St Helens Clinical Commissioning Group

# St Helens CCG Primary Care Committee Meeting

Date: **Wednesday, 20th September 2017**

Time: 9**.00 am – 11.00 am**

Venue: Conference Room A, St Helens Chamber

**Part 1 of this meeting will be held in public**

## Mission Statement:

***'Making a difference – right care, right place, right time'***

**St Helens Clinical Commissioning Group fully support and abide by the pledges set out within the NHS Constitution and we work to ensure we portray the values and behaviours expected of all NHS organisations**

**NHS ST HELENS CLINICAL COMMISSIONING GROUP**
**PRIMARY CARE COMMITTEE**

**WEDNESDAY, 20TH SEPTEMBER 2017 AT 9.00 AM**

**CONFERENCE ROOM A, ST HELENS CHAMBER,**
**SALISBURY STREET, ST HELENS WA10 1 FY**

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| **Apologies for absence:** |
| **Declarations of Interest:** |

| Item | Time | Agenda Item | Purpose | Presented by |
|---|---|---|---|---|
| PC170901 | | Welcome and Apologies | | Chair |
| PC170902 | | Conflicts of Interest | | Chair |
| PC170903 | | Minutes of the last meeting held on 28th June 2017 and Action log | | Chair |
| PC170904 | | Matters Arising | | Chair |
| PC170905 | | GP Federation Constitution and Governance Arrangements presentation | | GP Federation Representatives |
| PC170906 | | GP Federation proforma – access to GPFV funding | To Approve | Primary Care Contracts Manager |
| PC170907 | | Standard Operating Procedure Dashboard Escalation Plan for Primary Care | To Approve | Primary Care Commissioning and Contracts Manager |
| PC170908 | | Primary Care Dashboard - Experience | To Approve | Primary Care Contracts Manager |
| PC170909 | | Clinical Pharmacy Scheme | To note | Primary Care Commissioning and Contracts Manager |
| PC170910 | | Finance Report | To Approve | Chief Finance Officer |
| PC170911 | | PCSE Response | For Information | Interim Clinical Chief Executive |
| PC170912 | | PCQOG Key Issues from the last meeting held on 30th August 2017 | To note | Chair |

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| **PC170913** | | **Any other business** | | **Chair** |
| **PC170914** | | **Key Issues for the Governing Body** | | **Chair** |

**Date and time of next meeting: Wednesday, 15th November at 9.30 am in Conference Room A, St Helens Chamber**

# St Helens Clinical Commissioning Group

## Meeting of the St Helens CCG Primary Care Committee held on Wednesday, 19th July 2017 in Conference Room A, St Helens Chamber Salisbury Street, St Helens WA10 1FY

## Part I - Minutes

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| **Members:** | | | |
| | Geoffrey Appleton | GA | Chair, Governing Body/Committee Chair |
| | Prof Sarah O'Brien | SOB | Clinical Chief Executive |
| | Julie Abbott | JA | Deputy Chief Executive |
| | Iain Stoddart | IS | Chief Finance Officer |
| | Rachel Jones | RJ | Lay Member, PPI |
| | Tony Foy (Chair) | TF | Lay Member, Audit, Governance and Finance |
| | James Catania | JC | Secondary Care Consultant |
| | Dr Joe Banat | JB | GP Governing Body Member |
| | Dr Mike Ejuoneatse | ME | GP Governing Body Member |
| | Sue Forster | SF | Director of Public Health |
| | Margaret Geoghegan | MG | Assistant Director; Medicines Management |
| **In Attendance:** | Tom Hughes | TH | Chair, Healthwatch |
| | Rose Goreman | RG | NHSE |
| | Karen Leverett | KL | Primary Care Management Lead |
| | Clare O'Toole | CO | Primary Care Commissioning Contract Manager |
| **Minute Taker** | Cathy Edge | | PA - St Helens CCG |
| **Members of the Public** | 0 | | |

| | Chairs introduction | Action |
|---|---|---|
| **PC17/07/01** | **Apologies** | |
| **1.1** | Apologies were noted from: | |
| **1.2** | Dr Hilary Flett, GP Governing Body Member<br>Angela Delea, Associate Director; Corporate Governance<br>Lisa Ellis, Chief Nurse<br>Mike Wyatt, Strategic Director; People's Services<br>Dr Paul Rose, GP Governing Body Member | |
| **1.3** | The Chair welcomed the attendees to the Committee meeting and introduced the new Secondary Care Consultant. | |
| **PC17/07/02** | **Declarations of Interest** | |
| **2.1** | The Chair reminded Committee members of their obligation to declare any interest.<br><br>Declarations declared by members of the Primary Care Decision Making Committee are listed in the CCG's Register of Interests. The Register is available either via the Associate Director, Corporate Governance or the CCG website at the following link http://www.sthelensccg.nhs.uk/Library/public_info/Register_of_Interests/Register%20of%20Interest%20Returns%20St%20Helens%20CCG%20updated%20January%202017.pdf | |
| **2.2** | There were no declarations of interest received. | |
| **2.3** | **Nil returns were received from:**<br><br>Sarah O'Brien, Clinical Chief Executive<br>Geoffrey Appleton, Lay Chair<br>Tony Foy, Lay Governing Body Member<br>Julie Abbott, Deputy Chief Executive<br>Rachel Jones, Lay Member, Patient and Public Involvement<br>Tom Hughes, Healthwatch<br>Dr Joe Banat, GP Governing Body Member<br>Rose Goreman, NHSE<br>Iain Stoddard, Chief Finance Officer<br>Sue Forster, Director of Public Health<br>Mike Ejuoneatse, GP Governing Body Member<br>Margaret Geoghegan, Assistant Director; Medicines Management | |
| **2.4** | **The meeting was declared quorate.** | |

| PC17/07/03 | Minutes of Previous Meeting | |
|---|---|---|
| **3.1** | The minutes of the previous Extra Ordinary meeting held on 28th June 2017 were agreed as a true and accurate record of proceedings with the following amendments:- | |
| **3.2** | Page 3, Fourth paragraph, third sentence should read - The Interim Clinical Chief Executive noted this was a good observation and raised the question whether this needed to be highlighted as a risk with the LDS being at its infancy stage and noted that the lack of a robust challenge is a risk to the system. | |
| **3.3** | Page 4, sixth paragraph, last sentence should read - He further noted it would also be helpful to involve the Practices. | |
| **3.4** | Page 4, tenth paragraph, second sentence should read - Under provision for QOF in 16/17 and 17/18 | |
| **3.5** | Page 4, tenth paragraph, twelfth sentence should read - Notional Rent reimbursement remains a risk | |
| **3.6** | Page 5, third paragraph, first and second sentences should read - The Interim Clinical Chief Executive informed the Committee that she had attended an Executive to Executive Board meeting with the Trust on 27th June 2017 and noted from the meeting that all reported activity had decreased which reflected on RMS. However, A & E activity was up against the St Helens plan at month 2. The Committee noted the £5 million deficit control total and the consequences of failing to deliver this budget. | |
| **3.7** | Page 5, fourth paragraph, first sentence should read - There followed a discussion regarding whether individual letters should be sent to Practices or whether they should be peer grouped to discuss the variation, and whether it would be of benefit for an independent specialist to be in attendance. | |
| **3.8** | Page 5, fourth paragraph, second to last sentence should read - It was noted there is a clear message from NHSE regarding achieving the 95% 4 hour A & E target and that should the Trust fail to meet their target 15% of STF monies will be lost. | |
| **3.9** | Page 5, fifth paragraph should read - the Lay Member, Patient and Public Involvement noted that engagement is essential and, therefore, the Committee should not just focus on one indicator. | |

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| **3.10** | Page 5, 6th paragraph, second sentence should read - It was, therefore, not mature enough for publication. | |
| **3.11** | Page 5, 6th paragraph, third sentence should read - In response, the Lay Member, Patient and Public Involvement, noted that other CCGs do publish their Dashboards, however, they are more developed. | |
| **3.12** | Page 6, second paragraph - *IS to provide accurate correction* | |
| **3.13** | The Lay Chair arrived at the meeting. | |
| **PC17/07/04** | **Matters Arising** | |
| **4.1** | **<u>Action Points from the previous meeting</u>** | |
| **4.2** | <u>PC17.05.17(04) Review of Local Enhanced Services</u> – <u>Minor surgery</u> – The Deputy Chief Executive reported that the IVA relating to the minor surgery DES had been presented to ELT and the Primary Care Contract and Commissioning Manager was in the process of drafting the business case. The action was, therefore, closed. | |
| **4.3** | <u>Dermatology and community clinics</u> - The Deputy Chief Executive confirmed that this work continues with phase 1 considering the pathway. The action was, therefore, closed. | |
| **4.4** | <u>PC28.06.17(03) Updated Corporate Risk Register</u>- The Primary Care Management Lead confirmed that the Corporate Risk Register had been updated and the action was, therefore, closed. | |
| **4.4.1** | 1. The Primary Care Management Lead confirmed that she would link with Dr David Lawson regarding mobile devices and ITT.<br>2. The Primary Care Lead confirmed that the GP forward view funding had been presented to the GP Forum. The Interim Clinical Chief Executive confirmed that a letter had been sent out directly from NHSE to all practices with clarification required from the CCG to practices on how this funding will be accessed through a bidding process. The NHSE representative, RG, confirmed that locally NHSE had also been unaware of the letter but would raise the issue at their next meeting. The GP Governing Body Member, agreed that clarification for the practices on how to access the funding was paramount which was echoed by the Chief Finance Officer. | **KL**<br><br>**RG**<br>**KL/PB** |

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| **4.4.2** | The Interim Clinical Chief Executive requested that the Primary Care Management lead draft a response to Glen Coleman requesting a timetable for the bidding process. | **KL** |
| **4.4.3** | The Primary Care Management lead confirmed submission of the bid for the funding stream with the closing date of Friday, 21st July 2017 with a copy to the Chief Finance Officer. The action was, therefore, closed. | |
| **4.5** | PC28.06.17 Standard Operating Procedure Dashboard Escalation Plan – it was noted that this had been deferred from the meeting on 19th July with further work to be carried out by PCQOG and to be presented to the next meeting. The action was, therefore, closed. | |
| **4.6** | PC28.06.17(05) Finance Update - The Interim Clinical Chief Executive reiterated the need for the variation letters to be sent out to practices. She reported on a recent meeting of the A & E Board with Richard Barker, NHSE Director for the North, who highlighted the need for reaching 90% for the 4 hour target by October and 95% by March. She reported that St Helens is an outlier in A & E in this area. | |
| **4.6.1** | The Deputy Chief Executive confirmed work undertaken on urgent care looking at A & E admissions and readmissions, and that NHSE were now requesting peer reviews with practices on elective work, urgent care, planned care and RMS. She confirmed the need for a consistent approach to practice visits with a small team which will report back to the Committee. | |
| **4.6.2** | The GP Governing Body Member, ME, confirmed that these were challenging times for some practices with genuine capacity issues and requested that a GP should join the team visits which was confirmed as planned. | |
| **4.6.3** | The GP Governing Body Member, JB, confirmed that the A & E Quality Plan had been presented to the Quality and Performance Committee where the escalation process had been considered and much improved with earlier escalation which should ensure better management in the future. | |
| **4.6.4** | The Lay Member, Patient and Public Involvement asked the Committee to ensure that the CCG uses GP insight along side community perceptions with reference to the population of the practices which may provide a different view point. | |
| **4.6.5** | The GP Governing Body Member, JB, queried the | |

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| | effectiveness of the urgent care treatment centre at Halton which was confirmed by the Deputy Chief Executive. She noted that some of their pathways had been shared with the Project Management Office with a view to emulating them in the St Helens Walk in Centre. The Interim Clinical Chief Executive reported from a recent meeting with Halton CCG's Interim Chief Executive and confirmed better A & E attendances but conversion to admissions remains the same. | |
| **4.6.6** | The Lay Chair noted that variation would be a useful area for the federation to support practices with solutions and plans for improvement supported by transformation monies. | |
| **4.6.7** | The Deputy Chief Executive confirmed that Mike Roscoe, North West Boroughs was also sighted on the "hot spots" and the need for partners to work more closely together. | |
| **4.6.8** | The GP Governing Body Member, ME, provided an example of difficulty accessing the falls response team. | |
| **4.6.9** | The Assistant Director; Medicines Management provided an example of improvements made to a practice by a new GP and the benefits of sharing good practice. | |
| **4.6.10** | The Committee requested an interim report on the management of the risk of A & E over performance linked to primary care with goals for the federation. | **CL/KL** |
| **4.6.11** | The action was closed. | |
| **PC17/07/05** | **GP Forward View** | |
| **5.1** | The Primary Care Commissioning Contracts Manager presented the GP Forward View report. The purpose of the report was to provide a rationale for the development of a template for completion in relation to funding for General Practice Forward View initiatives and gain approval for the use of the template. | |
| **5.2** | The Deputy Chief Executive reported that the goals for the federation were missing from the report. She noted that the Federation should be up and running by mid August and that their priorities needed to be considered to be presented to the next Committee in September. | |
| **5.3** | The Lay Member, Patient and Public Involvement, agreed that the Committee needed to consider the desirable outcomes from the funding with favour to be shown to those bids put together in partnership as an incentive for the | |

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| | Federation. | |
| **5.4** | The Interim Clinical Chief Executive agreed that the business cases should be linked to the top two priorities, one of which being access. | |
| **5.5** | The Deputy Chief Executive endorsed this approach and noted the risk of spreading the funding on small, discrete schemes would dilute the impact for patients given the limited allocation of money. She noted that the form needs further development with more financial information required for processing the bids. She queried whether all bids should be submitted through the federation and whether the federation would choose which bids should be put forward. | |
| **5.6** | The Chief Finance officer proposed that the template should replicate the format that NHSE used for the resilience funds which was agreed. | |
| **5.7** | The Interim Chief Executive noted that the CCG needed to be assured that the Federation was a fit and proper organisation on a par with other NHS providers ensuring that all GP voices are represented. She noted that the Committee were yet to see the Federations constitution and governance arrangements. She proposed that the Federation should be invited to present this information to the next meeting and this was agreed. | **KL** |
| **5.8** | The GP Governing Body Member, JB, confirmed that the Federation principles were the same as the CCGs in wanting to improve the health of the Borough and how to address health inequalities which may need a targeted approach for different areas of the Borough. He noted that the Federation will need access to the relevant data and that the locality meetings, which are starting next week, will help in the focus of this. | |
| **5.9** | The Director of Public Health reported on the care management programme within St Helens Cares which is considering replicating a locality profile from Liverpool that has been successful. The GP Governing Body Member, JB, confirmed that he had met with the lead for this work which was very helpful. The Interim Clinical Chief Executive reported that the IVAs for this work were being developed for approval. | |
| **5.10** | The Interim Clinical Chief Executive proposed that the Federation representatives also be invited to discuss how the funding should be directed which was agreed. The GP | **KL** |

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| | Governing Body Member, ME, proposed that the funding streams could be bid for through the federation or directly from individual practices but echoed the Lay Member's proposal that joint bids would be more likely to be successful. | |
| **5.11** | The Interim Clinical Chief Executive left the meeting. | |
| **5.12** | **NHS St Helens Primary Care Decision Making Committee:-**<br>• **Noted** the content of the report<br>• **Agreed** to invite the Federation to present their constitution and governance arrangements | |
| **PC17/07/06** | **Finance Update - July 2017** | |
| **6.1** | The Chief Finance Officer presented the Finance Update - July 2017. The purpose of the report was to inform the Committee of the full year forecast outturn based on information at June 2017. The report included devolved budgets set based on the delegated primary care allocation received from NHSE plus additional local investment. | |
| **6.2** | The report also highlighted those budgets that contain the greatest degree of risk. | |
| **6.3** | The Chief Finance Officer reported that this report would usually be presented to the Primary Care Quality Operational Group (PCQOG) before Primary Care Committee. He highlighted to the Committee the potential outturn overspend of £200K due to QOF issues carried over from last year, however, the recent acute underspend had offset this to some degree. He noted that this was still showing a significant amount of risk due to the unknown QOF payments for this year. He also highlighted £250K as unidentified QIPP and some practice caretaking costs that may become a pressure this year which amounts to £600K, and increased locum costs of up to £150K. The Chief Finance Officer confirmed that the PCQOG would consider solutions to mitigate against this at their next meeting. It was proposed that not having to disperse the Eldercare list would mitigate some of the cost. | |
| **6.4** | The Chief Finance Officer provided an update on the submission to NHSE of the resilience bid for £212K and practice development funding. | |
| **6.5** | The Lay Chair expressed his concern for the unidentified QIPP and requested a review of the budget detail to be presented to the next Committee with mitigations. | **IS/PB** |

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| **6.6** | The Primary Care Management Lead confirmed that there was a small amount of flexibility on LESs but that the DESs were part of the wider primary care budget that sits with other teams where savings may be identified. The Chief Finance Officer confirmed that this would be considered | |
| **6.7** | The GP Governing Body Member, JB, queried the caretaking costs for Sherdley Medical Centre and whether this was additional to the cost of the contract. The Chief Finance Officer confirmed that those assumptions had been made in December last year and so have been tested over the last month and may put additional pressure on that budget. He confirmed that this would be considered further to ensure it is not duplicating the running costs. | |
| **6.8** | The Primary Care Management Lead confirmed that the new provider was already working with the current provider to ensure the quality, safety and continuity of care for the patients. She reported on the 'wrap around' support from the frailty team and community matrons. She noted that there were no additional payments to the new provider but that the CCG were unable to return this contract to a GMS contract during the caretaking period. | |
| **6.9** | **NHS St Helens Primary Care Decision Making Committee:-**<br>• **Noted** the content of the report<br>• **Requested** an updated report for the next meeting | |
| **PC17/07/07** | **Minutes for Noting** | |
| **7.1** | Minutes from the Primary Care Quality & Operations Group meeting on 29th June 2017 were noted. | |
| **7.2** | The Key Issues were highlighted as:-<br>• Zero tolerance provider<br>• Transfer of Eldercare Patients<br>• Workforce Strategy<br>• PCSE concerns<br>• Locum costs | |
| **7.3** | The Lay Member, Audit, Governance and Finance, requested that a PCSE representative be invited to the Primary Care Committee to address the concerns associated with payments to practices and pensions. The Chief Finance officer agreed to raise this at the next National Finance Working Group meeting. | **PB/KL** |
| **7.4** | **NHS St Helens Primary Care Decision Making** | |

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| | **Committee:-**<br>• **Noted** the content of the minutes | |
| **PC17/01/08** | **Key Issues for the Governing Body** | |
| **8.1** | PC170705 GP Forward View - a larger piece of work is required on the shared outcomes with the federation. | |
| **8.1.1** | Need to ensure that engagement and communication with patients and public groups is evidenced and recorded appropriately in the risk registers. | |
| **8.1.2** | The GP Federation will be invited to present their constitution to the next Committee meeting in September and discuss locality borough working. Work on validation to provide the intelligence to enable the Federation and the CCG to make transformational change bids will continue.<br>An update on the bidding progress to be provided at the next meeting. | |
| **8.2** | PC170706 Finance Update - July 2017 - the risk of failing to deliver the planned budget and actions to address this. | |
| **PC170709** | **Any Other Business** | |
| **9.1** | There was no other business. | |
| | **Date and Time of Next Meeting** | |
| The next meeting of the St Helens CCG Primary Care Committee will take place on Wednesday, 20th September at 9 am in Conference Room A, St Helens Chamber | | |

# ACTION POINTS FROM ST HELENS CCG Primary Care Committee 19.07.17

| Ref | Who | Item | By When | Closed |
|---|---|---|---|---|
| **PC17.05.17 (04)** | | **Review of Local Enhanced Services** | | |
| | **JA/SH** | 1. JA to link in with SH regarding delivery of Minor Surgery within Primary Care. | **19.7.17** | **Closed** |
| | **SH** | 2. SH to discuss Dermatology and Community Clinics Pathways with C Lees and R Hunter. | **19.7.17** | **Closed** |
| **PC28.06.17 (03)** | | **Updated Corporate Risk Register** | | |
| | **KL** | 1. Draft email to be provided by the Primary Care Team on behalf of David Lawson to be sent out to GP Practices. | **19.7.17** | |
| | **KL** | 2. Members Council to be appraised of centralised funding which could attract more funding into the CCG. | **19.7.17** | **Closed** |
| | **KL/PB** | Clarification for the Practices on how to access the funding was requested. The Primary Care Management Lead to draft a response to Glen Coleman. | **20.09.17** | |
| | **KL** | 3. KL to ensure that the Primary Care Committee Members are sighted with a copy of the bid once submitted. (The Clinical Chief Executive observed from the discussions that the Committee agreed in principle that a bid should be developed. KL to liaise with PB and HF. A Report should be submitted to the next Primary Care Committee with further information and noting that the bid was submitted in line with the deadline (12th July 2017), as this is prior to the next Committee meeting). | **TBA**<br>**19.7.17** | **Closed**<br>**Closed** |
| | **LE** | 4. LE to liaise with AD to ascertain whether patient public involvement should be reflected in both Risk Registers. | | **Closed** |
| | **CO'T** | 5. CO'T to incorporate Federations as a Provider as a risk in the Corporate Risk Register. | | **Closed** |
| **PCC28.06.17 (04)** | | **Standard Operating Procedure Dashboard Escalation Plan** | | |
| | **SH** | 1. Flowchart to be updated and to include the RAG Ratings. | **19.7.17** | **Closed** |

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| **PCC 28.06.17 (05)** | **SH/KL/JA/ (CL)** | **Finance Update**<br><br>1. All Practices should receive the data and invite the Practices concerned to individual meetings to ask for their feedback. The data should anonymise with the RAG rating. SH and KL to liaise with C Lees and J Abbott with a view to taking the lead on this work.<br>2. IS and KL to meet outside of the Primary Care Committee to discuss budget allocations. | **19.7.17**<br><br>**19.7.17** | **Closed**<br><br>**Closed** |
| **PC170704** | **KL/CL** | **Action Points from 28.06.17**<br><br>An interim report was requested on the management of the risk of A & E over-performance linked to primary care with goals for the federation. | **20.09.17** | |
| **PC170705** | **KL** | **GP Forward View**<br><br>Invite the GP Federation to present their constitution and governance arrangements to the next Primary Care Committee meeting and discuss how funding bids should be directed. | **20.09.17** | |
| **PC170707** | **KL/PB** | **PCQOG Minutes from 29th June 2017**<br><br>A PCSE representative be invited to attend the Primary Care Committee to address the concerns associated with payments to practices and pensions. | **20.09.17** | |

| Report to Primary Care Committee | |
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| **Date of meeting:** | 20 September 2017 |
| **Governing Body Member Lead:** | Clinical Chief Executive |
| **Accountable Director:** | Associate Director; Primary Care |
| **Report title:** | General Practice Business Case/Project Plan Form And Federation Bid |

| **Item for:** | **Decision →** | X | **Assurance →** | | **Information →** | | *(Please insert X as appropriate)* |
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| **Strategic Objectives** | This report supports the following CCG Strategic Objectives. Please insert 'x' as appropriate. | |
| | 1. To deliver financial sustainability | X |
| | 2. To deliver improvements through system redesign and in priority areas. | |
| | 3. To deliver improved outcomes for patients | |
| | 4. To develop primary care capacity and capability as system leaders | |

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| **Governance and Risk** | Does this report provide assurance against any of the risks identified in the Assurance Framework? (please specify)<br><br>What level of assurance does it provide? |
| | Is this report required under NHS guidance or for statutory purpose? (please specify)<br><br>No |

**Purpose of this paper**

1) To gain approval from the Primary Care Committee for the use of a Business Case/Project Plan for practices/federation applications for funding linked to the General Practice Forward View that is managed by NHS St Helens Clinical Commissioning Group.
2) To gain approval to fund federation costs as per funding request

**Further explanatory information required**:

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| **Does this paper link to any of the 10 key themes of the CCG's Improvement Plan. If yes, please specify.** | N/A |
| **How will this benefit the health and wellbeing of St Helens residents or the Clinical Commissioning Group?** | N/A |
| **Please describe any possible Conflicts of Interest associated with this paper.** | N/A |
| **Please identify any current services or roles that may be affected by issues within this paper.** | N/A |
| **What risks may arise as a result of this paper? How can they be mitigated?** | N/A |

## 1. Executive Summary

Following publication of the General Practice Forward View it was clear a number of funding streams would be available. Some of the funds would be managed by NHS England and others directly by Clinical Commissioning Groups.

As part of the process to form a borough wide federation a request for funding was submitted, however, this was a few lines in an e-mail and not a robust business case. Further correspondence has been received and as such a decision needs to be made on level of funding.

In order to be assured funds are being allocated and used appropriately a business case/project plan form has been developed.

## 2. Background and Update

The General Practice Forward View was first published in 2016 and detailed a host of initiatives aimed at securing General Practice and making it sustainable into the future. A number of funding streams were detailed.

A transformation fund was set up by St Helens CCG at £3 per head of population. This can used to fund the establishment of federations. A fund of £294,000 per year in 2017/18 and 2018/19 is set aside. However, the funding does not have to be spent in year, an underspend could be used to offset any shortfall in the primary care budget although not spending the funds this year would put a pressure on budgets in 2018/19.

**Part 1 – Business Case Documentation**:

To ensure there is a robust audit trail and also to ensure there is accountability with those receiving funds a template has been drawn up for completion by applicants for funds that would be submitted to St Helens CCG. To maintain uniformity the template has been based on the template currently used for internal business case applications with a few amendments to make it more General Practice focused.

A draft template is attached to this paper at Appendix 1.

The template requires applicants to set timescales and outcomes for the use of funding so projects can be monitored by St Helens CCG.

To ensure the audit trail is robust and free from conflict the template details a process of approval. Applications will initially go to the Primary Care Quality and Operational Group for review and approval and then be brought to Primary Care Committee with recommendations for final approval.

**Part 2 – Federation Funding Application**:

On the 14 June 2017 an e-mail was received from the federation asking for funding, the table below is the content of the e-mail:

| Purpose | Monthly Cost | Annual Cost |
|---|---|---|
| GP Temporary Lead (1 session per week) | £1,085.00 | £13,020.00 |
| Project Manager | £2,500.00 | £30,000.00 |
| Management Consultant(1 day per week) | £2,600.00 | £31,200.00 |
| **Total** | **£6,185.00** | **£74,220.00** |
| Event Costs (already incurred) | | £ 630.00 |
| Website development | | £ 1,000.00 |
| **Total** | | **£ 1,630.00** |
| **Grand Total** | | **£75,850.00** |

There were no details of timescale, outcomes or benefits of the federation receiving this funding.

A further letter has been received dated 29 August 2017 from the federation stating that as at the end of August a total of £36,000 has been spent on federation set up costs by ROTA. As with the initial request no detail as to what had cost £36,000 was included with the letter, although a request for the business case documentation was made.

Whilst the above table details some of the costs associated with the federation the Management Consultant element is above the figure the CCG could reasonably approve.

Given the total funds available has to potentially cover a number of schemes it is proposed the federation have an upper limit of funding of £60,000 for set up costs. It is proposed not to cover the full cost on the basis that the Management Consultant appears expensive at £600 per day and is above what the CCG would deem a reasonable value. Anything above £600 per day or for 6 months or more requires NHS England approval.

If funds are approved documentation will be requested to provide an audit trail.

## 3. Next Steps (as appropriate)

If the members of the Primary Care Committee approve the template this will be provided to any provider wishing to apply for funding in relation to GP Forward View and transformation.

Inform the federation of how much is agreed for set up costs and the new process of application for any additional funds plus completion of a business case.

## 4. Recommendations

The Committee are asked to:

1) Note the contents of this report
2) Approve the template for use in the application for funding process for GPFV
3) Approve the process of future funding approval
4) Approve maximum funding available to the federation of £60,000.00

# Appendix 1
# Business Case/Project Plan

*(The Business Case/Project Plan document should be completed and submitted in advance of any schemes commencement where funding support is requested via NHS St Helens Clinical Commissioning Group. This is to provide the relevant information on purpose, cost and expected outcomes. Once completed submit your idea to the ?? mailbox. If approved, this template will support the development of a detailed plan and outcome document.*

## Proposed Business/Project Plan Title:

Date:
Author:

| CCG Strategic Objectives supported by this Idea | |
|---|---|
| To deliver Improvements through System Redesign and in Priority Areas. | ☐ |
| To deliver improved Outcomes for Patients | ☐ |
| To develop Primary Care Capacity and Capability as System Leaders | ☐ |
| To deliver Financial Sustainability | ☐ |

| Type of idea: | | | |
|---|---|---|---|
| Service Improvement | ☐ | Efficiency Saving | ☐ |

| Focusing on: | | | |
|---|---|---|---|
| Quality ☐ | Innovation ☐ | Productivity ☐ | Prevention ☐ |

| Improvement Plan Theme: | |
|---|---|
| Primary Care/sustainability/Access/Workforce ☐ | Federation ☐ |

## 1.0 Project Idea

*What is your Idea - what is in Scope and what is Out of Scope: What are the drivers for the Idea? What is the Evidence Base? What are the Proposed Changes?*
*NOTE: If this is a Decommissioning, Reduction or Cessation Project Idea then an EIA and QIA will need to be completed.*

## 2.0 Project Objectives, Outcomes and Outputs:

*(What will the Project Deliver and what changes will it bring about? What are the actual Products/Outputs to be delivered?)*

2.1: Objectives: *(What we are Aiming to Achieve)*

2.2: Outputs: *(What we actually Deliver - Product; Key Deliverable)*

2.3: Outcomes: *(What is the Change; what is the impact on the System; the Measure of the Change; Key Performance Indicator)*

## 3.0 Benefits: Outcome Measures

***How will the Project contribute to the sustainability and transformation of Primary Care Services? Outline Key Benefits and High Level Measures/ Metrics Including-:***

**3.1: Activity**
**3.2: Financial Savings**
**3.3: Quality**
**3.4: Patient Experience**
**3.5: Contributing to Improvement and Assessment Framework Targets**

## 4.0 Risks

*What are the main Risks at this Stage e.g. Linked to not doing the Project, or what may impact on the Implementation of the Project?*

## 5.0 Project Approach and Resources

*Outline any initial ideas on the Project Team - who will need to contribute; Resources Required including Prescribing, Primary Care and Estates; any associated set-up costs to Implementing the Project Plan*

## 6.0 Clinical Lead Involvement and Sign off

**The relevant Clinical Commissioning Group Clinical Lead has reviewed this Business Case/Project Plan and supports the proposed changes**

Name:
Date:

| Submission for Approval: | |
|---|---|
| Primary Care Quality and Operational Group (PCQOG): | Date: |
| Primary Care Committee (PCC): | Date: |
| Outcome/Decision: Approved by PCQOG Yes: ☐ No: ☐<br>Approved by PCC Yes: ☐ No: ☐ | |

# Project Plan:

*The Project Plan should build on the Business Case and develop a persuasive and compelling argument for implementation. Use previous information from the Business Case but enhance each section fully.*

| **Project Title:** | | **PMO No:** | |
|---|---|---|---|
| **Project Manager/Lead:** | | | |
| **Executive Sponsor/Lead:** | | | |
| **Clinical Lead:** | | | |
| | | | |
| **Amendment History** | | | |
| **Version** | **Date** | **Author** | **Reason** |
| | | | |
| | | | |

| **1. Drivers for Change** |
|---|
| *National, Local* |

| **2. Options Appraisal: (Based on Business Case)** | | |
|---|---|---|
| *Include Option of doing nothing:*<br>*Include Risk Analysis and Benefits Analysis for each Option:* | | |
| **Option** | **Benefits** | **Risks** |
| | | |
| | | |
| | | |

| **3. Preferred Option/ Recommendations:** |
|---|
| |

**Complete the following Sections based on the preferred Option to support your argument**

| **4. Dependencies:** |
|---|
| *What other Projects may be linked with this Project - or are interdependent - link to Timescales* |

| **5. Quality Impact Assessment** |
| --- |
| *Any Actions identified that need including in the Action/Delivery Plan (Any Links with Communications and Engagement)(Complete separate QIA Template if required)* |

| **6. Equality Impact Assessment** |
| --- |
| *Any Actions identified that need including in the Action/ Delivery Plan (Any Links with Communications and Engagement)(Complete separate EIA Template if required)* |

| **7. Risks and Mitigations** |
| --- |
| *What are the Key Risks identified and what Mitigating Actions are to be taken to minimize the Risk* |

| **8. Communications and Engagement - Consultation** |
| --- |
| *Is there a requirement for formal Consultation and if so, ensure Timescales are identified (EIA will identify any needs)*<br>*Stakeholder Mapping to identify Who, What Where and When Re: Messages/Information/Engagement* |

| **9. Costs: Initial Expenditure/Set-up Costs** |
| --- |
| *What are the Initial Costs and where this will be Funded from* |

| **10. Procurement** |
| --- |
| *Is there a requirement for a Procurement Process and if so what will be the Timescales and who needs to be involved: ensure this is reflected in the Action/Delivery Plan* |

| **11. Benefits Realisation: Activity (Set Specific Measures)** |
| --- |
| *Based on current Activity Levels, Baseline Data; ensure Data can be collected and reported on; Frequency of Data Collection; will this require a change to Information Schedules within Contracts: Set Targets, Thresholds and Trajectories* |

| **12. Benefits Realisation: Quality (Set Specific Measures)** |
| --- |
| *Set Measurable Quality Outcomes and identify how these will be measured and reported: what will be the Benefits in terms of Quality for Stakeholders, Public, and Patients etc.* |

| **13. Benefits Realisation: Financial (Set Specific Measures)** |
| --- |

| |
|---|
| *Will this be Cash Releasing, Resource Release and therefore Non-cashable Release or Cost Avoidance; how will this be Measured and Reported; Set Targets, Thresholds and Trajectories - ensure Systems in place to monitor the Cost Benefit.* |

| **14. Other Areas to Consider:** |
|---|
| *Do any of the following need to specifically be involved:*<br>*Primary Care:*<br>*Medicines Management*<br>*Estates*<br>*HR* |

| **15. Project Milestones/ Deliverables and Timescales** |
|---|
| *What are the High Level Milestones/ Deliverables and estimated Timescales (then complete a detailed Implementation/Delivery Plan)* |

| **16. Approval:** |
|---|
| **Primary Care Quality and Operational Group**<br>**Date Approved:** |
| **Primary Care Committee:**<br>**Date Approved:** |

**Progress to/complete full Project Documentation:**

**Checklist:**

| | |
|---|---|
| **Project Plan** | ☐ |
| **QIA** | ☐ |
| **EIA** | ☐ |
| **Performance Dashboard** | ☐ |
| **Communication and Engagement Plan** | ☐ |
| **Risk Register** | ☐ |
| **Privacy Impact Assessment** | ☐ |

## DOCUMENT DEVELOPMENT

| Process | Yes | No | Not applicable | Comments & Date (i.e. presentation, verbal, actual report) | Outcome |
|---|---|---|---|---|---|
| Public Engagement (please detail the method i.e. survey, event, consultation) | | | X | | |
| Clinical Engagement (please detail the method i.e. survey, event, consultation) | | | X | | |
| Has 'due regard' been given to Equality Analysis (EA) and any adverse impacts? (Please detail outcomes, including risks and how these will be managed) | | | X | | |
| Legal Advice Sought | | | X | | |
| Presented to any other groups or committees including Partnership Groups – Internal/External (please specify in comments) | X | | | An original template has been presented to PCQOG where recommendations were made to alter the format. | |

**Note:** Please ensure that it is clear in the comments and date column how and when particular stakeholders were involved in this work and ensure there is clarity in the outcome column showing what the key message or decision was from that group and whether amendments were requested about a particular part of the work.

NHS
St Helens Clinical Commissioning Group

| Report to: Primary Care Committee | |
|---|---|
| **Date of meeting:** | 20th September 2017 |
| **Governing Body Member Lead:** | Deputy Chair |
| **Accountable Director:** | Associate Director: Primary Care |
| **Report title:** | Standard Operating Procedure Dashboard Escalation Plan |

| **Item for:** | **Decision →** | ☑ | **Assurance →** | ☐ | **Information →** | ☑ | *(Please insert X as appropriate)* |
|---|---|---|---|---|---|---|---|

| | |
|---|---|
| **Strategic Objectives** | This report supports the following CCG Strategic Objectives. Please insert 'x' as appropriate.<br><br>1. To deliver financial sustainability ☐<br>2. To deliver improvements through system redesign and in priority areas. ☐<br>3. To deliver improved outcomes for patients ☑<br>4. To develop primary care capacity and capability as system leaders ☐ |

| | |
|---|---|
| **Governance and Risk** | Does this report provide assurance against any of the risks identified in the Assurance Framework? No ☐ Yes ☐ (please specify)<br><br>C1 - Failure to commission effective services that improve quality and outcomes for patients<br><br>What level of assurance does it provide?<br><br>Limited |
| | Is this report required under NHS guidance or for statutory purpose?<br>No ☑ Yes ☐ (please specify) |

| **Purpose of this paper** |
|---|
| To inform the committee of the standard operating procedure in place for the dashboard escalation plan. |

**Further explanatory information required**:

| | |
|---|---|
| **Does this paper link to any of the 10 key themes of the CCG's Improvement Plan. If yes, please specify.** | Yes – Primary Care General Practice Forward View |
| **How will this benefit the health and wellbeing of St Helens residents or the Clinical Commissioning Group?** | Reviewing the dashboard will highlight areas of concern to be managed by NHS St Helens CCG which, in turn will ensure a safe, high quality service for patients |
| **Please describe any possible Conflicts of Interest associated with this paper.** | There may be conflicts of interest for GPs who are Partners in Member Practices. |
| **Please identify any current services or roles that may be affected by issues within this paper.** | N/A |
| **What risks may arise as a result of this paper? How can they be mitigated?** | N/A |

## 1. Executive Summary

The Primary Care dashboard escalation plan has been developed to review the provision of Primary Care over three domains:-

1. Safe
2. Effective
3. Patient experience

## 2. Background and Update

As part of the development of the dashboard a decision was made to examine one of the above domains in detail each month. Following this a report would be provided for the Primary Care Committee, on a regular basis, to highlight the findings of the review and any actions taken.

As part of this process it was agreed that a Standard Operating Procedure Escalation Plan (SOP) was required which would detail what the process would be when concerns were highlighted to PCQOG and further action was necessary.

The escalation plan will ensure that any concerns are raised and actioned in a consistent manner.

This plan has been developed in conjunction with the Quality & Performance team and is reliant on existing policies and procedures already in place.

## 3. Next Steps

Upon approval from the committee, this SOP will be implemented with continued monitoring and reporting back to PCQOG and further SOPs will be developed for the “effective” & “patient experience” domains. Please note to the SOP includes a schedule of CCG MDT officers, policies and procedures and a library of available resources which will continue to be developed.

## 4. Recommendations

The committee is asked to approve this process,

## DOCUMENT DEVELOPMENT

| Process | Yes | No | N/A | Comments & Date (i.e. presentation, verbal, actual report) | Outcome |
|---|---|---|---|---|---|
| Public Engagement (please detail the method i.e. survey, event, consultation) | ☐ | ☐ | ☑ | | |
| Clinical Engagement (please detail the method i.e. survey, event, consultation) | ☐ | ☐ | ☑ | | |
| Has 'due regard' been given to Equality Analysis (EA) and any adverse impacts? (Please detail outcomes, including risks and how these will be managed) | ☐ | ☐ | ☑ | | |
| Legal Advice Sought | ☐ | ☐ | ☑ | | |
| Presented to any other groups or committees including Partnership Groups – Internal/External (please specify in comments) | ☐ | ☐ | ☑ | | |

**Note:** Please ensure that it is clear in the comments and date column how and when particular stakeholders were involved in this work and ensure there is clarity in the outcome column showing what the key message or decision was from that group and whether amendments were requested about a particular part of the work.

# Schedule 1
## SOP Primary Care Dashboard Escalation Plan

| | Measure | Source | CCG officer MDT Representitive | CCG or NHSE process in place for individual indicator |
|---|---|---|---|---|
| Safe | No of Serious Incidents YTD | Reporting in Development - Karen.Edwardson2@sthelensccg.nhs.uk | KE/MH | YES |
| | No of Serious Incidents in month | | KE/MH | YES |
| | No of near misses | | KE/MH | YES |
| | No of complaints dealt with by NHSE | Karen.Edwardson2@sthelensccg.nhs.uk | KE/PC TEAM | YES |
| | KO41b Complaint data | Primary Care Webtool - latest data not availble until later in 2017 | Unable to dril down to practice level | YES |
| | GP Children Safeguarding Training up-to-date (Y/N) excl Locums - annual audit | Karen.Edwardson2@sthelensccg.nhs.uk | CF | |
| | Primary care workforce: Number of GPs and Practice Nurses (FTE) per 1,000 weighted patients (New indicator in IAF) | Clare.OToole@sthelensccg.nhs.uk | COT/MH | |
| | Percentage Cephs, Quins and Coamoxiclav of 'selected' other Antibiotics (as specified in Quality Premium 1617) | Nigel.Cosford@sthelensccg.nhs.uk | NCo | |
| | Antibacterial Items Per 1000 StarPU | Meds Management - Nigel.Cosford@sthelensccg.nhs.uk | NCo | |
| | Total Prescribing Costs per 1000 APU | Meds Management - Nigel.Cosford@sthelensccg.nhs.uk | NCo | |
| | No of Cdiff registered to Practice YTD | Karen.Edwardson2@sthelensccg.nhs.uk | KE/SHo | |
| | No of Cdiff registered to Practice NEW | Karen.Edwardson2@sthelensccg.nhs.uk | KE/SHo | |
| | No of MRSA registered to Practice YTD | Karen.Edwardson2@sthelensccg.nhs.uk | KE/SHo | |
| | No of MRSA registered to Practice NEW | Karen.Edwardson2@sthelensccg.nhs.uk | KE/SHo | |
| | Mortality (DSR all age all cause) | Needs to be a GP | ? | |
| | Number of prescribing clinicians in surgery | Awaiting Data Meds Management - Nicola.Cartwright@sthelensccg.nhs.uk | | |
| | Number of non-medical prescribers | Meds Management - Nicola.Cartwright@sthelensccg.nhs.uk | NC | |
| | Number of resignations | Clare.OToole@sthelensccg.nhs.uk | COT/MH | |
| | Controlled Drug Prescribing | Meds Management - Nicola.Cartwright@sthelensccg.nhs.uk | NC | |
| Experience | FFT(Core question% recommended) | https://www.england.nhs.uk/ourwork/pe/fft/ | PS | |
| | FFT Number of responses | https://www.england.nhs.uk/ourwork/pe/fft/ | COT | YES |
| | PES Overall Experience of GP practice | https://gp-patient.co.uk/surveys-and-reports | PS/PC team | |
| | PES -Ease of getting through via phone | https://gp-patient.co.uk/surveys-and-reports | PS/PC team | |
| | % Able to get an appointment to see or speak to someone - total responses | https://gp-patient.co.uk/surveys-and-reports | PS/PC team | |
| | Patient Experience Survey of Accessing GP (% overall score) - % who have seen or spoken to a GP in the past 6 months (Q18 patient survey/CCG quality premium) | https://gp-patient.co.uk/surveys-and-reports | PS/PC team | |
| | Variance in number of patients joining or leaving the practice | | JK | |
| | % of patients feeling supported to manage their LTC (GP Patient Survey) | https://gp-patient.co.uk/surveys-and-reports | PS/PC team | |
| Effective | CQC Overall Rating | Clare.OToole@sthelensccg.nhs.uk | COT | YES |
| | Contract Breach (Yes/ No) | Clare.OToole@sthelensccg.nhs.uk | PCTeam | YES |
| | Flu Vaccine for aged 65 and over | https://portal.immform.dh.gov.uk Jean.Keenan@sthelensccg.nhs.uk | JS | |
| | % of deaths occuring in hospital | SUS data - run SQL queries from file - 'Deaths in Hospital' J:\St Helens CCG\CORPORATE\Finance and Performance\Finance and Performance\Performance management team\Primary Care - Performance Team\Raw Data for each indicators | PT/GP | |
| | Number of emergency admissions for under 70's urgent care sensitive conditions per 1000 registered patients (IAF/MyNHS) | Urgent Care Access Report | PT/GP | |
| | % of total practice referrals, made via e-Referrals (local, to be agreed) | e-referrals not available at practice level - CCG position from IAF dashboard? | PT/GP | YES |
| | % practices streaming data for risk stratification (DSA = Data Sharing Agreement) | louise.owen5@nhs.net | PT/GP | |
| | Cancers diagnosed at an early stage (IAF/MyNHS) | Unavailable at this moment | PT/GP | |
| | % of LD patients on GP registers receiving annual health checks (IAF/MyNHS) | LD primary care audit - Primary Care team | PT/GP | |
| | % of eligible people receiving an NHS Health Check per year | Public Health | JS | YES |
| | % of women screened for cervical cancer | https://fingertips.phe.org.uk/profile/cancerservices/data#page/0 | JS | |
| | 0-5 years routine immunisations at 12 months old | Public Health | JS | |
| | **Multi Disciplinary Review Officers** | | | |

| | |
|---|---|
| | Karen Edwardson: KE |
| | Megan Harris: MH |
| | Primary Care Team: PCTeam |
| | Carmel Farmer: CF |
| | Clare O'Toole: COT |
| | Nigel Cosford: NCo |
| | Nicola Cartwright: NC |
| | Jean Keenan: JK |
| | Performance Team: PT |
| | Sandra Holt: SHo |
| | Joanne Scriven: JS |
| | Paul Steele:PS |
| | |
| | |

# Report to Primary Care Committee

| | |
|---|---|
| **Date of meeting:** | 20 September 2017 |
| **Governing Body Member Lead:** | Interim Clinical Chief Executive |
| **Accountable Director:** | Associate Director; Primary Care |
| **Report title:** | General Practice Quality Dashboard |

| **Item for:** | **Decision →** | | **Assurance →** | X | **Information →** | | *(Please insert X as appropriate)* |
|---|---|---|---|---|---|---|---|

| | | |
|---|---|---|
| **Strategic Objectives** | This report supports the following CCG Strategic Objectives. Please insert 'x' as appropriate. | |
| | 1. To deliver financial sustainability | |
| | 2. To deliver improvements through system redesign and in priority areas. | |
| | 3. To deliver improved outcomes for patients | X |
| | 4. To develop primary care capacity and capability as system leaders | |

| | |
|---|---|
| **Governance and Risk** | Does this report provide assurance against any of the risks identified in the Assurance Framework? (please specify)<br><br>Quality and Primary Care in the operational plan<br><br>What level of assurance does it provide?<br>Low |
| | Is this report required under NHS guidance or for statutory purpose? (please specify)<br><br>No |

| **Purpose of this paper** |
|---|
| To provide information from the Primary Care Dashboard relating to Patient Experience. |

**Further explanatory information required**:

| | |
|---|---|
| **Does this paper link to any of the 10 key themes of the CCG's Improvement Plan. If yes, please specify.** | N/A |
| **How will this benefit the health and wellbeing of St Helens residents or the Clinical Commissioning Group?** | N/A |
| **Please describe any possible Conflicts of Interest associated with this paper.** | There may be conflicts of interest for GPs who are Partners in Member Practices. |
| **Please identify any current services or roles that may be affected by issues within this paper.** | N/A |
| **What risks may arise as a result of this paper? How can they be mitigated?** | N/A |

| **1. Executive Summary** |
|---|
| Following delegation of commissioning from NHSE, the CCG agree that it is important to understand the quality of care and experience delivered by its membership. Previously the committee agreed the contents of the dashboard, this month the patient experience element is investigated in more detail. |

## 2. Background and Update

As a commissioning organisation NHS St Helens Clinical Commissioning Group (CCG) needs to be assured patients are receiving high quality services. A dashboard has been developed and is attached as appendix A. The dashboard provides an overview of the performance for General Practices at a high level in defined areas of effectiveness, safety and experience. However, the attached dashboard focuses on experience and it should be noted that this should be used with other Practice intelligence and not as a stand-alone document.

The experience dashboard contains the latest Friends and Family Test results from July 2017 and the latest patient survey results gathered between January and March 2017.

The dashboard works on a red or green indicator basis and as such this means some reds would be amber if a full RAG rating was used. Also it appears that some Practices achieve the average but are still red. This is due to rounding in some cases so for example a Practice achieves 88.6% for Friends and Family Test which rounded up is 89% but the spreadsheet reads the data as below the average.

Elements that state “no data” are where a Practice is active on CQRS but missed the deadline for submission of data. Where a Practice has less than 5 submissions the data is supressed with an asterisk (*) to reduce the risk of disclosure of patient identifiable data.

The review of the Experience element within the dashboard highlighted the following:

- Only one Practice is green for all indicators
- 17 out of 35 are red for management of Long Term Conditions
- 3 Practices are red in all indicators that have reportable data
- 3 Practices have just 1 green indicator

It would appear from the dashboard that there are areas of concern and the majority of indicators are highlighted as red. Whilst Friends and Family tests are subjective put in context with difficulty to get through via the telephone it can be surmised that there are areas that are not acceptable from a patient perspective. It should be noted however that it is up to the patient to complete the form and so there is a reliance on compliance with filling out the questionnaire and is based on the latest experience of the patient.

It is of interest to note that Practices with the greater amount of green indicators appear to be within the medium size Practice (4000-8000 patients) and it appears on face value that larger Practices fair less favourably.

Please note that Marshalls Cross Medical Centre data relates to the previous provider.

## 3. Next Steps (as appropriate)

As the results on patient experience appear to be generally poor it would be beneficial to raise this issue at a Protected Learning Time event. Those Practices with significant amounts of green may be able to share good Practice that could be supported via the GP Forward View programmes for example implementing the 10 High Impact Actions.

An understanding of why Practices are struggling in these indicators needs to be gathered

and raised with the federation to start to look at ways the federation could support members to improve the patient experience.

**4. Recommendations**

The Committee are asked to:

1) Note the contents of this report

## DOCUMENT DEVELOPMENT

| Process | Yes | No | Not applicable | Comments & Date (i.e. presentation, verbal, actual report) | Outcome |
|---|---|---|---|---|---|
| Public Engagement (please detail the method i.e. survey, event, consultation) | | | X | | |
| Clinical Engagement (please detail the method i.e. survey, event, consultation) | | | X | | |
| Has 'due regard' been given to Equality Analysis (EA) and any adverse impacts? (Please detail outcomes, including risks and how these will be managed) | | | X | | |
| Legal Advice Sought | | | X | | |
| Presented to any other groups or committees including Partnership Groups – Internal/External (please specify in comments) | | | X | | |

**Note:** Please ensure that it is clear in the comments and date column how and when particular stakeholders were involved in this work and ensure there is clarity in the outcome column showing what the key message or decision was from that group and whether amendments were requested about a particular part of the work.

St Helens Clinical Commissioning Group

# NHS St Helens CCG
# GENERAL PRACTICE QUALITY DASHBOARD 2017-2018

| Practice Details | | | | | Experience | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Practice Number | Practice Code | Practice Name | Weighted List Size | Localities | FFT (core question % recommended) | FFT Number of responses | PES Overall Experience of GP practice | PES -Ease of getting through via phone | % Able to get an appointment to see or speak to someone - total responses | Patient Experience Survey of Accessing GP (% overall score) - % who have seen or spoken to a GP in the past 6 months (Q18 patient survey/CCG quality premium) | % of patients feeling supported to manage their LTC (GP Patient Survey) |
| | Data Period | | 01/01/2017 | | Jun-17 | Jun-17 | Jan - Mar 17 | Jan - Mar 17 | Jan - Mar 17 | Jan - Mar 17 | Jan - Mar 17 |
| 1 | N83001 | Rainbow Medical Centre | 16,309 | South | 90% | 49 | 80% | 54% | 85% | 61% | 62% |
| 2 | N83002 | Patterdale Lodge Medical Centre | 13,874 | Newton & Haydock | 76% | 21 | 77% | 50% | 75% | 60% | 52% |
| 3 | N83003 | Ormskirk House | 9,377 | North | 73% | 30 | 88% | 62% | 83% | 67% | 69% |
| 4 | N83005 | Market Street Surgery | 9,137 | Newton & Haydock | 73% | 15 | 82% | 38% | 73% | 59% | 69% |
| 5 | N83006 | Phoenix Medical Centre | 3,723 | North | * | 2 | 90% | 79% | 91% | 67% | 73% |
| 6 | N83007 | Lingholme Health Centre | 2,611 | North | 100% | 5 | 95% | 88% | 92% | 73% | 76% |
| 7 | N83008 | Ferguson Family Medical Practice (Berrymead) | 8,980 | South | 79% | 28 | 86% | 43% | 73% | 77% | 73% |
| 8 | N83010 | Rainhill Village Surgery | 7,754 | South | * | 1 | 98% | 95% | 97% | 65% | 76% |
| 9 | N83012 | Mill Street Medical Centre | 13,840 | North | | no data | 70% | 36% | 69% | 66% | 54% |
| 10 | N83017 | Hall Street Medical Centre | 4,997 | South | 95% | 22 | 95% | 89% | 90% | 73% | 67% |
| 11 | N83019 | Billinge Surgery | 11,034 | North | | no data | 72% | 39% | 67% | 57% | 67% |
| 12 | N83020 | Dr Breach & Partners | 8,343 | Newton & Haydock | 50% | 14 | 73% | 40% | 79% | 60% | 67% |
| 13 | N83021 | Four Acre Surgery | 9,391 | South | 88% | 252 | 83% | 42% | 79% | 70% | 73% |
| 14 | N83022 | Lime Grove Surgery | 9,162 | N&H | 90% | 10 | 85% | 40% | 84% | 60% | 55% |
| 15 | N83023 | Park House Surgery | 7,902 | South | | no data | 85% | 57% | 81% | 58% | 64% |
| 16 | N83026 | ParkField Surgery | 3,142 | North | NA | 0 | 93% | 92% | 93% | 67% | 76% |
| 17 | N83027 | Central Surgery | 7,367 | North | | no data | 97% | 68% | 91% | 73% | 64% |
| 18 | N83035 | Spinney Medical Centre | 7,905 | South | | no data | 94% | 69% | 84% | 68% | 64% |
| 19 | N83041 | Rainford Health Centre | 5,600 | North | 89% | 44 | 91% | 81% | 93% | 68% | 61% |
| 20 | N83045 | Newton MC (Bridge St) | 4,644 | N&H | 63% | 8 | 93% | 65% | 83% | 68% | 68% |
| 21 | N83049 | Kenneth MacRae Medical Centre | 4,470 | North | * | 2 | 98% | 88% | 82% | 76% | 59% |
| 22 | N83050 | The Bowery Medical Centre | 4,117 | South | * | 3 | 85% | 67% | 86% | 67% | 67% |
| 23 | N83053 | Longton Medical Centre | 5,419 | South | 100% | 14 | 87% | 82% | 81% | 69% | 62% |
| 24 | N83054 | Bethany Medical Centre | 3,928 | North | | no data | 95% | 95% | 92% | 77% | 63% |
| 25 | N83060 | Holly Bank Surgery | 5,002 | South | 97% | 33 | 88% | 60% | 68% | 59% | 80% |
| 26 | N83604 | Cornerstone Surgery | 2,972 | South | 100% | 22 | 90% | 78% | 82% | 68% | 77% |
| 27 | N83614 | Eccleston Medical Centre | 2,897 | North | 100% | 11 | 87% | 83% | 76% | 69% | 67% |
| 28 | N83620 | Sandfield Medical Centre | 3,186 | North | | no data | 84% | 83% | 85% | 59% | 83% |
| 29 | N83624 | Dr Rahil's Surgery | 3,170 | N&H | 100% | 6 | 95% | 97% | 93% | 71% | 69% |
| 30 | N83628 | Newton Community Hospital Practice | 3,089 | N&H | * | 2 | 86% | 88% | 86% | 73% | 69% |
| 31 | N83635 | The Crossroads Surgery | 3,146 | South | * | 2 | 76% | 69% | 63% | 63% | 67% |
| 32 | N83637 | Newholme Surgery | 3,916 | North | NA | 0 | 87% | 82% | 82% | 53% | 64% |
| 33 | Y00475 | Garswood Surgery | 4,688 | North | * | 2 | 98% | 72% | 76% | 73% | 64% |
| 34 | Y02510 | Marshalls Cross Medical Centre | 4,968 | South | 94% | 47 | 88% | 74% | 89% | 68% | 57% |
| 35 | Y02511 | ElderCare | 2,325 | South | * | | | | | | |
| | 01X | NHS St Helens CCG (based on Median - those in blue) | | | 89% | 11 | 87% | 70% | **83%** | **68%** | **67%** |

NHS
St Helens Clinical Commissioning Group

# Report to Primary Care Committee

| | |
|---|---|
| **Date of Meeting:** | 20th September 2017 |
| **Governing Body Member Lead:** | Clinical Chief Executive |
| **Accountable Director:** | Associate Director: Primary Care |
| **Report Title:** | Clinical Pharmacists in General Practice Programme |

| **Item for:** | **Decision →** | | **Assurance →** | | **Information →** | x | *(Please insert X as appropriate)* |
|---|---|---|---|---|---|---|---|

| | | |
|---|---|---|
| **Strategic Objectives** | This Report supports the following CCG Strategic Objectives. Please insert 'x' as appropriate:- | |
| | 1. To deliver Financial Sustainability | |
| | 2. To deliver Improvements through System Redesign and in priority areas. | |
| | 3. To deliver improved Outcomes for Patients. | x |
| | 4. To develop Primary Care Capacity and Capability as System Leaders | x |

| | |
|---|---|
| **Governance and Risk** | Does this Report provide Assurance against any of the Risks identified in the Assurance Framework? (please specify)<br><br>C1 - Failure to commission effective services that improve quality and outcomes for patients<br><br>What Level of Assurance does it provide?<br>Limited |
| | Is this Report required under NHS Guidance or for Statutory Purpose? (please specify)<br>No |

**Purpose of this Paper**

To inform PCC of funding available, via the General Practice Forward View (GPFV), to enable recruitment of Clinical Pharmacists.

Enhanced Service Clinical Pharmacists in

**Further Explanatory Information Required**:

| | |
|---|---|
| **Does this Paper link to any of the 10 Key Themes of the CCG's Improvement Plan. If yes, please specify.** | Yes – Primary Care General Practice Forward View |
| **How will this benefit the Health and Wellbeing of St Helens Residents or the Clinical Commissioning Group?** | The recruitment of Clinical Pharmacists will enable Practices/ the Federation to recruit to current vacant posts and ensure a more resilient Primary Care workforce for St Helens |
| **Please describe any possible Conflicts of Interest associated with this Paper.** | N/A |
| **Please identify any current Services or Roles that may be affected by issues within this Paper.** | N/A |
| **What Risks may arise as a result of this Paper? How can they be Mitigated?** | 1. The risk that Practices/the Federation will not engage with the opportunity to recruit Clinical Pharmacists<br>2. Practices may be unable to meet the criteria and be able to demonstrate in their application that they are working at scale, across a minimum population of at least 30,000. They may have to join with other practices (to form a network or collaborative) or form part of the Federation's bid so that the criteria of the programme can be met, including the required population size and supervision arrangements.<br>3. The CCG will need to be assured that each clinical pharmacist will receive the required supervision session per month by the senior clinical pharmacist. This could be achieved by utilising existing senior |

| | |
|---|---|
| | clinical pharmacists in general practice to provide support and supervision to clinical pharmacists who are funded by this Enhanced Service, however this would need to be agreed by employers of the clinical pharmacist and of the senior Clinical Pharmacist.<br><br>4. Financial Risk to the Employer as the Funding is only a contribution towards the cost of recruitment and employment and will be tapered over a three year period. After three years the employer will be expected to fully employ the clinical pharmacist which could be mid-point of a Band 7 (46k per annum). |

## 1. Executive Summary

NHS St Helens CCG's GPFV work plan was approved by NHSE in March 2017. One of the key areas identified as crucial to providing a sustainable workforce in Primary Care was the recruitment and retention of staff. The need to look at new ways of working has been identified and benefits of the Clinical Pharmacist Scheme are:

- Increase GP Practice capacity to see and help more members of the public.
- Ensure safer prescribing and improvement in patient safety and quality of care
- Improved Integration with the community and hospital pharmacy teams
- Improvement in the clinical and cost effective use of medicines
- Optimisation of the patient journey through the healthcare system

Following the approval of the GPFV work plan the Primary Care Committee (PCC) recommended that workforce was a key area to be focused on in year 1 of the GPFV commencing in April 2017. This view was also endorsed by GP Member Practices at the Members' Council in April 2017.

## 2. Background and Update

NHS England has launched a scheme to get 1,500 more clinical pharmacists working in GP surgeries – a move set to benefit patients across the country. Clinical pharmacists are highly trained experts in disease and medication that can work as part of the general practice team to provide specialist advice for patients, particularly the elderly and those with multiple conditions. By taking responsibility for patients with chronic diseases, clinical pharmacists can free up GPs for other appointments and so reducing the numbers of people presenting at A&E departments. They will work closely with community and hospital pharmacists to provide joined-up NHS pharmacy services for patients and so ease pressures on other parts of the health service.

This is the 3rd tranche of Clinical Pharmacists with two Pharmacists being employed by St Helens Practices as part of the 1st Tranche.

NHS England has recently issued a draft new service specification which is attached for information. This will provide further information on the requirements of the service specification. Some key area's to the document are:

- Clinical Pharmacists must be employed to be patient facing to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas. They will be prescribers or training to become prescribers, and will work with and alongside the practice team.
- It would be an option that the CCG or Hospital Trust employ the clinical pharmacist, subject to the appropriate management of conflict of interest, and/or provide administrative support to the signatories of the Enhanced Service.

**Benefits to Patients**

- Supporting Patients to get the best use of their medicines and identifying medicines related issues.
- Independent Prescribing qualification for pharmacists which will improve timely access to medicines for the public, deliver care closer to home, reduce general practice workload, enable self-care and self-management of conditions.
- Improve patient safety and improve treatment results of conditions and improve treatment results for patients by maximising the benefits of clinical pharmacists.

**The Criteria**

- To successfully apply for this Enhanced Service a potential signatory to this ES must demonstrate that they/their application site are working at scale, across a minimum population of at least 30,000. The GP Forward View refers to 1 WTE clinical pharmacist per 30,000 of the population.

- The funding will only be used to support the establishment of clinical pharmacist service in general practice.

**The Funding**

- The funding provided by NHS will be a tapered amount over a three year period, from the date of employment of the clinical pharmacist. The funding is a contribution towards the cost of recruiting and employing a clinical pharmacist and it is a set amount each year for three years.

The funding details are available in section 8 of the attached document.

**Supervision**

Each clinical pharmacist will receive a minimum of one supervision session per month by the senior clinical pharmacist. There will be one Full-time senior clinical pharmacist to five (total number not WTE) clinical pharmacists.

The clinical pharmacists will form part of the Lead Practices or participating practice's review and appraisal process. Where the clinical pharmacist is working across a Lead practice and a number of participating practices the clinical pharmacist would normally be appraised by the employer.

## 3. Next Steps (as appropriate)

This Enhanced Service begins on 1 April 2017 and it will be open for practices to join until 31 March 2020. Some practices or Super Practices may be able to submit an application on their own if their practice covers a suitable population, however it is likely that in order to participate in the Enhanced Service and gain the benefit it is anticipated clinical pharmacists will provide, practices in a particular geographical area or site, may have to join with other practices (to form a network or collaborative) or form part of the Federation's bid so that the criteria of the programme can be met, including the required population size and supervision arrangements.

Practices participating in the Enhanced Service may employ the clinical pharmacist directly or the clinical pharmacist can be employed by other practices (where there is a network or collaborative arrangement) or a third party (for example a GP Federation, Clinical Commissioning Group or Trust.

The Deadline for the next wave of Applications is 29 September 2017.

## 4. Recommendations

PCC is asked to note and consider the contents of this paper and the associated Enhanced Service Specification. The view of PCC is requested on the new facility for this group of staff to be employed by the CCG.

St Helens Clinical Commissioning Group

## DOCUMENT DEVELOPMENT

| Process | Yes | No | Not applicable | Comments & Date (i.e. presentation, verbal, actual report) | Outcome |
|---|---|---|---|---|---|
| Public Engagement (please detail the method i.e. survey, event, consultation) | | | N/A | | |
| Clinical Engagement (please detail the method i.e. survey, event, consultation) | | | N/A | | |
| Has 'due regard' been given to Equality Analysis (EA) and any adverse impacts? (Please detail outcomes, including risks and how these will be managed) | | | N/A | | |
| Legal Advice Sought | | | N/A | | |
| Presented to any other groups or committees including Partnership Groups - Internal/External (please specify in comments) | | No | | | |

**Note:** Please ensure that it is clear in the comments and date column how and when particular stakeholders were involved in this work and ensure there is clarity in the outcome column showing what the key message or decision was from that group and whether amendments were requested about a particular part of the work.

# Enhanced Service Specification

## General Practice Forward View (GPFV) - Clinical Pharmacists in General Practice Phase 2 Programme

# Enhanced Service Specification

## General Practice Forward View – Clinical Pharmacists in General Practice Phase 2 Programme

Version number:

First published:

Prepared by: NHS England

Classification: Official

Equalities and Health Inequalities Statement:

"Promoting equality and addressing health inequalities are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.”

# Contents

# 1 Introduction

1.1 This enhanced service (ES) is designed to allocate the financial offer to providers of primary medical services for employing or gaining access to a clinical pharmacist and/or senior clinical pharmacist through the Clinical Pharmacists in General Practice Phase 2 programme.

# 2 Background

2.1 In July 2015 NHS England launched a pilot scheme to support clinical pharmacists working in general practice in patient facing roles. Funding was made available to support more than 450 clinical pharmacists in 650 practices across 90 pilot sites.

2.2 The General Practice Forward View (GPFV) includes a commitment to deliver an additional 5,000 clinical and non-clinical staff in general practice. Out of these 5,000 additional staff members there is a commitment to have ‘’a pharmacist per 30,000 of the population… leading to a further 1,500 pharmacists in general practice by 2020’’.

2.3 Funding is now available for the deployment of the 1500 clinical pharmacists by 2020. The funding outlined in the ES will contribute to the costs of recruitment and employment.

# 3 The role of clinical pharmacists in general practice

3.1 Clinical pharmacists will work in general practice as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas.

3.2 They will be prescribers, or training to become prescribers, and will work with and alongside the general practice team. They will take responsibility for patients with chronic diseases and undertake clinical medication reviews to proactively manage people with complex polypharmacy, especially for the elderly, people in care homes and those with multiple co-morbidities.

3.3 They will provide specialist expertise in medicines use while helping to address both the public health and social care needs of a patient at the practice (s).[i]

3.4 Clinical pharmacists will provide leadership on person centred medicines optimisation (including ensuring prescribers in the practice conserve antibiotics in line with local antimicrobial stewardship guidance) and quality improvement while contributing to the quality and outcomes framework and enhanced services.

3.5 Clinical pharmacists will have a leadership role in supporting further integration of general practice with the wider healthcare teams (including community and hospital pharmacy) to help improve patient outcomes, ensure better access to healthcare and help manage general practice workload. The role has the potential to significantly improve quality of care and patient safety.

# 4 Aims

4.1 The aim of this ES is to encourage GP practices to employ or otherwise use the services of a clinical pharmacist as described in the specification in order to realise the benefits described below:

4.1.1 Benefits to the patients

- Supporting patients to get the best use of their medicines and identifying medicines related issues
- Independent prescribing qualification for pharmacists which will improve timely access to medicines for the pubic, deliver care closer to home, reduce general practice workload, enable self-care and self-management of conditions, improve patient safety and improve treatment results of conditions and improve treatment results for patients by maximising the benefits of clinical pharmacists.

4.1.2 Benefits to general practice

- Expanding the general practice team to include clinical pharmacists, with their skills and knowledge. This will allow reallocation of general practice workload.
- Increase GP practice capacity to see and help more members of the pubic.
- Ensure safer prescribing and improvement in patient safety and quality of care.

- Increase capacity to offer more on the day appointments and provide extended hours services.
- Improved integration with the community and hospital pharmacy teams.

4.1.3 Benefits to the wider healthcare system

- Improvement in the clinical and cost effective use of medicines
- Better integration with the wider healthcare systems/teams due to the clinical pharmacist being a key point of contact for primary and secondary care services
- Optimisation of the patient journey through the healthcare system.

# 5 Process

5.1 This ES begins on 1 April 2017 and it will be open for practices to join until 31 March 2020.. Practices who wish to participate in this ES should apply on-line via the Clinical Pharmacist Application Portal https://clinicalpharmacists.england.nhs.uk. Subject to compliance with the processes set out below, funding will be available for three years starting from the date of employment of the clinical pharmacist(s).

5.2 Some practices and super practices may be able to submit an application on their own if their practice covers a suitable population (please refer to the Guidance for Applications on the application portal).

5.3 However it is likely that in order to participate in the ES and gain the benefit it is anticipated clinical pharmacists will provide, practices in a particular geographical area or Site, may have to join with other practices (to form a network or collaborative) or form part of a Federation's bid so that the criteria of the programme can be met, including the required population size and supervision arrangements.

5.4 Practices signing up to the ES will need to meet the criteria set out in the Guidance for Applications.

5.5 Practices participating in the ES may employ the clinical pharmacist directly or the clinical pharmacist can be employed by other practices (where there is a network or collaborative arrangement) or a third party (for example a GP Federation, Clinical Commissioning Group or Trust). Where practices are

considering collaborating or working at scale NHS England anticipates that practices in applicant sites may fall into one of the following examples (please note that these are not meant to be prescriptive, nor do they represent the only models that NHS England considers acceptable):

5.5.1 Practices may collaborate with/join a GP Federation.

5.5.1.1 Where the GP Federation holds a primary medical services contract, the GP Federation may elect to employ the clinical pharmacists and/or provide administrative support to federation members. In this example either the GP Federation or federation members could be signatories to the ES. Alternatively, the GP Federation may nominate one or more Lead Practices to be signatory to the ES and potentially employ the clinical pharmacist(s) or all of the participating practices may become signatories to the ES.

5.5.1.2 Where the GP Federation does not hold a primary medical services contract or the GP Federation does not wish to support member practices as described in 5.5.1.1 above, again the GP Federation may nominate one or more Lead Practices or participating practices to be signatory to the ES and potentially employ the clinical pharmacist(s).

5.5.2 Practices may collaborate with their local Clinical Commissioning Group or hospital trusts.

5.5.2.1 This example would operate with similar flexibilities to the two options described for GP Federations as regards Lead Practices or participating practices, except that CCGs or trusts are not able to become signatories to the ES.

5.5.2.2 It would be an option that a CCG or hospital trust to employ the clinical pharmacists, subject to the appropriate management of conflicts of interest, and/or provide administrative support to the signatories of the ES.

5.5.3 Practices may elect to collaborative with a network of other practices.

5.5.3.1 The network of practices may nominate one or more Lead Practices to be signatory to the ES and potentially employ the clinical pharmacist(s) or all of the participating practices may become signatories to the ES.

5.5.4 For the avoidance of doubt, it will be the signatory to the ES who will receive the funding available through this ES. Signatories to the ES will be required to submit a CQRS application and will be responsible for the complying and meeting the requirements of the ES. Where appropriate, the employers of clinical pharmacists will put in place appropriate service level agreements (SLAs) with all participating practices to ensure those practices have access the requisite level of clinical pharmacist provision. Those SLAs are to be agreed shared with and agreed by the local NHS England team.

5.6 The funding is a contribution towards the cost of recruiting and employing pharmacists. It will begin on the date of employment of the clinical pharmacist.

# 6 The Service Specification

## 6.1 The Funding

6.1.1 The funding provided by NHS England will be a tapered amount over a three year period, from the date of employment of the clinical pharmacist. The funding details are available in section 8 `Payment and Validation` below.

6.1.2 The funding is a contribution towards the cost of recruiting and employing a clinical pharmacist and it is a set amount each year for three years.

## 6.2 The Criteria

A set of criteria have been developed that will define the model:

6.2.1 To successfully apply for this ES a potential signatory to this ES must demonstrate that they/their application site are working at scale, across a minimum population of at least 30,000**.** The GP FV refers to 1 WTE clinical pharmacist per 30,000 of the population. Applications will be considered for exceptional circumstances.

6.2.2 The funding provided by the ES will only be used to support the establishment of clinical pharmacist service in general practice

6.2.3 Signatories to this ES must ensure the role of clinical pharmacist in the general practice is clinical and patient facing. These roles must support people living in the community including those in care home settings. The role must be in line with the Overview and Narrative of the role of clinical pharmacists as described above**;**

6.2.4 Signatories to this ES must ensure that the clinical pharmacists are embedded within participating practices and be fully integrated members of the clinical multi-disciplinary team. They will have access to other healthcare professionals, electronic 'live' and paper based record systems and access to admin/office support and training and development;

6.2.5 The clinical pharmacists will form part of the Lead Practice's or participating practice's review and appraisal process. Where the clinical pharmacist is working across a Lead Practice and a number of participating practices the clinical pharmacist would normally be appraised by the employer ;

6.2.6 Signatories to this ES will ensure that clinical pharmacists are part of a professional clinical network and will be clinically supervised by a senior clinical pharmacist and GP clinical supervisor. NHS England recommends the following programme of supervision should be in place for clinical pharmacists under this ES:

i. Each clinical pharmacist will receive a minimum of one supervision session per month by the senior clinical pharmacist;

ii. The senior clinical pharmacist will receive a minimum of one supervision session every three months by a GP clinical supervisor; and

iii. All clinical pharmacists will have access to an assigned GP clinical supervisor for support and development.

6.2.6 There will be one-full time senior clinical pharmacist to five (total number not WTE) clinical pharmacists. There is an expectation that all clinical pharmacists will be in full-time substantive posts where possible.

6.2.7 Flexible and innovative approaches to the formation of clinical networks can be adopted and promoted to enhance collaboration/integration across healthcare interfaces.

6.2.8 Senior clinical pharmacists will be independent prescribers, or will be working towards the independent prescribing qualification and will be independent

prescribers by 2020/21.. Employers should follow NHS England recommendations that:

i All senior clinical pharmacists will have been qualified for 5 years or more; and

ii All clinical pharmacists will have been qualified for at least 2 years and will be independent prescribers by 2020/21.

6.2.9 **IMPORTANT NOTES TO CONSIDER:**

The NHS England programme criteria states that one senior clinical pharmacist will support five clinical pharmacists (1:5 ratio). Where signatories to this ES are applying for lower than the 1:5 ratio, they need to consider and maybe required to:

i Demonstrate how supervision and support will be provided to clinical pharmacists in applications that request clinical pharmacists only without a senior clinical pharmacist. This could be achieved by utilising existing senior clinical pharmacists in general practice to provide support and supervision to clinical pharmacists who are funded by this ES, or by linking up with another NHS England programme site(s) to share their senior clinical pharmacist resource.

ii If signatories to this ES request a senior clinical pharmacist and less than five clinical pharmacists, the senior clinical pharmacist would need to be shared across a locality to support other clinical pharmacists to facilitate the recommended 1:5 ratio model.

iii The NHS England expects that both clinical pharmacists and senior clinical pharmacists will be employed on a full time basis rather than a greater number of part time staff (e.g. 1 WTE clinical pharmacist rather than two 0.5 WTE pharmacists). This is to ensure that every clinical pharmacist that is part of this programme is able to gain timely access to the education/training pathway and independent prescribing course.

iv The clinical pharmacist will be employed for at least 8 sessions per week (that is at least 0.8 WTE) by the employing organisation. They may work less sessions in participating practices.

v Conflicts of interest: If applications are received by the review panel where there could be real or perceived conflicts of interest then they have to satisfy themselves that appropriate mitigation has been put in

place to guard against those conflicts. For example a pharmacist should not be employed where their decisions or influence can have an effect on any business that they have a financial or other interest in, and there must be clear separation between clinical decision making and medicines supply.

vi. We expect providers of general practice medical services when recruiting to ensure there is specific reference to NHS England Clinical Pharmacist in General Practice Phase 2 Programme in job adverts**.**

## 6.3 Further Requirements

In addition to meeting the criteria, signatories to this ES must comply with the following additional requirements:

6.3.1 Signatories to this ES will deploy clinical pharmacists as described in the criteria and job descriptions (link to job descriptions in the Guidance for Applicants available on the Application Portal) https://clinicalpharmacists.england.nhs.uk

6.3.2 Signatories to this ES will ensure that clinical pharmacists access the training, education and development provided. As part of the scheme there is a training pathway that clinical pharmacists will follow to support their continual professional development. This will include independent prescribing. There will be no cost to the clinical pharmacist or signatories to this ES for this training.

6.3.3 Signatories to this ES will ensure that appropriate members of staff participate in the practice development provided. This practice development is to enable signatories to this ES to support the clinical pharmacists in their new role and to realise the benefits of this programme. Further details of practice development will be available to signatories to this ES.

6.3.4 Signatories to this ES must comply with reporting requirements and support evaluation of the scheme. Signatories to this ES will be responsible for the submission of reports to NHS England on a monthly and annual basis. The reporting will cover the following:

- Number of appointments offered by clinical pharmacists in general practice per month

    - Number of clinical face to face appointments offered per month by the clinical pharmacists
    - Number of home visits/care home visits offered per month by the clinical pharmacists
    - Number of extended hours appointments offered per month by the clinical pharmacists
- Number and types of face to face appointments offered by clinical pharmacists per month
    - Common ailments
    - Long term conditions/QOF/DES/
    - Medication Reviews
    - Medicine related queries
    - Transfer of care medicine reviews/medicines reconciliation
    - Care Home/Home Visits
- Number and types of telephone consultation/appointments offered by clinical pharmacists per month:
    - Common ailments
    - Long term conditions/QOF/DES/ES
    - Medication Reviews
    - Medicine related queries
    - Transfer of care medicine reviews/medicines reconciliation
    - Care Home/Home Visits
- Number and type of specific clinical administrative tasks performed in the Participating Practices (i.e. patient not seen or spoken to)
    - Clinical Post (Number of patients excluding transfer of care medicines review/medicines reconciliation)
    - Reviewing pathology/blood tests (Number of patients)
    - Medication review (number of patient episodes)
    - Medicine related queries (number of patient episodes)
    - Referral to community pharmacy (number of patients).

6.3.5 Applicant sites must be able to demonstrate the ability to sustain funding throughout the programme and beyond.

6.3.6 Where applicant sites are sharing the services of a clinical pharmacist across Lead and participating practices, they must have a documented agreement

that details the agreement between those practices and/or employing organisation, and how liabilities will be met. This must be shared with the NHS England local office team. For clarity, NHS England will hold the signatories to this ES as responsible for complying with the terms of this ES.

6.3.7 Signatories to this ES must notify the NHS England local team of any changes to the clinical pharmacist(s) (i.e. new starters and leavers).

6.3.8 Signatories to this ES must notify the NHS England local team of any changes to the arrangements for the sharing of the clinical pharmacist services.

6.3.9 Signatories to this ES's current contractual indemnity requirement will apply to the ES – namely that the contractor (and any subcontractors/participating practices) are required to have and maintain appropriate indemnity cover.

6.3.10 Signatories to this ES will have the contractual responsibility and liability to fulfil the requirements of the ES. Where a signatories to this ES intends to subcontract out the clinical pharmacist services funded by this ES, they must obtain NHS England agreement to the proposed arrangement, which must mirror the requirements of this ES.

6.3.11 For the avoidance of doubt, any provision in this ES, to the extent that it conflicts with the requirements of the Signatories to this ES's primary care contract, does not override the provision in the primary care contract. The provision in the primary care contract takes precedence.

# 7. Monitoring

7.1 Submission of claims and payment calculations will be made using the Calculating Payment Reporting Services (CQRS) under this ES. Signatories to this ES will have the responsibility for the submission of a claims, which will be done through a manual input of data into CQRS. Applicant sites are free to make local arrangements for how this will be achieved in practice.

7.2 Prior to NHS England local teams approving the CQRS claim, signatories to this ES will be responsible for the submission of monthly and annual reports via the Clinical Pharmacist Application Portal as a requirement of payment.

7.3 Details of the reporting requirements are provided in Section 6.3 above.

# 8 Payment and validation

8.1 Payment under this ES, or any part thereof (where the clinical pharmacist works part-time in a participating practice), will be made only if the Lead

Practice or employer of the clinical pharmacist satisfies the following conditions:

i The Lead Practice or the employer of the clinical pharmacist continues to employ or and the participating practice continues to have access to a clinical pharmacist;

ii The signatory to the ES must make available to commissioners any information under this ES, which the commissioner needs and the signatory to the ES either has or could be reasonably be expected to obtain;

iii The signatory to the ES must make any returns required of it (whether computerised or otherwise) to the Clinical Pharmacist Application Portal or CQRS and do so promptly and fully; and

iv All information supplied pursuant to or in accordance with this paragraph must be accurate.

8.2 Payment available to Lead Practices under this ES is as follows:

8.2.1 The funding provided by NHS England is a contribution towards the cost of recruitment and employment. The contribution will be tapered over a three year period, from the date of employment of the clinical pharmacist.

| | NHS England contribution WTE | | | Total contribution from NHS England over the three years |
|---|---|---|---|---|
| | Yr 1 | Yr 2 | Yr 3 | |
| Clinical Pharmacist | £29,000 | £20,000 | £11,000 | £60,000 |
| Senior Clinical Pharmacist | £36,000 | £24,000 | £13,000 | £73,000 |

*Please note that the figures quoted above relate to a WTE or full time clinical pharmacist. Where the practice employs or make use of a part-time clinical pharmacist, then the contribution will be adjusted pro-rata.*

8.2.2 Lead Practices signing up to the ES will receive an upfront start up payment equivalent to 3 month's funding.

8.2.3 Claims for payments for under this ES should be made monthly following the month of activity and the required reports (see below) have been submitted. Where claims are entered manually this should be within 12 days of the end of the month following activity undertaken there.

8.2.4 Payment will be made by the last day of the month following the month in which the Lead Practice validates and commissioners approve the payment. Payments will commence provided that the Lead Practice has manually entered achievement.

8.2.5 Lead Practices will only be eligible for payment for this ES in circumstances where all of the following requirements have been met:

i Lead Practices will be required to submit their monthly report, as noted in Section 6 above as a requirement of the payment being made. Where it has been agreed that participating practices will submit their own reports, payment is still contingent on the report being submitted.

ii Please note the payments available under this ES include payments for periods of annual leave for the clinical pharmacist.

8.3 Lead Practices and any other organisations – including NHS bodies - employing clinical pharmacists should note that, in making the payments available under this ES:

- NHS England does not envisage a scenario under which the payment will attract a VAT liability for NHS England;
- NHS England expects practices and other organisations employing clinical pharmacists to consider and make appropriate arrangements so that the VAT position is addressed; and
- Additional payments will not be made by NHS England to any Lead Practice or any other organisation to cover a VAT liability attracted by the engagement of the clinical pharmacist's services.

8.4 Administrative provisions relating to payments under this ES are set out in the Annex.

## Annex. Administrative provisions relating to payments under the ES

1. Payments under this ES are to be treated for accounting and superannuation purposes as gross income of the Lead Practice in the financial year.

2. Claims for payments for this programme should be made monthly following the month of activity. Where claims are entered manually this should be within 12 days of the end of the month when the activity was completed. Where there is an automated data collection, there is a five day period following the completion of the activity, when the practices must ensure all activity is recorded by the cut-off date to ensure payment.

3. Payment will be made by the last day of the month following the month in which the practice validates and commissioners approve the payment.

4. Payment under this ES, or any part thereof, will be made only if the Lead Practice satisfies the following conditions:
    a. the signatory to the ES must make available to commissioners any information under this ES, which the commissioner needs and the signatory to the ES either has or could be reasonably expected to obtain.
    b. the signatory to the ES must make any returns required of it (whether computerised or otherwise) to the Clinical Pharmacist Application Portal or CQRS, and do so promptly and fully; and
    c. all information supplied pursuant to and in accordance with this paragraph, must be accurate.

5. If a signatory to this ES does not satisfy any of the above conditions, commissioners may, in appropriate circumstances, withhold payment of any, or any part of, an amount due under this ES that is otherwise payable.

6. If a commissioner makes a payment to a Lead Practice under this ES and:
    a. the Lead Practice was not entitled to receive all of part thereof, whether because it did not meet the entitlement conditions for the payment or because the payment was calculated incorrectly (including where a payment on account overestimates that is due to fall due); or

b. the commissioner was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money has already been paid; of

c. the commissioner is entitled to repayment of all or part of the money paid;

commissioners may recover the money paid by deducting an equivalent amount from any payment payable to the Lead Practice and where no such deduction can be made, it is a condition of the payments made under this ES that the contractor must pay to the commissioner that equivalent amount.

7. Where the commissioner is entitled under this ES to withhold all or part of a payment because of a breach of a payment condition, and the commissioner recovers the money by deducting an equivalent amount from another payment in accordance with paragraph 6 of this annex, it may, where it sees fit to do so, reimburse the contractor the amount withheld or recovered, if the breach is cured.

## Provisions relating to Lead Practices that terminate or withdraw from this ES prior to the end of their three year funding (subject to the provisions below for termination attributable to a Lead Practice split or merger)

8. Where a Lead Practice or participating practice has entered into this ES but its primary medical care contract subsequently terminates or that practice no longer wishes to utilise a clinical pharmacist prior to the end of the three year funding, the Lead Practice is entitled to a payment in respect of its or other practice's participation if such a payment has not already been made, calculated in accordance with the provisions set out below. Any payment calculated will fall due on the last day of the month following the month during which the clinical pharmacist was utilised.

9. In order to qualify for payment in respect of participation under this ES, the Lead Practice must provide the commissioner with the information in this ES specification or as agreed with commissioners before payment will be made.

This information should be provided in writing, within 28 days following the termination of the contract or the withdrawal from the ES agreement.

10. The payment due to Lead Practices that terminate or withdraw from the ES agreement prior to the end of their 3 year funding, will be based on the number of sessions the clinical pharmacist has worked, prior to the termination or withdrawal.

## Provisions relating to GP practices who merge or split

11. Where two or more Lead Practices or participating practices merge or are formed following a contractual split of a single GP practice and as a result the registered population is combined or divided between new GP practice(s), the new GP practice(s) may, subject to meeting the criteria and requirements of this ES, be nominated as a Lead Practice or a participating practice and enter into a new agreement to provide this ES.
12. Where there is a contractual split the existing arrangements for either the Lead Practice or the participating practice will be treated as having terminated and the entitlement of the Lead Practice(s) to any payment will be assessed on the basis of the provisions of paragraph 8 of this annex.
13. The entitlement to any payment(s) of the Lead Practice(s), formed following a contractual merger or split, entering into the agreement for this ES, will be assessed and any new arrangements that may be agreed in writing with the commissioner, will commence at the time the Lead Practice(s) starts to provide such arrangements.
14. Where that new or varied agreement is entered into and the arrangements commence within 28 days of the new Lead Practice or the participating practice being formed, the new arrangements are deemed to have commenced on the date of the new Lead Practice or the participating practice being formed. Payment will be assessed in line with this ES specification as of this commencement date.

## Provisions relating to non-standard splits and mergers

15. Where the Lead Practice participating in the ES is subject to a split or a merger and:

a. the application of the provisions set out above in respect of splits or mergers would, in the reasonable opinion of the commissioner, lead to an inequitable result; or

b. the circumstances of the split or merger are such that the provisions set out in this section cannot be applied,

commissioners may, in consultation with the Lead Practice or practices concerned, agree to such payments as in the commissioner's opinion is reasonable in all circumstances.

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[i] `Modernising Pharmacy Careers Programme: Review of pharmacist undergraduate education and pre-registration training and proposals for reform`. Report to the Medical Education England Board. April 2011 https://hee.nhs.uk/sites/default/files/documents/Pharmacist-pre-registration-training-proposals-for-reform.pdf

ii. https://www.england.nhs.uk/2013/05/med-opt/

iii. https://www.nice.org.uk/guidance/sc1

iv. https://www.nice.org.uk/guidance/qs85

v. https://www.nice.org.uk/guidance/qs120

vi. http://www.rpharms.com/our-campaigns/pharmacists-and-gp-surgeries.asp

| Report to Primary Care Committee | |
|---|---|
| **Date of meeting:** | Wednesday 20th Sept 2017 |
| **Governing Body Member Lead:** | Chief Finance Officer |
| **Accountable Director:** | Chief Finance Officer |
| **Report title:** | Finance Update – August 2017 |

| **Item for:** | **Decision →** | | **Assurance →** | | **Information →** | X | *(Please insert X as appropriate)* |
|---|---|---|---|---|---|---|---|

| | | |
|---|---|---|
| **Strategic Objectives** | This report supports the following CCG Strategic Objectives. Please insert 'x' as appropriate. | |
| | 1. To deliver financial sustainability | X |
| | 2. To deliver improvements through system redesign and in priority areas. | |
| | 3. To deliver improved outcomes for patients | X |
| | 4. To develop primary care capacity and capability as system leaders | |

| | |
|---|---|
| **Governance and Risk** | Does this report provide assurance against any of the risks identified in the Assurance Framework? (please specify)<br><br>**C2 – Failure to achieve financial target**<br><br>What level of assurance does it provide?<br>(List levels i.e. Limited/Reasonable/Significant) |
| | Is this report required under NHS guidance or for statutory purpose? No |

| **Purpose of this paper** |
|---|
| The report informs the Committee of the full year forecast outturn based on information at August 2017. This includes devolved budgets set based on the delegated primary care allocation received from NHSE plus additional local investment.<br><br>The report also highlights those budgets that contain the greatest degree of risk. |

**Further explanatory information required**:

| | |
|---|---|
| **Does this paper link to any of the 10 key themes of the CCG's Improvement Plan. If yes, please specify.** | |
| **How will this benefit the health and wellbeing of St Helens residents or the Clinical Commissioning Group?** | The finance report provides the CCG with an update on the forecast outturn for both the delegated primary care allocation and also the CCGs local investment within primary (medical) care.<br><br>The report also details those areas of expenditure which contain the greatest degree of risk. |
| **Please describe any possible Conflicts of Interest associated with this paper.** | |
| **Please identify any current services or roles that may be affected by issues within this paper.** | |
| **What risks may arise as a result of this paper? How can they be mitigated?** | Those budgets that contain the greatest risk are identified in section 4 of the report. |

## 1. Executive Summary

Nationally NHS England (NHSE) notified CCG's of their total planned allocations for 2016/17 to 2020/21 in January 2016. Contained in the document was the Primary Care Medical allocation for each year. This represents the level of funding that has been made available to enable the CCG to meet the requirements of delegated primary care commissioning.

This report provides a forecast outturn position based on the devolved budgets that have previously been noted by the Primary Care Committee following receipt of the allocation. The estimates included in this report are based on the financial position at August 2017.

The report also contains details of the financial position against the local investment in primary medical care.

The report outlines those budgets which contain the greatest risk and provides a summary of the key issues which may impact on the current forecast.

## 2. Background and Update

The CCG receives an annual primary care allocation which enables the CCG to commission primary medical services on behalf of the local registered population. Additionally, the CCG commits to the funding of Local Enhanced Services and the continuation of a GP Quality Contract.

A monthly finance update is presented to the Primary Care Quality and Operational Group which provides a detailed analysis of expenditure against devolved budgets. A summary finance report is then prepared for the Primary Care Committee which highlights those budgets that contain the greatest degree of risk.

## 3. Next Steps (as appropriate)

Primary care budgets will continue to be reviewed and risk assessed in the context of the overall financial position. The Primary Care Committee will be kept informed of any changes to the financial position.

## 4. Recommendations

It is recommended that the Committee note the content of the report.

## DOCUMENT DEVELOPMENT

| Process | Yes | No | Not applicable | Comments & Date (i.e. presentation, verbal, actual report) | Outcome |
|---|---|---|---|---|---|
| Public Engagement (please detail the method i.e. survey, event, consultation) | | | N/A | | |
| Clinical Engagement (please detail the method i.e. survey, event, consultation) | | | N/A | | |
| Has 'due regard' been given to Equality Analysis (EA) and any adverse impacts? (Please detail outcomes, including risks and how these will be managed) | | | N/A | | |
| Legal Advice Sought | | | N/A | | |
| Presented to any other groups or committees including Partnership Groups – Internal/External (please specify in comments) | | | N/A | | |

**Note:** Please ensure that it is clear in the comments and date column how and when particular stakeholders were involved in this work and ensure there is clarity in the outcome column showing what the key message or decision was from that group and whether amendments were requested about a particular part of the work.

# Finance Report – Primary Care Committee

## 1. Introduction

This report provides a forecast outturn based on the devolved budgets which have previously been noted by the Primary Care Committee. The estimates included in this report are based on the financial position at August 2017.

The report outlines those budgets which contain the greatest degree of risk and provides a summary of the key issues which may impact on the current forecast.

## 2. Background

Nationally NHS England (NHSE) notified CCGs of their total planned allocations for 2016/17 to 2020/21 in January 2016. Contained in the document was the Primary Care Medical allocation for each year. This represents the level of funding which has been made available to enable the CCG to meet the requirements of delegated primary care commissioning.

The total allocation the CCG has received for 2017/18 is £28,018k. This is equivalent to £142.20 per patient.

This includes growth funding of £506k which is an uplift of 1.8% above the allocation received in 2016/17.

NHSE published two new Gateways in March and April 2017. These detail the outcome of the national negotiations between NHSE and the General Practitioners Committees (GPC) of the British Medical Association.

Each of the Gateways set out the changes that CCGs, working under delegated agreement, must apply to GMS, PMS and APMS contracts.

The primary care allocation has been devolved across a range of subjectives which will enable the accurate reporting of expenditure – these were noted by the Primary Care Committee in May. The budgets that have been set for 2017/18 reflect the national changes that have been announced by NHSE.

## 3. Forecast Outturn

### 3.1 Appendix 1 – Primary Care allocation

It is currently projected that the delegated primary care allocation will overspend by £424k full year. This is based on expenditure at August 2017 and full details can be seen in Appendix 1.

The CCG has approached NHSE in relation to the QOF overspend that is a result of actual QOF achievements being greater than had been anticipated for 2016/17. Due to the national problems with the CQRS system, and the delay this caused in practice declarations being approved, the CCG is seeking financial support from NHSE. Previously this had been highlighted as a risk but has been included within the outturn position from July due to the probability that this will be funded being low. However, the CCG will continue to pursue this as it puts the delivery of the financial position at risk due to circumstances beyond our control.

A caretaking agreement has been reached so that primary care medical services can continue to be provided at Marshalls Cross Medical Centre. It is projected that the interim arrangement, which will commence in September 2017 for a minimum of five months and a maximum of seven months, will cause an additional pressure of approximately £91k. This is due to the service being funded at an equivalent rate to the previous APMS contract. Budgets had been set based on the contract being procured at a GMS rate from August 2017.

A further pressure has also been identified following receipt of the GMS/PMS practice weighted list sizes which were published in July 2017. Growth in practice list sizes between January and July 2017 has resulted in an increase to the global sum payments that are projected to be paid in future months. The CCG has approached Primary Care Support England to gain assurance that the list sizes are correct and are due to an increase in the number of patients registering with local practices. If list sizes have grown to the extent that they put at risk the achievement of breakeven against the delegated co commissioning budget, the CCG will also approach NHS England to confirm if additional funding will be available in respect of increased list sizes.

National guidance received for 2017/18 requires CCGs to reimburse GP practices for the cost of CQC registration. It is anticipated that the total cost to the CCG will be £136k. This is £38k above the original plan.

Premises costs are expected to overspend in total by £15k. Within this projection are reimbursable and subsidy costs associated with GP practices that occupy space in Community Health Partnership (CHP) buildings. Since April 2017 CHP management fees have been charged to the CCG rather than direct to GP practices. There is currently no funding set aside to support these additional costs. The CCG has made NHSE aware of this and are seeking clarification to whether a further allocation will be received to support these costs.

### 3.2 Appendix 2 – Local Enhanced Services

The total additional local investment in primary care is £1,733k. This includes the commissioning of local enhanced services, a GP Quality Contract and also an Out of Hours service provided by St Helens Rota.

Based on current expenditure it is anticipated that local enhanced services will underspend by £3k. Details can be found in Appendix 2.

The CCG has now received two additional allocations to support plans outlined in the GP Forward View. These allocations are for the delivery of WIFI in GP practices (£107k) and Training Care Navigators £34k). It is anticipated that the allocations will be fully utilised in 2017/18. The CCG is working with the HIS to understand whether any savings can be achieved by working across more than 1 CCG to deliver the WIFI project.

## 4. Risks

The primary care allocation received for 2017/18 has been fully devolved to support the recurring cost of commissioning primary care medical services. This takes account of the national negotiations that have been announced by NHSE. As a result no contingency reserve is available.

The financial risk to the CCG is difficult to quantify but the Primary Care Committee need to be aware, based on previous years and local knowledge, of the potential risks which may impact on the current budgets.

The key risks currently are:

i. QIPP target – to ensure financial balance, QIPP savings of £300k need to be identified either from within the existing primary care allocation or using primary care to make savings elsewhere within CCG budgets;

ii. Locum costs – although the budget was increased to £150k from £37k last year it is highly likely that this will be insufficient to support the total cost of reimbursing locum fees to support sickness, adoption, maternity and paternity leave. Based on known applications received so far, it is anticipated that existing locum costs will be £104k. This means that the budget would not remain in balance if any future applications are received to fund either long-term sickness or maternity leave.

iii. QOF – additional to the QOF under provision detailed above, which relates to 2016/17, the budget for 2017/18 is set based on the new national rate of £172.10 per point. However, there will be an additional financial pressure

should practices achieve a greater number of QOF points. The maximum number of points achievable is 559. Last year 10 practices achieved the maximum.

iv. Premises – Current Market Rents (CMR) are reviewed every 3 years by the District Valuation Office. Any increase to the valuation, and in particular any challenge to the valuation, is a known risk to the CCG.

v. The CCG is still awaiting detailed information from NHS Property Services (NHSPS) for the new annual charges for 2017/18. It is currently projected that all reimbursable and subsidy costs, which are funded from the primary care allocation, will remain on budget. The CCG have requested repeatedly that NHSPS provide a detailed list of charges, by site, as a matter of urgency.

## 5. Resilience Funding

The CCG has been successful in securing resilience funding of £8.7k from NHSE. This will support the transfer of Eldercare patients to a new provider and will enable long term plans to be created for each patient.

## 6. Conclusion

The Committee are asked to note the financial position and the key risks identified based on information at August 2017.

**NHS St Helens CCG**
**Primary Care Committee**

**Delegate**

| | Annual Budget |
|---|---|
| **Contract Value** | **19,532,898** |
| APMS | 605,878 |
| PMS | 4,373,156 |
| PMS Premium | 159,506 |
| GMS MPIG | 39,766 |
| GMS | 14,354,592 |
| **Enhanced Services** | **480,300** |
| Extended Hours | 232,846 |
| Learning Disabilities | 66,269 |
| Minor Surgery | 178,973 |
| Unplanned Admissions | 0 |
| Violent Patients | 2,212 |
| **Other** | **734,430** |
| CQC Reimbursement | 98,000 |
| Locum - Maternity/Paternity/Adoption | 150,000 |
| Prescribing fees | 153,747 |
| Seniority | 306,594 |
| Professional fees | 26,089 |
| **Premises** | **3,967,232** |
| Clinical Waste | 59,725 |
| Cost Rent | 45,718 |
| Notional Rent | 1,042,585 |
| Premises Other | 2,270,385 |
| Rates | 254,901 |
| Water Rates | 36,752 |
| Actual Rent | 257,166 |
| **QOF** | **3,009,140** |
| Achievement | 935,968 |
| Aspiration | 2,073,172 |
| **Sub Total** | **27,724,000** |
| Contribution to Quality Contract | 294,000 |
| **Grand Total** | **28,018,000** |

**Appendix 1**

## ed Primary Care Commissioning

| Outturn | Variance |
|---|---|
| **19,717,340** | **184,442** |
| 605,878 | 0 |
| 4,386,414 | 13,258 |
| 159,506 | 0 |
| 39,766 | 0 |
| 14,525,776 | 171,184 |
| **467,482** | **(12,818)** |
| 232,846 | 0 |
| 66,269 | 0 |
| 178,973 | 0 |
| (14,037) | (14,037) |
| 3,431 | 1,219 |
| **772,753** | **38,323** |
| 136,323 | 38,323 |
| 150,000 | 0 |
| 153,747 | 0 |
| 306,594 | 0 |
| 26,089 | 0 |
| **3,982,547** | **15,315** |
| 56,206 | (3,519) |
| 21,984 | (23,734) |
| 1,019,822 | (22,763) |
| 2,336,012 | 65,627 |
| 254,605 | (296) |
| 36,752 | 0 |
| 257,166 | 0 |
| **3,207,867** | **198,727** |
| 1,135,968 | 200,000 |
| 2,071,899 | (1,273) |
| **28,147,989** | **423,989** |
| 294,000 | 0 |
| **28,441,989** | **423,989** |

**NHS St Helens CCG** **Appendix 2**

**Primary Care Committee**

## Other Primary Medical Care Budgets

| | Annual Budget | Forecast Outturn | Variance |
|---|---|---|---|
| Local Enhanced Services | 611,742 | 609,208 | (2,534) |
| 24 Hour Blood Pressure | 107,500 | 115,500 | 8,000 |
| Care of Older People | 0 | 8,000 | 8,000 |
| Near Patient Testing | 48,708 | 48,708 | 0 |
| ECG Incentive | 26,534 | 48,000 | 21,466 |
| Anti-Coag | 429,000 | 389,000 | (40,000) |
| Out of Hours | 462,697 | 462,697 | 0 |
| St Helens Rota - Core | 100,000 | 100,000 | 0 |
| St Helens Rota - Visiting Service | 200,000 | 200,000 | 0 |
| St Helens Rota - GP Out of Hours | 162,697 | 162,697 | 0 |
| Other | 659,000 | 659,000 | 0 |
| GP Quality Contract | 365,000 | 365,000 | 0 |
| £3 per head - GPFV | 294,000 | 294,000 | 0 |
| Total Local Investment | 1,733,439 | 1,730,905 | (2,534) |

| | Allocation | Forecast Outturn | Variance |
|---|---|---|---|
| WiFi allocation | 107,000 | 107,000 | 0 |
| GP Receptionist training | 34,000 | 34,000 | 0 |
| Total Allocations | 141,000 | 141,000 | 0 |

St Helens Clinical Commissioning Group

| Report to: Primary Care Committee | |
|---|---|
| **Date of meeting:** | 20th September 2017 |
| **Governing Body Member Lead:** | Clinical Chief Executive |
| **Accountable Director:** | Associate Director: Primary Care |
| **Report title:** | Primary Care Support – Response from NHS England |

| **Item for:** | **Decision →** ☐ | **Assurance →** ☐ | **Information →** ☐ | *(Please insert X as appropriate)* |
|---|---|---|---|---|

| | |
|---|---|
| **Strategic Objectives** | This report supports the following CCG Strategic Objectives. Please insert 'x' as appropriate.<br><br>1. To deliver financial sustainability ☑<br>2. To deliver improvements through system redesign and in priority areas. ☑<br>3. To deliver improved outcomes for patients ☑<br>4. To develop primary care capacity and capability as system leaders ☑ |

| | |
|---|---|
| **Governance and Risk** | Does this report provide assurance against any of the risks identified in the Assurance Framework? No ☐ Yes ☐(please specify)<br><br>C1:Failure to commission services that improve quality and outcomes for patients<br>C4:Failure to commission services that reduce health inequalities within the CCG's local economy |
| | Is this report required under NHS guidance or for statutory purpose?<br>No ☑ Yes ☐(please specify) |

**Purpose of this paper**

For Members Information:

Following results from a survey that was e-mailed to all St Helens CCG Practice Managers and the amount of issues on Primary Care Support that were being received by the Primary Care Team it was agreed at Primary Care Quality and Operations Group (PCQOG) that a letter escalating concerns should be sent from Sarah O'Brien to NHS England.

A response to this letter has recently been received from Head of Service Management at NHS England. Please see attached.

**Further explanatory information required**:

| | |
|---|---|
| **Does this paper link to any of the 10 key themes of the CCG's Improvement Plan. If yes, please specify.** | Primary Care |
| **How will this benefit the health and wellbeing of St Helens residents or the Clinical Commissioning Group?** | Keeping sighted on emerging risks/issues and ensuring NHS England take account of these |
| **Please describe any possible Conflicts of Interest associated with this paper.** | None |
| **Please identify any current services or roles that may be affected by issues within this paper.** | General Practice Services |
| **What risks may arise as a result of this paper? How can they be mitigated?** | PCQOG to work with NHSE to mitigate risks, particularly for 'out of scope' services. Monthly Stakeholder Meetings with Contract Holder. Regular reporting of issues. |

## 1. Executive Summary

In 2015 NHS England Transferred Primary Care Support Services to a private provider with a 40% efficiency plan required from day one of contract resulting in a reduction in the number of bases and staff reduction from 1000 to 400 across England. Following the Closure of Offices the service provision significantly deteriorated.

Due to the high volume of issues with Primary Care Support, NHSE Risk Summit has taken place and a review on Performer Lists, Medical Records and Payments have recently been conducted. A new Management Board is now in place. Regular local stakeholder meetings are taking place with NHSE/CCG/PCS representative.

## 2. Background and Update

The CCG reports all issues with Primary Care Support to NHS England who are monitoring the Contract held by Capita. The CCG attends quarterly stakeholder meetings held at NHSE to review risks and receive updates on work being done to improve the contract and fulfil their requirements. There have been major issues with Payments and Pensions which affect Practice cash flow, Performer List Applications, Clinically urgent Medical Record requests, Patient Registrations and Deductions, all the issues are creating additional workload for Practices.

PCS made a good will payment of £250.00 which was paid to Practices in June.

NHSE are feeding all issues to the service management team and to assist in providing evidence of the on-going issues the CCG conducted a survey to Practices. The results have been escalated to the NHSE National Stakeholder Forum.

The issues and the results from the Practice survey were reported into Primary Care Quality Operations Group in June who agreed that a letter should be sent to NHS England from Sarah O'Brien to escalate our concerns and seek assurance that NHS England are addressing these matters with the urgency and attention to details that is currently required. We also included an invite in the letter for NHS England to attend a future Primary Care Committee to provide detailed assurance that NHS England is addressing our issues.

The CCG has now received a response to our letter which is attached for information.

## 3. Recommendations

For this letter to be noted by members.

## DOCUMENT DEVELOPMENT

| Process | Yes | No | N/A | Comments & Date (i.e. presentation, verbal, actual report) | Outcome |
|---|---|---|---|---|---|
| Public Engagement (please detail the method i.e. survey, event, consultation) | ☐ | ☑ | ☐ | | |
| Clinical Engagement (please detail the method i.e. survey, event, consultation) | ☑ | ☐ | ☐ | PCS survey sent to all Practice Managers in April 2017 | |
| Has 'due regard' been given to Equality Analysis (EA) and any adverse impacts? (Please detail outcomes, including risks and how these will be managed) | ☐ | ☐ | ☑ | | |
| Legal Advice Sought | ☐ | ☐ | ☑ | | |
| Presented to any other groups or committees including Partnership Groups – Internal/External (please specify in comments) | ☑ | ☐ | ☐ | On-going review at Primary Care Quality Operations Group. | |

**Note:** Please ensure that it is clear in the comments and date column how and when particular stakeholders were involved in this work and ensure there is clarity in the outcome column showing what the key message or decision was from that group and whether amendments were requested about a particular part of the work.

Transformation and Corporate
Operations Directorate
NHS England
Skipton House
80 London Road
London
SE1 6LH

Professor Sarah O'Brien
Interim Clinical Chief Executive
NHS St Helens Clinical Commissioning
Group St Helens Chamber of Commerce
Salisbury Street
Off Chalon Way
St Helens
WA10 1FY

7 September 2017

By Email: sarah.obrien@sthelensccg.nhs.uk

Dear Professor O'Brien

I have been passed your letter to Karen Wheeler, who has now left our organisation, dated 14 July 2017. I am responding as Head of Service responsible for this area.

Firstly, I would like to apologise for the delay in responding to your letter. I wanted to ensure that we had detailed responses, from PCSE and my colleagues in NHS England, following investigation of all the points you raised. Unfortunately, this has taken longer than anticipated.

I note all the points raised in your letter and am sorry that the practices in your area are still experiencing issues with the delivery of the PCSE service. I have provided the following updates and hope that this provides your Primary Care Commissioning Committee with some assurance. However, if you have any further queries or questions, I am very happy to arrange a time to discuss these.

I would preface my update with recognition that there have been some significant issues with these services and we in no way under estimate the impacts felt by practices. NHS England is committed to supporting Capita in resolving all the remaining issues until PCSE is fully recovered. Capita have reconfirmed their commitment to make every effort to complete the recovery of all PCSE services.

PCSE has improved significantly over recent months as the agreed recovery plans have been implemented. We have seen this demonstrated through improvement in performance levels, reductions in backlogs and complaints, and improvements in customer satisfaction, as measured in the most recent user satisfaction survey. However, we know that there is more to do in completing recovery actions, improving services and delivering the expected service transformation.

**Performer List Adjustments**

NHS England is continuing, with expert input from other stakeholders, to support PCSE to address the remaining issues with the performers list service. There have been significant improvements and the current cohorts of performer list applicants are progressing well.

I acknowledge that there have been issues with the backlog of change notifications and applications previously. These issues have improved significantly, however, we know that there are still delays. The processes currently used are involved and there is often key information missing, which PCSE are reliant on third parties to provide, otherwise this leads to delays the processing of changes. Guidance on the current NPL2 and 3 processes has been produced. The guidance has been circulated to practices and is available on the PCSE website.

If there are any stubborn issues you are unable to resolve with PCSE directly, please highlight them to us, via our SMT email address and we will explore with PCSE any particular issues with these cases.

NHS England has been working with PCSE to streamline their Standard Operating Procedures in order to make the process, for change notifications in particular, much more efficient with fewer requirements being placed on individual practices. Once these procedures have been signed off and implemented, there should be a further improvement in the timescales for processing performers list adjustments, in particular for new salaried and principal GPs.

We were also aware that the process for acknowledging communications could be improved. PCSE have introduced an indexing process for their generic email address pcse.performerslist@nhs.net. PCSE have advised that all communications relating to the performers list should be sent to this address and senders should receive an acknowledgement.

Should any of the practices in your area continue to experience these difficulties from September, please let us know and we will see if we can intervene to resolve your concerns.

**Registrations/Patient Deductions**

We are aware of the incident outlined in your letter and are assured that PCSE have conducted a full administrative investigation. This found that there was a delay outside of the expected SLA in deducting the patient from her previous GP Practice, which was across NHAIS system boundaries. In cases where patients move between GP Practices on the same NHAIS system, then the processing of the registration in PCSE does immediately remove the patient from their previous GP Practice. However, in cases where there is a movement across NHAIS systems, then a secondary process needs to take place which introduces the risk of a delay.

This delay is inherent in the current NHS Digital registration system, even if all administrative actions take place within SLA. However, PCSE have acknowledged that in this case there was an extended delay in deducting the patient.
This may have contributed to the risk of an incorrect prescription being dispensed; however, it is not clear if this was indeed the case.

PCSE's Medical Director, Dr Charles Young, is currently continuing to investigate the aspects of this case. This is to review the areas which are outside of PCSE remit, such as the process at the practice, at the pharmacy and nursing home, to identify whether the prescription had been issued prior to the admission to hospital and change to medication.

**NHS Numbers**

The contractual Key Performance Indicator for PCSE is that the majority of new registration transactions should be processed on the NHAIS system within 3 days and none should take longer than 10 days. This includes the allocation of NHS Numbers for new entrants to the NHS and confirmation of numbers for babies.

Allocation of NHS numbers requires careful checking of the national systems to prevent duplicates being created and sometimes referring back to GP Practices for clarification of additional details for the same reason.

If an NHS number is required urgently for clinical reasons, such as referral to secondary care, GP Practices should contact the PCSE Customer Service Centre on 0333 014 2884 and inform the call handler of the urgency. The case will be passed immediately to the Registration Back Office team for resolution.

**Contract Variations**

As part of the review of PCSE's Standard Operating Procedures, NHS England have provided advice on how to manage contract variations more efficiently between commissioners, practices and performers. PCSE are required to obtain confirmation from the NHS England local office that any variations to the contract have been approved before they are able to action the change. We recognise that this has not been undertaken in the most efficient way to date and as a result this is being addressed in the revised procedures that should be implemented in September.

As mentioned previously, PCSE have advised that requests received into the performers list email address will be acknowledged. If you find that this is not the case, please contact us and we will investigate.

**Payments**

The final areas to complete their recovery actions over the next few months include GP Payments / Pension service. We know that as a result there are issues for some practices, particularly around ensuring that pension contributions are being deducted accurately and getting timely responses to queries.

PCSE has committed to a service improvement programme that will improve the service in the following areas:

- Query management – PCSE have created a standalone team that will focus on all queries relating to payments and pensions. They have commenced further recruitment to allow them to deal with queries in an acceptable time frame;

- Historical pensions updates – Historically, not all GPs have been aware of the requirement to send annual pension documentation to PCSE. We are working with the Pensions Agency and PCSE to determine how best to address these historical issues;

- LMC levy calculations – PCSE have created a standalone team that will deal with all LMC levy calculations. Historically, LMC levy calculations were non-standardised, varied by region and are complex to calculate. This team will own and deliver the calculations in line with LMC requirements;

- Centralisation of key payment and pension activities – PCSE are centralising all payment processing to their new GP Payments and Pensions facility in Blackburn. This is to improve standardisation and control.

- Registrar Reimbursements / expenses – PCSE have standardised the processing of all elements of registrar work. They have worked alongside NHS England and Health Education England to ensure consistency across the service.

**Contact Centre**

Generally, we are continuing to see an improved level and quality of call handling from PCSE's Customer Support Centre (CSC), so I was sorry to read that some practices, in your area, are still experiencing problems. This should not be happening and I would be interested to receive specific examples, including dates and times so that I can investigate these cases further.

We do know that timely acknowledgement and response to queries is a key expectation that is not yet being achieved in all cases. Work is underway to roll out an improved information management system which will support CSC staff and further improve the customer experience.

If practices have any concerns, we suggest they raise these with the PCSE National Engagement Team local managers. A list of these people can be found at http://pcse.england.nhs.uk/net/.

If a satisfactory resolution to any issues is not achieved, then concerns can escalated to my team at england.smtinfo@nhs.net.

**Changes to Prescribing Information**

I understand that, when moving practices, some doctors have been using the same prescribing number across practices because of delays in obtaining a new number from PCSE. We recognised this as a serious issue, for reasons you describe in your letter. In addition, we found that, historically, there were local variations in the way the new numbers were issued; NHS England's local offices had a range different requirements of PCSE.

To address this, we have been working closely with PCSE on a procedural review to ensure that changes are made consistently and to the timescale we expect and performers need. We now have a standardised approach which includes the provision of a new prescribing number.

PCSE were operating with a backlog of issuing prescribing numbers for some months earlier this year but this was cleared by the end of June 2017. Therefore, if know of any performer that has not received their prescribing number they should raise this with PCSE.

**PCIS Access for CCGs**

Following discussions with NHS digital, we understand that access for CCGs to PCIS is possible. However, to enable us to progress this we require information on which colleagues would require access and what functions, on PCIS, they would carry out. If you could provide this, we are happy to progress this.

**Additional points**

PCSE have appointed a director of the NET team, Guy Dickie. I am sure that Guy would be happy to attend your Primary Care Committee so that he can provide an update on the work that PCSE is doing to support the primary care community in resolving outstanding issues.

NHS England continue to hold regular, detailed reviews of the PCSE services with Capita and hold them to account for ensuring that every possible effort is being made to deliver the improvements that are needed. There are now service line boards established to oversee detailed operational delivery at a service line level. These boards feed into the overarching Service Management Board which provides the overall oversight of the service.

In addition, representatives from NHS England regularly meet with representatives of the BMA GPC to keep them apprised of the steps being taken to operationally improve and transform these services.

NHS England also communicates, on a regular basis, with other membership bodies, NHS England Heads of Primary Care and Communications Leads about progress so that information can be cascaded to CCGs and practices as appropriate.

I do hope that this update goes some way to providing you with additional reassurance as we move to complete the PCSE recovery work.

Yours sincerely

Gus Williamson
Head of Service Management

CC:
Tom Knight, Head of Primary Care, NHS England North (Cheshire and Merseyside)
Rose Gorman, Senior Commissioning Manager, NHS England North (Cheshire and Merseyside)
Jill Matthews, Managing Director, NHS England Intensive Expert Management Team Primary Care Support Services

# KEY ISSUES REPORT

## Primary Care Quality and Operational Group

Meeting Date: 30th August 2017

| Agenda Item Ref: | CCG Improvement Plan Theme | Key Issue: | Decision / Action: | Corporate Risk / GBAF Reference: - Mitigation |
|---|---|---|---|---|
| 5 | Primary Care | **Extended Access in Primary Care**<br>Deemed a significant risk | Clarity to be sought and to be shared with PCC as to what is expected. Timeline to be provided. | |
| 6a | Primary Care | **Risk Register:**<br>Sherdley Medical Centre.<br>ElderCare<br><br>PCS | Summary to be presented to PCC on process to provide assurance and to inform of the reduction in rating.<br><br>A high risk and Tom Knight to be invited to the PCC and COT to continue to escalate to Capita. | |
| 9a | Primary Care | **Finance**<br>Qtr 2 list size showed an increase in borough population<br><br>ROTA. Practices possibly opting out and the associated financial risks. | Further investigation into data to take place and review.<br><br>Impact of risk to be escalated to PCC subject to the GP Members council views. | |
| 9b | Primary Care | QIPP Update<br><br>To identify QIPP Schemes | Summary of potential schemes to be presented to PCC for 2018/19. | |
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| **Key Issues Report** | **Date** |
|---|---|
| Prepared by: Carol Green, PA | 30.08.17 |
| Verified by: Tony Foy | 13.09.17 |
| **NOTE:**<br>A copy of any papers referenced in this Key Issues Report will be made available on request to the Committee Chair.<br>Formal Minutes, once approved, will be provided to the Audit Committee and Governing Body. | |