NHS
Darlington
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

Tuesday 25th April 2017
14:00 – 15:00

Meeting Rooms 1&2, Dr. Piper House, Darlington

Time	Item No.	Item	Attached or verbal	Presented by
14:00	**PCCC/17/09**	**Apologies for absence**	Verbal	All
	PCCC/17/10	**Declarations of Interest**	Verbal	Chair
14:05	**PCCC/17/11**	**Minutes of the meeting held on 21st March 2016**	Attached	Chair
	PCCC/17/12	**Action Log**	Attached	Chair
Performance/Operational				
14:20	**PCCC/17/13**	**Summary of 2017/18 General Medical Services Contract Negotiations**	Attached	Wendy Stevens
14:35	**PCCC/17/14**	**Felix House Premises Update**	Verbal	Graeme Niven
Any Other Business				
14:50	**PCCC/17/15**	**Any Other Business**	Verbal	All
	Date/Time/Venue of Next Meeting 16th May 2017 at 1pm in Meeting Rooms 1&2, Dr Piper House			

Contact for the meeting:
Rachael White, Committee Secretary
Tel: 01325 621407 or email: rachaelwhite1@nhs.net

NHS
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Clinical Commissioning Group

Draft Minutes of the NHS Darlington Clinical Commissioning Group Primary Care Commissioning Committee

Held on Tuesday 21st March 2016 at 1:00pm In the Board Room, Dr Piper House, DL3 6JL

Present

Andie Mackay (Chair)	Lay Member Finance
Angela Galloway	Secondary Care Clinician
Graeme Niven	Chief Finance Officer
Michelle Thompson	Lay Member Patient & Public Involvement
Ali Wilson	Chief Officer

In Attendance

Paul Irving	Primary Care Development and Commissioning Manager
Pauline Lax	Practice Nurse LiNK
Jenny Steel	Executive GP - Transformation
Rachael White	Committee Secretary

PCCC/17/01 Apologies for Absence

01.1 Apologies were received from Richard Harker, GP Quality Lead; Liz McAllister, Healthwatch Darlington and Diane Murphy, Director of Nursing and Quality.

PCCC/17/02 Declaration of Interest

02.1 No declarations were made.

PCCC/17/03 Unconfirmed minutes of the meeting held on Tuesday 13th December 2016

03.1 The Committee APPROVED the minutes as an accurate record.

PCCC/17/04 Action Log

04.1 The Committee reviewed the actions currently open on the action log for which no updates had been provided. It was requested that Rachael White ask for an update for the next meeting.

In regards to the last action, the Committee sought clarification of who was the agreed guardian for whistleblowing and for the details to be circulated to the Committee.

ACTION: PCCC/17/01 (Rachael White)

PCCC/17/05 Darlington Practice Nurse Mapping Report

05.1 The Primary Care Commissioning Committee reviewed the report presented by Pauline Lax which outlined the mapping exercise that was performed across all practices in County Durham and Darlington. The purpose of the exercise was to understand the current workforce, service delivery, qualifications, skills, clinical

supervision and the predicted future workforce within the next 3 to 10 years and the implications. The Committee was advised that the information was based on individuals rather than a whole time equivalent however that information could be provided.

ACTION: PCCC/17/02 (Pauline Lax)

05.2 The key findings from the data collected were:

- The majority of practice nursing staff were aged over 40years with almost 55% being over the age of 51years
- 50% of staff were eligible for retirement over the next 10 years with 36.5% within the next 5 years
- Nursing workforce models were practice specific
- There was a broad range of training available to support development but there was variation in the type of training accessed and funding opportunities.
- There was no agreed pay scale and salaries varied within each job role as there was no national pay structure
- Some stated that salary was not received whilst on sick leave.

05.3 As 10 out of the 11 practices were now using the workforce planning tool it was felt that this could help manage the situation. However Jenny Steel advised that feedback had been received that the tool was not proving to be as efficient as hoped which was a concern and needed to be addressed.

ACTION: PCCC/17/03 (Paul Irving)

05.4 Pauline advised that there were a significant number of nurses in secondary care who would like to work in a primary care / community services role however practices could sometimes struggle to recruit them if they did not have the required primary care experience. Due to training not being available to them until they were in a primary care role, some practices were trying to provide training earlier so that the individual had the necessary skills when starting the role. Paul Irving informed the Committee that there was also work underway to encourage more student nurses to choose primary care while in education.

05.5 The Committee agreed that there was a need for the CCG to establish what services it wanted to commission through primary care and what support could be put in place to help practices do so. It was felt that it would be beneficial for practices to work together to establish training needs and how to boost skills in those areas. It was suggested that the information be passed onto Practice Managers and the GP Federation to raise awareness of the situation.

ACTION: PCCC/17/04 (Paul Irving)

It was also agreed that this needed to be discussed with the CCG Primary Care Team. The Committee asked that Pauline share and discuss the information with Karen Hawkins and Sue Greaves.

ACTION: PCCC/17/05 (Pauline Lax)

The Committee NOTED the information provided.

PCCC/17/06 NHS England Commissioner Guidelines: Responding to Requests from Practice to Temporarily Suspend Patient Registration

06.1 Paul Irving advised the Committee that he would present the report as there was no representative available from NHS England.

06.2 The guidelines had been produced to support a managed approach for commissioners to respond to requests; reiterate to the process for managing formal list closures and set out the process to be adopted for informal or temporary list closures. The guidelines help to encourage practices to contact the CCG to work together to resolve any issues and agree a level of support. IT was felt that this would be very beneficial for Darlington due to 8 of the 11 practices sharing boundaries and would help the process of redirecting patients.

06.3 Jenny Steel highlighted the need for practices to be aware of these changes in guidance and also to be reminded of their contractual requirements. Jenny advised that she would ask Andrea Jones to discuss the guidelines with the Local Medical Council and to also establish the process in the Durham area in order to ensure a consistent approach. This was also to be feedback to Sue Prout who was leading the work from a CCG perspective.

ACTION: PCCC/17/06 (Jenny Steel / Rachael White)

The Committee NOTED the Date of the information provided.

PCCC/17/07 Violent Patient Scheme

07.1 The Primary Care Commissioning Committee were provided with an update on the current status of the Violent Patient Schemes operating in the area. Paul Irving advised that there were no providers in Darlington and the current service was being hosted by Durham Dales, Easington and Sedgefield CCG and was die to end on the 31st March 2017.

07.2 In June 2016 the CCG reviewed a number of options and it was agreed to offer as a new service to an existing GMS/PMS provider in the Darlington locality. However if there were no practices willing to deliver the service, it would remain with the current provider. It was agreed to offer the new service as a block contract with a sum of £10,000 per annum for 3 years however no applications were received.

07.3 Therefore, in line with the decision made in June 2016, the Violent Patient Scheme would continue with the current provider for an extended period of 3 years. The estimated cost of the service was £10,129 per annum which was within the financial budget and the provider had agreed to continue the service on the standard service level agreement. It was noted that the contract was yet to be signed and the Committee requested that the CCG contact NHS England to progress this.

ACTION: PCCC/17/07 (Paul Irving/Karen Hawkins)

The Committee NOTED the update.

PCCC/17/08 Any Other Business

08.1 Graeme Niven advised that NHS England were preparing a paper outlining the changes to the GP GMS contract and asked that it be added to the agenda for the next meeting.

ACTION: PCCC/17/08 (Rachael White)

08.2 The Committee raised concern that there had not been a meeting since December due to a lack of agenda items. The Chair asked that Andrew Carter be included in the meeting scheduled with Sue Greaves to discuss how the Committee would operate going forward.

ACTION: PCCC/17/09 (Rachael White)

PCCC/17/09 Date and Time of Next Meeting

31.1 The next in public meeting is scheduled to take place on Tuesday 25th April 2017 at 1:00pm in Ground Floor Meeting Rooms 1&2, Dr Piper House, Darlington.

Signed: …….. Date: ……

Andie Mackay
Chair of the Primary Care Commissioning Committee meeting

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Primary Care Commissioning Committee
Action Log 21st March 2017

No	Date	Action	Responsible officer	Completion date	Progress	Status
1.	11.08.16	**Stop Smoking Service Spec** - any implications for GP Practices as a result of the procurement and their responsibilities be clear in the documentation produced.	MD	Update for next meeting	Miriam is currently on annual leave until the 10th May. An update will be provided on her return.	Open
2.	11.10.16	**Primary Care Finance** There was a query regarding the QOF element on the report and it was identified that the reference against QOF needs correcting	LT/GT	For next meeting		Open
3.		**Whistleblowing Guidance** 1. CCG to be kept informed of the number of practices signing up for training once available. 2. The document to be uploaded to GP TeamNet	DJ RW	TBC	 Complete	Open
PCCC/17/01	21.03.17	**Action Log** The Committee sought clarification of who was the agreed guardian for whistleblowing and for the details to be circulated to the Committee	Rachael White	25 April 2017	The Freedom to Speak Up Guardian is John Flook. Information circulated by Ali Wilson	Complete

No	Date	Action	Responsible officer	Completion date	Progress	Status
PCCC/17/02	21.03.17	**Practice Nurse Mapping Report 1** The Committee was advised that the information was based on individuals rather than a whole time equivalent however that information could be provided. Pauline Lax to provide.	Pauline Lax	25 April 2017		Open
PCCC/17/03	21.03.17	**Primary Care Workforce Planning Tool** 10 out of the 11 practices however feedback had been received that the tool was not proving to be as efficient as hoped which was a concern and needed to be addressed. Paul Irving was to contact those practice	Paul Irving	25 April 2017		Open
PCCC/17/04	21.03.17	**Practice Nurse Mapping Report 2** The information was to be passed onto Practice Managers and the GP Federation to raise awareness of the situation.	Paul Irving	25 April 2017		Open
PCCC/17/05	21.03.17	**Practice Nurse Mapping Report 3** The Committee asked that Pauline share and discuss the information with Karen Hawkins and Sue Greaves.	Pauline Lax	25 April 2017		Open
PCCC/17/06	21.03.17	**NHSE Commissioner Guidelines** Jenny Steel highlighted the need for practices to be aware of these changes in guidance and also to be reminded of their contractual requirements. Jenny advised that she would ask Andrea Jones to discuss the guidelines with the Local Medical Council and to also establish the process in the Durham area in order to ensure a consistent approach. This was also to be feedback to Sue Prout who was leading the work from a CCG perspective.	Jenny Steel / Rachael White	25 April 2017		Open

No	Date	Action	Responsible officer	Completion date	Progress	Status
PCCC/17/07	21.03.17	**Violent Patient Scheme** The Violent Patient Scheme would continue with the current provider for an extended period of 3 years. It was noted that the contract was yet to be signed and the Committee requested that the CCG contact NHS England to progress this.	Paul Irving / Karen Hawkins	25 April 2017		Open
PCCC/17/08	21.03.17	**Future Agenda Item** Graeme Niven advised that NHS England were preparing a paper outlining the changes to the GP GMS contract and asked that it be added to the agenda for the next meeting.	Rachael White	25 April 2017	On the agenda for 25th April meeting	Complete
PCCC/17/08	21.03.17	**Future Meeting Arrangements** The Committee raised concern that there had not been a meeting since December due to a lack of agenda items. The Chair asked that Andrew Carter be included in the meeting scheduled with Sue Greaves to discuss how the Committee would operate going forward.	Rachael White / Andrew Carter	25 April 2017	The meeting took place on the 24 March.	Complete

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NHS Darlington Clinical Commissioning Group Primary Care Commissioning Committee Agenda Item: 13 25th April 2017			
Title	Summary of 2017/18 General Medical Services Contract Negotiations		
Purpose	**Approval** ☐	**Discussion** ☐	**Information** ☒
Category	**Strategy & Planning** ☐	**Performance & Operational** ☒	**Governance & Assurance** ☐
Responsible Portfolio Lead	Chrisitne Keen, Director of Commissioning, NHS England		
Clinical Sponsor	Not applicable.		
Author of Report	Kelly Wilson, Primary Care Business Manager, NHS England		
Recommendation(s)	The Committee is asked to note the contents of the summary, further detailed guidance is expected to be published later in March/April.		
Executive Summary	The purpose of this paper is to provide a summary to the Committee of the attached General Medical Services contract negotiations for 2017/18, **Appendix 1**. This paper sets out a summary of the key changes to the General Medical Services (GMS) contract in England for 2017/18. These changes have been agreed between NHS Employers, on behalf of NHS England and the General Practitioners Committees (GPC) of the British Medical Association. The summary of changes include; • A pay uplift of one per cent and general expenses uplift of 1.4 per cent. • A change in the value of a Quality and Outcomes Framework (QOF) point as a result of a Contractor Population Index (CPI) adjustment. There will be no changes this year to the number of QOF points, indicators or thresholds. • An increase in the payment for Learning Disabilities Health Check Scheme. • Changes to the GP Retention Scheme with an additional £1 million investment. • Funding to cover expenses relating to submission of data		

	for the NHS Digital Workforce Census (£1.5 million), contractual changes relating to overseas visitors (£5 million) and pensions administration levy (estimated £3.8 million). This funding will be added to the global sum allocation without the out-of-hours (OOH) deduction applied. • A recurrent payment of £2 million for workload related to transfer of patient records. This figure will be reviewed from time to time with regards to workload issues. It will be added to the global sum allocation without the OOH deduction applied. • Estimated costs to support changes to payment arrangements for parental leave and sickness absence. • Funding to cover expenses relating to Care Quality Commission (CQC) costs (estimated £22.5 million), indemnity fee increases (£30 million) and Business Improvement District (BID) levies (estimated £1 million). CQC and BID levy costs will be reimbursed directly and indemnity costs will be reimbursed based on practice list size. More detailed guidance regarding the key changes is expected to be published later in March, beginning of April.
Clinical Engagement	Not applicable.
Does this report provide evidence of assurance for the Assurance Framework and / or mitigate risk included on the CCG's Risk Register?	Not applicable.
Has an Equality Analysis been completed?	Not applicable.
Attachments	**Appendix 1 –** Summary of 201718 GMS Contract negotiations.

CCG strategic objectives supported by this report

Objective	Domain	Tick
1.	Well-led Organisation *To be well-led and governed ensuring continuous development of the CCG*	☐
2.	Delegated Functions *Delivery of the CCG's delegated functions including joint commissioning of primary care and GPIT, whilst exploring and preparing for further opportunities*	☐

3.	Financial Management *Delivery of financial balance including the 1% surplus, value for money and efficiencies to enable the CCG to reinvest to deliver our strategic plans*	☐
4.	Performance *Ensuring measurable improvement of the quality and safety of the services that we commission*	☐
5.	Planning *Identify commissioning opportunities and working in collaboration with partners, including Local Health and care providers and the voluntary sector to improve the health and wellbeing of patients and communities and to reduce health inequalities.* *Delivery of innovative and new models of care* *To demonstrate system leadership across the health and social care economy*	☐
Other Committees/Meetings where this report has been presented	None.	
Does this need to be reported to another Committee/Meeting?	None.	

FEBRUARY 2017

SUMMARY OF 2017/18 GENERAL MEDICAL SERVICES CONTRACT NEGOTIATIONS

This note sets out a summary of the key changes to the General Medical Services (GMS) contract in England for 2017/18. These changes have been agreed between NHS Employers, on behalf of NHS England and the General Practitioners Committees (GPC) of the British Medical Association.

Contract uplift and expenses

The contract for 2017/18 will see an investment of some £238.7 million. This includes:

— A pay uplift of one per cent and general expenses uplift of 1.4 per cent.

— A change in the value of a Quality and Outcomes Framework (QOF) point as a result of a Contractor Population Index (CPI) adjustment. There will be no changes this year to the number of QOF points, indicators or thresholds.

— An increase in the payment for Learning Disabilities Health Check Scheme.

— Changes to the GP Retention Scheme with an additional £1 million investment.

— Funding to cover expenses relating to submission of data for the NHS Digital Workforce Census (£1.5 million), contractual changes relating to overseas visitors (£5 million) and pensions administration levy (estimated £3.8 million). This funding will be added to the global sum allocation without the out-of-hours (OOH) deduction applied.

— A recurrent payment of £2 million for workload related to transfer of patient records. This figure will be reviewed from time to time with regards to workload issues. It will be added to the global sum allocation without the OOH deduction applied.

— Estimated costs to support changes to payment arrangements for parental leave and sickness absence.

— Funding to cover expenses relating to Care Quality Commission (CQC) costs (estimated £22.5 million), indemnity fee increases (£30 million) and Business Improvement District (BID) levies (estimated £1 million). CQC and BID levy costs will be reimbursed directly and indemnity costs will be reimbursed based on practice list size.

Enhanced services

Avoiding unplanned admissions

The Avoiding Unplanned Admissions Directed Enhanced Service (DES) will be discontinued as of 31 March 2017. The 2016/17 spend of £156.7 million will be transferred into global sum, without the OOH deduction applied, and used to support work on frailty (see below).

Learning disabilities

The payment for the Learning Disabilities Health Check Scheme will increase from £116 to £140 per health check. A new health check template has been developed by NHS England for practice use if they so choose. All other requirements of the DES remain unchanged.

Extended Hours Access

The Extended Hours Access DES will continue unchanged until 30 September 2017.

New conditions will be introduced from 1 October 2017 which will mean that practices who regularly close for a half day, on a weekly basis, will not ordinarily qualify for the DES. This change is to support the joint commitment to ensure locally responsive, safe and appropriate access to general practice for all patients in England during contracted hours. Local Medical Committees should be integral partners in working with local commissioners in ensuring practices are fulfilling their contractual requirements.

Identification and management of patients with frailty

From 1 July 2017 at the earliest, practices will use an appropriate tool eg Electronic Frailty Index (eFI) to identify patients aged 65 and over who are living with moderate and severe frailty. For those patients identified as living with severe frailty, the practice will deliver a clinical review providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions. In addition, where a patient does not already have an enriched Summary Care Record (SCR) the practice will promote this, seeking informed patient consent to activate the enriched SCR.

Practices will code clinical interventions for this group appropriately. Data will be collected on the number of patients:

— recorded with a diagnosis of moderate frailty

— with severe frailty

— with severe frailty with an annual medication review

— with severe frailty who are recorded as having had a fall in the preceding twelve months

— severely frail, who provided explicit consent to activate their enriched SCR.

NHS England will use this information to understand the nature of the interventions made and the prevalence of frailty by degree among practice populations and nationally. This data will not be used for performance management purposes.

Data collection

From 1 July 2017 at the earliest, practices will be contractually required to allow collection of data related to the National Diabetes Audit, the NHS Digital Workforce Census and for a selection of activity no longer incentivised through QOF (INLIQ) and retired ESs[1] .

[1] NHS Employers. QOF 2017/18. www.nhsemployers.org/qof1718

Registration of prisoners

A contractual change will be introduced from 1 July 2017, at the earliest, to allow prisoners to register with a practice before they leave prison. The agreement includes the timely transfer of clinical information from the prison to the practice, with an emphasis on medication history and substance misuse management plans, to enable better care when a new patient first presents at the practice.

Access to healthcare

NHS Employers and GPC have agreed contractual changes that help to identify European Economic Area (EEA) patients who may be subject to the NHS (Charges to Overseas Visitors) Regulations 2015.

Practices will be required to provide all new patients with a revised GMS1 form, which includes supplementary questions to determine a patient's eligibility to healthcare. For those patients who self-declare that they hold either a non-UK issued European Health Insurance Card (EHIC) or a S1 form, the practice will be required to manually record that the patient holds either a non-UK issued EHIC or a S1 form in the patient's medical record and then send the form and supplementary questions to NHS Digital (for non-UK issued EHIC cards) or the Overseas Healthcare Team (for S1 forms) via email or post. The Department of Health has agreed to provide practices with hardcopy patient leaflets, which will explain the rules and entitlements for overseas patients accessing the NHS in England.

Agreement has also been reached for NHS England and GPC to work with GP system suppliers to put in place an automated process, as soon as possible. This would include discussions on development of systems to support collection of GP appointment data for these patients.

Once the technical solution to automatically collect this data is in place, we have agreed that further discussions on implementing the system to support collection of the data will take place.

New recurrent investment of £5 million will be added to global sum allocation, without the OOH deduction applied, to support this requirement.

GP retention scheme

A new GP retention scheme has been agreed which is open to all GPs who are seriously considering leaving or have left general practice due to personal reasons, approaching retirement or who require greater flexibility. It is intended as an incentive for both the GP and practice to enable the GP to remain in clinical practice, working up to a maximum four sessions per week. It builds on the previous scheme by providing an increased payment to practices and more flexibility and clarity for GPs.

Key changes are as follows:

— In 2016, under an interim scheme, the practice payment rose from £59.18 to £76.92 per session, an increase of approximately 30 per cent. NHS England will fund the 2017 scheme wholly from within the primary care allocation budget and the practice payment and professional expenses supplement will remain the same as the 2016 scheme. The practice payment is to be used by the practice as an incentive to provide flexibility for the retained GP and should be used towards the retained GP's salary, to cover human resources administration costs and to provide funding to cover any educational support required from the practice, including course fees where relevant.

— A professional expenses supplement will be payable to the GP via the practice (on a sliding scale) and is to go towards the costs of the GP's indemnity cover, professional expenses and Continuing Professional Development (CPD) needs.

— A strong element of the future scheme is around education and CPD. The retained GP would be entitled to the pro rata full time equivalent of CPD as set out within the salaried model contract. The CPD aspects would be based on the needs of the individual, as established at their appraisal and in discussion with the educational supervisor.

— GPs can be on the scheme for a period of up to five years. In exceptional circumstances an extension can be made for up to a further 24 months.

Any retainers on the 2016 Retained Doctors Scheme will continue under these arrangements until 30 June 2019 after which time they will default to the new scheme.

Retainees who have been accepted on to the Retained Doctor Scheme 2016 (where the application form has been approved by the NHS England DCO) but who are not in post before 31 March 2017, will be accepted onto the GP Retention scheme without the need to re-apply.

Sickness leave reimbursement

The following changes will be applicable as from 1 April 2017, with all other requirements remaining unchanged:

— Cover may be provided by external locums or existing GPs already working in the practice but who do not work full time.

— An increase in the maximum amount payable from £1,131.74 to £1,734.18 per week.

— Payments will no longer be discretionary. The qualifying criteria for reimbursement will commence when the absence is two or more weeks (as opposed to previous arrangements which is linked to patient numbers and the period of absence).

— Sickness leave payments will not be made on a pro-rata basis and will be the lower of actual or invoiced costs up to the maximum amounts as set out in the Statement of Financial Entitlements (SFE).

Parental leave reimbursement

Parental leave payments will not be made on a pro-rata basis and will be the lower of actual or invoiced costs up to the maximum amounts as set out in the SFE. All other requirements will remain unchanged

Vaccination and immunisations

Changes include:

— Childhood seasonal influenza – the removal of four year olds from enhanced service patient cohort (transferring to schools programme) and the removal of the requirement to use Child Health Information Systems (CHIS).

— MenACWY programmes[2] – a reduction in the upper age limit from 'up to 26th birthday' to 'up to 25th birthday' (in line with the Green Book).

— Seasonal influenza – the inclusion of morbidly obese patients as an at-risk cohort and a reminder for practices that it is a contractual requirement to record all influenza vaccinations on ImmForm. Funding to cover this new cohort will be from Section 7A.

[2] Three affected programmes - MenACWY for patients aged 18 year on 31 August 2017, MenACWY freshers and meningococcal completing dose (was previously meningococcal booster)

— Pertussis or pregnant women – a reduction in the eligibility of patients for vaccination from 20 weeks to 16 weeks.

— Shingles (catch-up) – a change in patient eligibility to the date the patient turns 78 rather than on 1 September.

All other programmes remain unchanged. For a full list[3] please see NHS Employers website.

BID levies

Eligible practices will be reimbursed for costs relating to BID levies. The reimbursement is to be made by the NHS England local team or fully delegated CCG, as appropriate, via the Premises Costs Directions.

GMS Digital

NHS England and GPC have agreed to build on the work of recent years to develop high quality secure electronic systems and pro-actively encourage patients and practices to use them. The changes that we have agreed for 2017/18 will be taken forward through non-contractual working arrangements which we will jointly promote in guidance.

These include:

— Practice compliance with the ten new data security standards in the National Data Guardian Security Review.

— Practice completion of the NHS Digital Information Governance toolkit including attainment of level 2 accreditation and familiarisation with the July 2016 Information Governance Alliance guidance.

— An increased uptake of electronic repeat prescriptions to 25 per cent with reference to co-ordination with community pharmacy.

— An increased uptake of electronic referrals to 90 per cent where this is enabled by secondary care.

— Continued uptake of electronic repeat dispensing with reference to CCG use of medicines management and co-ordination with community pharmacy.

— Uptake of patient use of one or more online service to 20 per cent including where possible, apps to access those services and increased access to clinical correspondence online.

— Better sharing of data and patient records at local level, between practices and between primary and secondary care.

Further work

NHS Employers and GPC have agreed that a working group will be set up to immediately follow these negotiations to discuss the future of QOF after April 2017.

NHS Employers and GPC have also agreed to begin negotiations on amending the formula that underpins core funding of General Medical Services. Any changes will be effective from 1 April 2018 at the earliest.

NHS England and GPC have committed to take forward discussions in the coming months on a national programme of self-care and appropriate use of general practice services and information sharing between practices.

[3] NHS Employers. V&I. www.nhsemployers.org/vi17/18

NHS Employers

The NHS Employers organisation is the voice of employers in the NHS, supporting them to put patients first. Our vision is to be the authoritative voice of workforce leaders, experts in HR, negotiating fairly to get the best deal for patients.

We help employers make sense of current and emerging healthcare issues to ensure that their voice is front and centre of health policy and practice. We keep them up to date with the latest workforce thinking and expert opinion, providing practical advice and information, and generating opportunities to network and share knowledge and best practice.

We work with employers in the NHS to reflect their views and act on their behalf in four priority areas:

— pay and negotiations

— recruitment and planning the workforce

— healthy and productive workplaces

— employment policy and practice.

The NHS Employers organisation is part of the NHS Confederation.

Contact us

For more information on how to become involved in our work:
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