD SCHOOL MEDICAL PRACTICE	528.63	95%	7,373	7,426	**53**	0.8521	£67,099.28	**£68,244.66**	**£80,484.76**
TOLLERTON SURGERY	559.00	100%	3,372	3,346	**-26**	0.8642	£38,861.24	**£39,524.60**	**£32,991.53**
UNITY HEALTH	484.72	87%	21,781	20,910	**-871**	0.4260	£104,030.37	**£105,806.17**	**£91,128.55**
YORK MEDICAL GROUP	531.73	95%	32,266	43,636	**11,370**	0.8328	£339,703.48	**£345,502.21**	**£379,035.39**
TOTAL	**15,845.32**		**350,968**	**351,329**	**361**		**£4,103,010.07**	**£4,173,048.45**	**£4,070,612.03**

The 2016/17 budget was set based upon the 2015/16 outturn with the assumption of 1% uplift (to cover an expected increase in £ per point) and 0.6% for demographic growth. The 2016/17 outturn has moved significantly for the following reasons:

- The 2016/17 outturn was reduced after June 2016 when the actual QOF achievement for 2015/16 was calculated - £4,083,984.48 in total.
- Whilst the £ per point increased from £160.12 to £165.18 across years this was offset by an increase in the average national list size from 7,233 to 7,460 which meant that the overall uplift was negligible.
- Demographic growth was significantly lower than expected at circa 0.1% between years.
- Other adjustments for known movements in QOF.

As the table shows, 6 out of 29 practices achieved the maximum points of 559 in 2015/16, with the average number of points being 546.39. Note that the points for Tadcaster Medical Centre were manually adjusted to the points achieved in 2014/15 to take into account the impact of the floods on the practice.

Acronyms

A list of terms relating to primary care is available on the CCG website as linked below.

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

Recommendation

NHS Vale of York Clinical Commissioning Group Primary Care Commissioning Committee are asked note the financial position of Primary Care commissioning.

Item Number: 7

Name of Presenter: Tracey Preece

Meeting of the Primary Care Commissioning Committee

30 May 2017

NHS
Vale of York
Clinical Commissioning Group

Personal Medical Services (PMS) Monies 2017/18 Update

Purpose of Report

For Approval

Reason for Report

Following a national review of General Practice Personal Medical Services (PMS) contracts that was initiated by NHS England in 2014, the CCG is required to agree how the PMS Premium from its 5 PMS Practices will be reinvested back into General Practice each year.

At the18 May Council of Representatives Meeting a number of GP's asked that the proposed plans for reinvestment of PMS monies (as agreed at the 28 March meeting of the Primary Care Commissioning Committee) are reviewed.

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
The Primary Care Commissioning Committee is asked to consider the revised proposals and the suggested reporting/audit arrangements for 2017/18.

Responsible Executive Director and Title	**Report Author and Title**
Tracey Preece Chief Finance Officer	Shaun Macey Head of Transformation & Delivery

1. Background

At the 28 February 2017 meeting of the Primary Care Commissioning Committee, a number of principles were agreed in relation to the reinvestment of PMS monies into General Practice for the 2017/18 financial year, with one of the key priorities being.

*The funding should be used primarily to support the **development of locality working** arrangements and the **management of demand**, and to help Practices to lead the **development of locality/population based service models** and/or develop more active roles in the **coordination of care** for patients*.

At the 28 March meeting of the Primary Care Commissioning Committee, it was agreed that for the 2017/18 financial year:

i) £93,419.50 carried forward due to an underspend of PMS reinvestment monies in General Practice during the 2016/17 financial year (in part, due to the changes around the Vale of York Clinical Network) would be ringfenced for a review of Local Enhanced Services (as requested by the Local Medical Committee).

ii) The remaining £223,237.00 that was available from the 2017/18 PMS reinvestment monies would be allocated based on weighted Practice size to support General Practice engagement in the emerging locality programmes, and the development of an Accountable Care System. This money would be allocated on the proposed basis of localities, with £125,230.51 for City, £43,558.44 for North and £54,448.05 for South.

It should be noted that any agreements will apply to the 2017/18 financial year only, and that the reinvestment of PMS monies will be reviewed on an annual basis by the Primary Care Commissioning Committee.

2. Local Enhanced Service Review

The £93,419.50 that has been agreed for the Local Enhanced Services review for 2017/18 will initially be focused around the Shared Care Amber Drugs scheme, with a piece of work on this scheme's payment levels. The use of any remaining funding to support LES reviews from this ringfenced amount will be discussed with the Local Medical Committee to agree priorities. The CCG will also conduct a wider piece of work around Local Enhanced Services during 2017/18 to review payment levels, and explore opportunities for improving service specifications and offering contracts across groups of Practices to reduce administrative overheads. Resource has been identified within the CCG to undertake this work starting in June.

3. Update from 18 May Council of Representatives Meeting

At the18 May Council of Representatives meeting a number of GP's expressed a view that the PMS monies should be reinvested directly into General Practice in order to support the sustainability and development of General Practice, and should be redistributed across Practices on a capitation basis.

Tracey Preece reiterated the principles that were agreed at the 28 February 2017 meeting of the Primary Care Commissioning Committee, and explained that it was agreed that the funding could be used to support GP attendance at locality meetings, GP time spent working on locality projects, and also any additional resource (e.g. staff) that would support the delivery of locality based projects, or support the management of demand in General Practice.

4. Revised Proposal

As the suggestion from some Practices at the18 May Council of Representatives meeting was not wholly in accordance with the principles agreed at the 28 February meeting of the Primary Care Commissioning Committee, further discussions have taken place and a revised proposal is presented below. The Primary Care Commissioning Committee is asked to consider this proposal.

It is suggested that the £223,237.00 of PMS monies that have been allocated to support the development of locality working arrangements in 2017/18 is divided into three parts.

i) Costs to support GP attendance at locality meetings. Practices will be asked to calculate the costs of GP attendance at Accountable Care System and locality board meetings across the full 2017/18 financial year. This amount will be ringfenced to support GP attendance and engagement at these meetings. Payment will be made monthly to Practices based on attendance numbers.

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. This will involve meeting with Practices, other system Partners, and working with CCG teams to support the delivery of the priorities as described in section 1. GP leads for each locality will be expected to report back to ACS and locality boards on progress and any learning that can be shared. The Committee is asked to approve funding on the basis that the North and South localities should each release a GP for 1 session per week, and the Central locality should release 2 sessions of GP time per week to support this work. A total of 208 sessions per year at a locum backfill rate of £300 per session would equate to approximately £62,500 per year.

iii) It is suggested that any remaining funding, after deducting the amounts in sections i) and ii) above should be offered through localities to support constituent Practices in the management of demand. This could cover a range of projects across individual or groups of Practices, including meetings to share learning and to develop collaborative ways of working. A short ‘plan-on-a-page’ approach will be used to capture proposed plans and ensure alignment with the agreed principles.

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Item Number: 8

Name of Presenter: Michelle Carrington

Meeting of the Primary Care Commissioning Committee **30 May 2017**	NHS Vale of York Clinical Commissioning Group

Primary Care Quality Dashboard: Update on Progress

Purpose of Report
For Information

Reason for Report

This report follows on from the previous paper regarding the development of a primary care quality dashboard. It gives an update on progress while we await the Dr Foster tool to become functional and when there is improvement in data availability.

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**
Michelle Carrington, Chief Nurse	Michelle Carrington, Chief Nurse

Introduction:

Regardless of their co-commissioning status, CCGs have a responsibility under the Health and Social Care Act 2012 to assist and support NHS England in discharging its duty to secure continuous improvement in the quality of primary medical services. CCGs are expected to provide evidence of benchmarking on outcome indicators for primary medical care, state their commitment to openness, sharing of information and have a clear approach to peer review and strategies for improvement across practices.

Background:

Currently the CCG has on its risk register 'lack of assurance on quality and performance monitoring in primary care – quality assurance and monitoring processes need to be developed, agreed and embedded'. A previous paper described the suggested approach to reducing this risk which was agreed at Audit Committee and then at Primary Care Commissioning Committee earlier in the year.

A starter set of quality indicators was agreed which were based on a review of the evidence base of the plethora of indicators available. Those indicators were chosen because the evidence is centred on high impact combined with good quality evidence to support their use and what matters to patients. The CCG also included some indicators where outcomes were cited such as harm occurring to patients i.e. serious incidents and healthcare acquired infections.

Progress:

A workshop was held with Council of Representatives in March 2017 to outline the indicators and develop the case for change to share information with the CCG where this was currently not available. It was agreed to return to the quality agenda over the coming months, and in the meantime agreement was reached for primary care to share their 'significant event audits' with the CCG. The Quality Team would analyze the information, extract the learning and agree ways to share that learning to prevent recurrence. The Quality Team would also outline their 'offer' to primary care to support quality improvement.

Progress is not as fast as the CCG would like mainly due to the following issues:

- Engagement with primary care needs to have further reach
- Significant event audits have not yet been received into the CCG
- Capacity within the Quality Team while awaiting recruitment to key posts to support this agenda
- Priority of Bi and contracting to support the delivery of QIPP and the System Financial Envelope work
- The Dr. Foster tool not yet being readily available to provide some of the data.

This is in the overall context of primary care being good as described by the Care Quality Commission ratings for all practices.

Dr Foster tool via eMBED (our business intelligence provider):

Below is an update on the progress of the development and introduction of the Dr Foster tool to support information flows, performance analysis and quality.

Healthcare Intelligence Portal (HIP) tool

This tool has been developed to support Commissioning, Quality, Performance and Contracting Managers. It provides an interactive function to interrogate hospital inpatient, outpatient and A&E data, for use by non-information specialists to produce their own regular/ad-hoc reports, charts/graphs/tables and benchmarking to a granular level (such as specific age cohorts, diagnosis, HRG, performance breaches, delayed transfers, and so on). It's intended to support a host of commissioning functions and project areas, such as performance management, RightCare, QIPP identification/delivery, local/national benchmarking, and Commissioning for Value etc.

CCG staff have attended training on this tool during February and March.

Performance Dashboard

The Performance Dashboard is still undergoing further development. Although it is currently available to eMBED Business Intelligence colleagues, more key performance indicators need to be included before it will be made available for CCG's and GP Practices.

This tool is updated as the national performance data is published for each indicator to provide the performance against national KPIs in the CCG Assurance Framework, GP Outcomes Framework, Referral to treatment and waiting lists, Cancer etc. Users can access the performance in various views, with historic trends and comparison to peer groups i.e. against other CCGs and GP Practices nationally. As with the HIP tool, users can develop their own views to select the key performance indicators individuals need to be aware of in their roles.

Risk Stratification – with e-Frailty

The Risk Stratification tool is high up on eMBEDs priority list. This tool combines Inpatient, Outpatient, A&E and Primary Care data to predict patients / practices health needs and risk of hospitalisation. It also incorporates e-Frailty assessment scores, so that practices are able to view their registered population by frailty score, and whether this has increased or decreased over time. The National Enhanced Service for Risk Stratification ceased in March 2016 and has been replaced with a focus on frailty in patients registered to GP practices. The new Dr Foster Risk stratification tool aims to provide data to address this change in focus.

eMBED have been coordinating the sign-off of the Data Sharing Agreements (DSAs) but are having some issues with getting responses from a number of GP Practices

who are understandably protective of their data but this is an improving picture. 3 provisional Webex training dates have been arranged in June for GP practices to see the new risk stratification tool. These dates will be communicated to practices via GP practice communications, and will hopefully encourage all practices to sign data processing deeds, allowing the flow of primary care data into the risk stratification tool.

The SUS data will not start flowing into the Risk Stratification to populate it until April/ May.

Urgent Care

eMBED are considering the development of an Urgent Care Dashboard populated with real time data.

Potential indicators:

Below is a list of the all the indicators available from Dr Foster which could be used to assess elements of quality once up and running. These are based on the NHS Outcomes Framework. Alerts will signal when variation has occurred and where 2 standard deviation points are noted, this is seen as statistically significant against the CCG average and national average. It does not, however, note where performance is exceptionally good against the CCG and national average.

Users can log on as a GP practice to see only their data or as a CCG to see all practice data.

Domain:	**Indicators:**
Preventing people dying prematurely	Rates of cancer admissions Rates of smoking cessation advice for long term conditions (LTCs) Rates of mental health (depression) Rates of serious mental illness
Enhancing quality of life for people with long term conditions (LTCs)	Diagnosis rates for Chronic Obstructive Pulmonary Disease Diagnosis rates for continuing healthcare Prevalence rates for dementia
Helping people recover from a period of illness / injury	Emergency admission rates for people with LTCs Rate of A&E attendances
Help people have a positive experience of care	Satisfaction with quality of consultation at GP practice How good was the GP / Nurse at giving you enough time How good was the GP / Nurse at listening to you How good was the GP / Nurse at explaining tests or treatment How good was the GP / Nurse at involving you in decisions about your care How good was the GP / Nurse at treating you with

	care and concern Did you have confidence and trust in the GP / Nurse you saw and spoke to How confident are you that you can manage your own health Satisfaction in being able to see preferred doctor Satisfaction with accessing primary care Able to get an appointment to see / speak to someone Satisfaction with opening hours How easy is it to get through on the phone.

It is likely the CCG will want to add to these indicators as not all are included e.g. healthcare acquired infections, complaints, serious incidents and will need to decide presentationally, how these are reported. As mentioned previously, some of the data will need to be shared with CCGs directly or taken from other sources, such as public health, rather than being taken from the Dr Foster tool.

Calculating Quality Reporting Service (CQRS)

This is the NHS England system that allows practices and CCGs to run Quality Outcomes Framework (QoF) figures in-year, so we don't have to wait for QoF to be published annually. Examples such as dementia diagnosis rates are already published monthly, but diagnosis of other conditions atrial fibrillation/chronic obstructive pulmonary disease/continuing healthcare/diabetes etc are all QoF elements and it might be useful for the CCG to start looking at them with greater frequency. The CCG is in discussion with to NHS England around information Governance and potential cost implications (if any).

Conclusion:

Progress is being made on both engagement and availability of tools to demonstrate performance and quality in primary care. An example dashboard should be available for the next Primary Care Commissioning Committee but may be too early to be populated with meaningful, up to date data.

Michelle Carrington
Chief Nurse

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Item Number: 10

Name of Presenter: Dr Tim Maycock

Meeting of the Primary Care Commissioning Committee **30 May 2017**	NHS Vale of York Clinical Commissioning Group

General Practice Visits – Summary to April 2017

Purpose of Report

For Information

Reason for Report

Following on from the release of the General Practice Forward View last year and as acknowledgement that Staff from the CCG had not been able to spend as much time out with Practices as the CCG would have liked, a proposal was made to offer a visit to all member Practices before the end of the 2016/17 financial year. The majority of these visits have now been completed with plans in place for the remaining.

This report summarises the main themes and feedback from these Practice visits with a view to the CCG taking appropriate actions to support and resource the strengthening and sustainability of General Practice, to address any concerns or issues from Practice staff, and to inform CCG policy going forward.

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	Dr Tim Maycock Clinical Director

Practice Visit Report Summary

1. Introduction

Following on from the release of the General Practice Forward View (GPFV) last year and as acknowledgement that Staff from the CCG had not been able to spend as much time out with Practices as the CCG would have liked, a proposal was made to offer a visit to all member practices before the end of the 2016/17 financial year. The majority of these visits have now been completed with plans in place for the remaining. This has been a significant undertaking and acknowledgement goes to the staff at the CCG and Practices that helped make this happen.

This report summarises the main themes and feedback from these Practice visits with a view to the CCG taking appropriate actions to support and resource the strengthening and sustainability of General Practice, to address any concerns or issues from practice staff, and to inform CCG policy going forward.

2. Format and Agenda

The intention was for a clinician and managerial lead from the CCG to attend the Practice at a mutually convenient time, with an open agenda to discuss any issues for the Practice, either specifically around the GPFV or more generally. A short report was compiled following each visit and shared with members of the senior management team and clinical executive as part of the regular agenda.

3. Workforce and Workload

These were common issues at most visits. Several Practices reported having difficulty recruiting in the past year. Whilst no vacancies were declared at the time of visits, some Practices shared concerns for recruitment in the next 12 months to replace retiring partners and expressed genuine anxiety for the potential viability of their Practice if suitable replacements are not found. Increasing workload was an issue for the majority of Practices with a significant increase in patient contacts over the past few years. These cases have become increasingly complex and challenging to deal with in a traditional 10 minute consultation. All this has occurred on a background of decreasing real term funding and a significant reduction in funding was noted for the PMS Practices.

Following the introduction of the Optimising Outcomes policy in the New Year this aspect of the discussions became very much focussed on the significant increased workload for Practices and the frustration this caused, with numerous examples of inconsistent approach from the RRS team and clinically unjustifiable returns for patients where surgery was not even being contemplated. Many Practices also commented on several other CCG initiatives that they considered to be over complex and bureaucratic, and an associated increase on the administrative burden for Practice staff. These included the Bone protection Service, the PSA LES, OptimizeRx and aspects of the RSS referral system. Several Practices commented that they had tried to raise these issues with staff in the CCG but had not found them helpful or sympathetic.

4. **Skill mix**
   Most Practices were aware of the need incorporate new types of professional into the Primary Care team and there several good examples of how this was already happening. Acknowledgement was given to the fact that these roles were in limited supply and significant investment was required in some cases, only for staff to then seek employment elsewhere.

5. **Practice Resilience**
   This was more of an issue in the smaller Practices, with several acknowledging that they were “one retirement or long term absence” away from not being viable. Whilst working at scale provides a solution in some areas, this is significantly challenging for some of our more rural Practices.

6. **Premises and Estates**
   The majority of Practices reported issues in this area of varying degrees either due to lack of space or age of building. This issue is further compounded by significant building initiatives in certain areas putting pressure on existing services. Frustration was expressed at the lack of progress from the national Estates & Technology Transformation Fund and the lack of support from the CCG in moving these projects forward. If these issues are not addressed quickly, certain Practices may be forced to close their lists which would create a significant issue in providing alternative arrangements.

7. **Impact of other commissioned services**
   Most Practices expressed concern at the under provision of community services and the impact this had on Practices and their ability to proactively support patients and keep them out of hospital. Whilst working relations with staff on the ground were good, it was felt that these staff were too sparsely distributed to provide a comprehensive service to support Practices and help them to develop new and more integrated models of care.

   There were positive comments for the York Integrated Care Team in the City, but this was tempered by the lack of provision of service in the North of the area, which had been further compounded by withdrawal of the community outreach team. Practices in the south felt somewhat detached from the Integration pilot in their area.

8. **Support from the CCG**
   Whilst the staff from the CCG working with General Practice were highly commended, acknowledgement was made that the resources at the CCG available to support Practices was inadequate. Several Practices on the periphery noted the significantly greater support available for Practices in neighbouring CCGs. Some Practices felt very much on their own and would value more help and support in implementing CCG policy and applying for funding streams.

9. Technology

Many Practices demonstrated the intention to invest in new technology to help address future challenges but expressed frustration at their current service provider and lack of progress on areas such as WiFi access and online services. An understanding of the need to share data more effectively was noted, but current issues with Information Governance made it difficult for individual Practices to progress much further.

10. In Summary

Staff at the CCG would like to thank Practices for their universally warm welcome and hospitality. Despite unprecedented demand, General Practice in the Vale of York is just about coping and continues to deliver a universally good service as rated by the CQC.

However as this report illustrates, certain areas are in urgent need of attention if this is to continue.

The CCG looks forward to working with, Practices, federations and localities to help address some of these issues and continue to provide a quality Primary Care service for our population.

The Clinical Executive Committee is asked to note these findings and take appropriate supportive action where needed.

The Committee is also asked to reflect on this feedback and help to develop an agenda for the next wave of Practice visits that will start from April 2017.

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Item Number: 11

Name of Presenter: Chris Clarke

Meeting of the Primary Care Commissioning Committee **30 May 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
- ☐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	**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

Vale of York Update

Prepared by David Iley

Primary Care Assistant Contracts Manager

NHS ENGLAND – North (Yorkshire and The Humber)

15 May 2017

1. Clinical Pharmacists in General Practice

The General Practice Forward View committed to over £100m of investment to support an extra 1,500 clinical pharmacists to work in General Practice by 2020/21. This is in addition to over 490 clinical pharmacists already working in general practice as part of a pilot, launched in July 2015. NHS England, Health Education England, the Royal College of General Practitioners and the British Medical Association's GP Committee are working with the Royal Pharmaceutical Society to support this.

Providers participating in the programme will receive funding for three years to recruit and establish clinical pharmacists in their general practices for the long term. The latest wave of applications was due by 26 May 2017. NHS England will provide feedback on those received in due course.

Summary of pilot sites across the Humber Coast and Vale region to date:

Successful sites for 2017/18 Q1:		
Provider	**CCG**	**Participating Practices**
Wharfedale & Craven Alliance	Airedale, Wharfedale and Craven	5
Spa Surgery	Harrogate	3
Yorkshire Health Partners	East Riding	11
Existing Wave 1 - 2016/17 Pilot Sites		
City Health Care Partnerships	Hull	2
Haxby Group	Hull and York	5
Lincs Federation / Scartho Medical Centre	N E Lincolnshire	7
ECHO Federation/Falsgrave Surgery	Scarborough	7
Trent View Medical Practice	N Lincolnshire	3

The Committee is asked to note this update.

2. PMS/APMS uplift report 17/18

NHS England is committed to an equitable and consistent approach to funding the core services expected of all GP practices. Following the changes agreed to the General Medical Services (GMS) contract for 2017/18, the document attached sets out the approach to the funding changes that NHS England and CCGs will apply to

Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts.

CCGs working under delegation agreements will also apply the changes to local PMS and APMS contracts in line with this guidance. For the avoidance of doubt, this guidance represents guidance CCGs must comply with and implement under the provisions of Part 1 of Schedule 2 (Delegated Functions) of the Delegation Agreement made between NHS England and the CCG.

Increase to PMS and APMS contracts

To deliver an equitable and consistent approach to uplifting PMS and APMS contracts commissioners (NHS England teams or CCGs under delegation agreement) increases will apply, for those GMS changes that also impact on these arrangements that are equivalent to the value of the increases in the GMS price per weighted patient.

In summary, GP practices will receive increases in core funding as set out in table 1.

	GMS	PMS	APMS
	£/weighted patient	£/weighted patient	£/weighted patient
MPIG reinvestment	A [£0.48]	-	-
Seniority reinvestment	B [£0.31]	c [£0.31]	-
Elements of the deal	C [£0.21]	c [£0.21]	c [£0.21]
ES reinvestment	D [£2.69]	d [£2.69]	d [£2.69]
Inflation uplift	E [£1.06]	e [£1.06]	e [£1.06]
Total uplift	A+B+C+D+E [£4.76]	b+c+d+e [£4.27]	c+d+e [£3.97]

Link to full document
https://www.england.nhs.uk/wp-content/uploads/2017/03/apms-pms-contract-changes-17-18-v0.5.pdf

The Committee is asked to note the uplift to APMS/PMS contracts to be applied in 2017/18

3. Estates and Technology Transformation Fund (ETTF)

Due to the number of ETTF bids received across Yorkshire and The Humber and the capital value of the submissions being larger than the capital budget, NHS England have asked CCGs to focus on and submit Project Initiation Documents (PIDs) for 2 to 3 priority schemes at this stage. The CCG schemes with a lower priority will not be progressed until we are in a position to bring these forward for consideration and technical review, and where it is affordable to do so. However all schemes will still

remain on the pipeline unless advised otherwise by the CCG. Therefore it would still be appropriate for CCGs and practices to keep all schemes under review, with documentation prepared in readiness for consideration.

The CCG have reviewed the position of their ETTF schemes and have advised NHS England they wish to focus on 3 large scale strategic projects.

a.) Easingwold – Work commenced with York Foundation Trust on a mini options paper to understand likely estates impact for the health community. The CCG will look to progress the scheme under ETTF through a capital injection into a new build which addresses the strategic need for the area as a whole.
b.) Sherburn and South Milford Practices – significant discussion has taken place with both the parish and district councils where it is recognised that there is a need to invest in the health services to reflect the growing needs of the population expansion. The CCG will look to progress the scheme under ETTF through a capital injection into a new build which addresses the strategic need for the area as a whole.
c.) Centre in the Burnholme Health and Wellbeing Campus – The CCG will seek support from NHSE to secure feasibility funds from ETTF to scope this scheme further to better understand the capital and revenue impact.

The Committee is asked to note this update

4. Sickness and Parental Leave Protocol

NHS England have recently published the protocol in respect of locum cover or GP performer payments for parental and sickness leave. The policy and some FAQs are included as appendix 1 and appendix 2

The Committee is asked to note this update

NHS England

Protocol in respect of locum cover or GP performer payments for parental and sickness leave

NHS England INFORMATION READER BOX		
Directorate		
Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**06791**
Document Purpose	Policy
Document Name	Protocol in respect of locum cover or GP performer payments for parental and sickness leave
Author	NHS England
Publication Date	28 April 2017
Target Audience	CCG Accountable Officers, GPs
Additional Circulation List	
Description	This protocol sets out the provisions, conditions and payments relating to reimbursement to GP practices for GP performers covering parental leave and sickness leave
Cross Reference	statement of financial entitlements directions 2017
Superseded Docs (if applicable)	n/a
Action Required	payments to be made in accordance with this protocol
Timing / Deadlines (if applicable)	**n/a**
Contact Details for further information	GP Contracts Team Medical Directorate Quarry House Quarry Hill LS2 7UE england.gpcontracts@nhs.net https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/

Document Status

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Protocol in respect of locum cover or GP performer payments for parental and sickness leave

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Contents

Protocol in respect of locum cover or GP performer payments for parental and sickness leave

Background

1. The General Medical Services Contracts Statement of Financial Entitlement Directions 2013[1] (SFE) as amended in the SFE (amendment) Directions 2017 set out the provisions, conditions and payments relating to reimbursement to GP practices for GP performers covering parental leave and sickness leave.

2. This protocol applies only to GMS practices but commissioners should ensure they treat Primary Medical Services (PMS) practices equitably.

3. For the purposes of this protocol:

   - “parental leave” means ordinary or additional maternity leave, paternity leave, or ordinary or additional adoption leave;
   - "full-time" means nine sessions of clinical work per working week;
   - “working week” is defined as the core hours set out in the National Health Service (GMS Contracts) Regulations[2]: “the period beginning at 8am and ending at 6.30pm on any day from Monday to Friday except Good Friday, Christmas Day or bank holidays”.

4. The commissioner will not make payments in respect of locum or GP performer cover outside of core hours.

Parental and sickness leave payments

5. GP practices are entitled to claim reimbursement of the cost for providing GP performer cover when a GP performer is on parental leave or on sickness leave[3].

   The reimbursement of costs can be claimed where the cover is provided by:

   - a locum
   - a GP already working in the practice but who is not full-time (either employed or a partner)

6. Payments will not be made on a pro-rata basis having regard to the absent performer’s working pattern, and will be the lower of actual invoiced costs or maximum amount.

7. The SFE sets out the maximum amount of reimbursement for a GP performer providing cover as follows.

[1] https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013
[2] https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013
[3] Providing the provisions of paragraphs 15.3, 15.4, 16.3 and 16.4 of the SFE are met

Parental leave

8. In respect of maternity leave or adoption leave where the GP performer going on leave is the main care provider, the maximum amount payable is £1,131.74 per week for each of the first two weeks and then £1,734.18 per week for each of weeks 3 to 26.

9. In respect of paternity leave or special leave (which is equivalent to the terms and duration of paternity leave) where the GP performer going on leave is not the main care provider, the maximum amount payable is £1,131.74 per week for each of the first two weeks.

Sickness leave

10. In respect of sickness leave, for each period of sickness absence, there is a qualifying period of two weeks during which time no payments are made.

11. After two weeks, payments start and the maximum amount payable is £1,734.18 per week for each of weeks 3 to 28. Thereafter, the maximum amount payable is £867.09 per week for each of weeks 29 to 54. .

12. As set out in the SFE, for weeks 29 to 54 the commissioner will pay half of whatever it determined was payable for weeks 3 to 28. The SFE also sets out a methodology for calculating these periods with respect to any payments made in the previous 52 weeks and that methodology continues to apply.

Further discretionary payments

13. This protocol details (as required under paragraph 25.16 of the SFE) a number of policies the commissioner is obliged to set out:

- how the commissioner is likely to exercise its discretionary powers to make payments (including top-up payments) in respect of locum cover for parental or sickness leave, where it is not obliged to make such payments;
- where the commissioner is obliged to make payments in respect of cover for parental or sickness leave pursuant to Part 4 of the SFE, the circumstances in which it is likely to make payments of less than the maximum amount payable;
- how the commissioner is likely to exercise its discretionary powers to make payments in respect of cover for absent GP performers, which is provided by nurses or other health care professionals;
- how the commissioner is likely to exercise its discretionary powers to make payments to a partner or employee who is providing locum cover
- how the commissioner is likely to use its discretionary powers to make payments in respect of long term sickness absence exceeding 52 weeks

Discretionary powers in respect of cover for parental and sickness leave

14. The commissioner has discretion to make payments in circumstances where it is not obliged to under the terms of the SFE, including top-up payments above the level of the agreed weekly maximum.

15. The commissioner is likely to exercise these discretionary powers to make payments **only** in exceptional circumstances, for example (but not limited to) consideration of:

- demonstrable financial hardship
- areas of significant deprivation
- GP recruitment difficulties
- applications from single-handed GPs
- applications from nurse-led PMS practices

16. Where practices plan to apply for reimbursement in such circumstances they should always ensure they have written agreement from the commissioner prior to arranging cover.

Circumstances where it is likely payments will be less than the maximum amount payable

17. The commissioner will pay the maximum amount payable except in the following circumstances:

- Where actual invoiced costs are less than the maximum amount payable, then the commissioner will pay the actual invoiced costs subject to the provisions of this protocol including the bullet points below.

- With respect to parental leave, where the commissioner agrees to make payments for any weeks between weeks 27 to 52 for cover for additional maternity leave or adoption leave, the commissioner will pay the lower of either 50 per cent of the weekly rate it paid for weeks 3 to 26 or 50 per cent of the actual invoiced costs.

Payments for locum cover provided by nurses or other healthcare professionals

18. The commissioner will not pay for cover provided by nurses or other healthcare professionals.

Payments to a partner or employee who is providing cover

19. Where a contractor wishes to engage the services of a partner or shareholder in, or an employee of, that contractor, payments will be made to the GP practice in accordance with the normal provisions set out above. However, the GP performer providing cover would only be permitted to work up to the full-time limit of nine

clinical sessions per working week. The maximum of nine clinical sessions per working week is to include any existing / normal commitments by the GP performer providing the cover.

Discretionary payments in respect of long term sickness absence exceeding 52 weeks

20. Where a GP performer is on long term sickness leave, and locum payments are no longer payable under Section 16 of the SFE, it will be at the commissioner's discretion whether to continue to make payments.

21. In any case, those payments will not exceed the half rate payable in the second period of 26 weeks under paragraph 16.6(b) of the SFE, or the amount that would be payable under the NHS Pension Scheme Regulations if the performer retired on ground of permanent incapacity, whichever is the lower

Claims and payments

22. For parental leave, payments start from the day the GP performer goes on parental leave for the periods set out above and payment weeks are five working days.

23. For sickness leave, payments start two weeks from the day the GP performer goes on sick leave for the periods set out above and payment weeks are also five working days.

24. A sample claim form is at Annex A.

Annex A

Sample claim form

Claim for additional payments during parental or sickness leave

Please complete this form and send it to [NAME OF COMMISSIONER].

If circumstances should change after your application has been submitted, please complete a new form and forward it to [NAME] as soon as possible, before submitting a claim for payment.

Practice's Details

Practice name: ……..

Practice address: ……..

……..

…….. Post code: ...……..

Telephone number: ……..

Description of why additional payment is being sought

……
……
……
……
……

Details of GP performer taking leave

Surname: …… First Name: …….

Claim period: …….. Number of weeks[4]: ……..

Number of clinical sessions worked…….

Reason for claim *(delete as appropriate)*: MATERNITY / PATERNITY / ADOPTION / SICKNESS

[4] Weeks are defined as five working days

Declaration of GP performer taking leave

I …….. certify that:
(Full name in capitals)

The information shown on the reverse side of this form provides an explanation of how the practice intends to cover my period of absence.

Where necessary, I have already submitted (*please tick the box that applies*):

a. a certificate of confinement, a confirmation letter of prospective fatherhood or a letter confirming adoption leave from the appropriate adoption agency, in support of this claim ☐

b. a sick note from my GP stating the reason and expected length of absence ☐

I declare that the information provided in this claim is correct and complete. I agree to provide NHS England with written records demonstrating the actual cost of the cover and will inform NHS England if there is any change to the cover arrangements. I claim the appropriate payment for the practice.

Signature: …….. Date: ……
(An authorised signatory who is prepared to take responsibility for this declaration may sign here on behalf of the GP performer taking leave if he/she is not available to do so.)

Arrangements to cover GP performer absence

Please provide a brief explanation of how cover will be provided.
(i.e. will this be via a locum, GPs already working in the practice, or a combination)

……

……

……

……

……

……

……

Details of external GPs covering absence

If employing an external locum GP to cover the GP performer's absence, then please complete the information below (add more lines if required).

1. Name and surname: ……

   Period of cover: …… (No. of weeks: ……)

   Number of clinical sessions worked……..

   Amount paid to individual: £……..

2. Name and surname: ……

   Period of cover: …… (No. of weeks: ……)

   Number of clinical sessions worked……

   Amount paid to individual: £……..

3. Name and surname: …….

   Period of cover: …… (No. of weeks: …….)

   Number of clinical sessions worked……

   Amount paid to individual: £……..

Details of internal GPs covering absence

If employing an external locum GP to cover the GP performer's absence, then please complete the information below (add more lines if required).

4. Name and surname: ……

   Period of cover: …… (No. of weeks: ……)

   Number of clinical sessions worked……..

   Amount paid to individual: £……..

Please provide invoices in support of this claim.

2017/18 GMS AGREEMENT FAQs

Payments for GP performers covering sickness leave

What has been agreed?
NHS Employers, on behalf of NHS England, has agreed with GPC England a number of changes to the arrangements for making payments for GP performers covering sickness leave in 2017/18.

The key change is to the qualifying criteria. Payments are no longer linked to the number of patients that the remaining doctors have to treat. From 1 April 2017, all practices are entitled to reimbursement payments towards the cost of providing cover for GPs who are off work through sickness, where the period of absence is two or more weeks.

In addition, and in order to provide greater flexibility for practices and encourage continuity of care for patients, practices can now provide cover using either salaried or contractor GPs who already work at the practice as well as locums, in line with existing arrangements for parental leave cover.

Payments are no longer discretionary and will be the lower of the actual invoiced costs or the new weekly maximum of £1,734.18 per week. Those payments cannot be applied pro-rata to the working commitment of the absent GP.

There is an amendment to payment periods. Practices will now become eligible for payment each time the GP has been absent continuously for two weeks, rather than one. Then payments are made at the agreed rate for 26 weeks, and half of that for a further 26 weeks.

When do these changes come into force?
These changes come into force from 1 April 2017.

For the avoidance of doubt, they will be applied from 1 April to both new and ongoing periods of absence. As such, if a GP has been on sick leave prior to 1 April 2017 and this period of absence will continue, then that time can be counted towards the two week qualification period and the practice can claim the relevant reimbursement. Similarly, payments from 1 April 2017 will be the lower of the actual invoiced costs or the new weekly maximum amount.

Can practices claim the payments where a GP already working in the practice provides the cover instead of a locum?
Yes. However, the GP(s) providing the cover must already be working for the practice prior to the period of absence, must not be working full time, and can only provide cover to bring their own weekly commitment up to full time.

Does the two week qualifying period count to each instance of sickness absence before reimbursement payments can be made?
Yes. For each instance of sickness absence, the payments will only start once the period of sickness is two or more weeks. It is important to note that during the first two weeks of each instance of sickness absence, no payment is made and as such payments start from week three of the absence.

For how long will reimbursement payments be made?
Reimbursement payments will only apply from week three of each instance of absence. From week three, the payments will then be the lower of actual invoiced costs or weekly maximum amount for 26 weeks, followed by half that amount for the next 26 weeks.

The rolling aggregate period for counting leave previously taken in order to determine what payment is due, remains at 52 weeks.

When will the weekly maximum payment be made?
The weekly maximum amount of £1,734.18 will only be made where it is lower than the actual invoiced costs for providing cover.

Can the reimbursement payments be made pro-rata to the working commitments of the absence GP?
No. Payments can no longer be made on a pro-rata basis and will be the actual of invoiced costs or weekly maximum amount as applicable.

How can practices claim reimbursement payments?
Practices can claim for reimbursements the same way as before - by sending an application with invoiced costs and proof of GP absence (such as a fit note) to the commissioner.

What are the implications for practices – can they now cancel their sickness insurance?
These changes are intended to support practices in better managing the financial and workload implications of long-term sickness absence. NHS England cannot offer

specific advice on managing insurance cover as this is a business decision for the individual practice.

However, practices should note that the following conditions apply:

- there are no payments at all for the first two weeks on each occasion that a GP is absent;
- the continuous two week qualification period applies to every absence and does not 'carry over';
- these reimbursement payments only cover GPs, not other practice staff;
- they only cover core hours;
- as previously, payments will only be made to cover salaried GPs where the practice is paying the GP their full salary entitlement under their contract while absent through sickness

Are there any long-term medical conditions that would prevent the practice receiving reimbursement?
There are no changes to the Statement of Financial Entitlements (SFE) with regard to what constitutes sickness absence.

Below are some worked examples of how the changes will apply.

- GP A is absent 20 March 2017 – 24 April 2017 – reimbursement starts from 1 April 2017 but absence prior to that can be counted towards the two week qualification period. The practice becomes eligible to apply for payments from 3 April – 24 April, and can claim the lower of actual invoiced costs or three weekly maximum payments.

- GP B is absent 3 April 2017 – 13 April 2017 – less than two weeks so no payment.

- GP C is absent 3 April 2017 – 26 April 2017 – two week qualification period, then practice is eligible to apply for lower of actual invoiced costs or weekly maximum for the period 17-26 April.

- GP D is absent 10 July 2017 – 19 July 2017, then 25 July 2017 – 25 August 2017 – the first instance of absence is less than two continuous weeks so does not count towards payments. The second instance of absence is longer than two continuous weeks and therefore the practice is eligible to apply for lower of actual invoiced costs or weekly maximum for the period 8-25 August, after the two week qualifying period for that instance of absence.

- GP E is absent 1 May 2017 – 1 January 2018 – two week qualification period so practice is eligible to apply for the lower of actual invoiced costs or weekly maximum for 25 weeks, from 15 May – 6 November. From then until 1 January the practice will be eligible for half of whatever was paid in the first period.

- GP F is absent 1 March 2017 – 1 March 2018 – the two week qualification period starts immediately so payments start on 1 April 2017. There are then 26 weeks at the lower of actual, invoiced costs or the weekly maximum. After 26 weeks, there are then 26 weeks at half of whatever amount was paid in the first payment period.