NHS England

NHS Aylesbury Vale Clinical Commissioning Group

# Primary Care Commissioning Committee

## Agenda

Thursday 8th September 2016 3.30pm – 5.00pm

Bevan Room, Aylesbury Vale CCG, 2nd Floor The Gateway, Gatehouse Road, Aylesbury, Bucks HP19 8FF

| | Agenda Item | Desired Outcome(s) | Contributor | Papers/Times |
|---|---|---|---|---|
| 1 | **Welcome and Introductions:**<br>**Apologies:** | | Graham Smith **CHAIR** | **3.30 – 3.40pm** |
| 2 | **Declarations of Interest** | | Graham Smith **CHAIR** | |
| 3 | **Questions from members of the public** | | Graham Smith **CHAIR** | |
| 4 | **Minutes of the June 2016 meeting and action log** | **Approve** | Graham Smith **CHAIR** | **Paper A** |
| **Clinical Commissioning** | | | | |
| 5 | **Primary Care Commissioning Committee Terms of Reference** | **Approve** | Helen Delaitre, AVCCG | **3.40 – 3.45pm**<br>**Paper B** |
| 6 | **Mandeville Practice Procurement and the Practice Group APMS Contract** | **Decision** | Helen Delaitre, AVCCG | **3.45 – 4.05pm**<br>**Paper C** |
| 7 | **Vulnerable Practice Scheme/General Practice Resilience Programme** | **Decision/ Comment** | Helen Delaitre AVCCG | **4.05 – 4.25pm**<br>**Paper D** |
| 8 | **Verney Close Practice, Buckingham Update** | **Note** | Nicky Wadely, NHSE | **4.25 – 4.40pm**<br>**Verbal** |
| 9 | **Report on Safeguarding in Primary Care** | **Note** | John Trevains, NHSE | **4.40 – 4.50pm**<br>**Paper E** |
| **Any Other Business** | | | | |
| 10 | **Any Other Business** | | Graham Smith **CHAIR** | **4.50 – 5.00pm** |
| **For Information Only** | | | | |
| | **Finance Report** | **Paper for information only** | | **Paper F** |
| | **Report from the Primary Care Operational Group** | **Paper for information only** | | **Paper G** |

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**Agenda Item 4 – Paper A**

# Primary Care Commissioning Committee (PCCC)

Thursday 2nd June 2016, 3.30pm – 5.00pm
AVCCG Conference Room 1, the Gateway, Gatehouse Road, Aylesbury, Bucks

**Present:**

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| Graham Smith, Lay Member for AVCCG | (GS) | **CHAIR** | **Voting Rights** |
| Colin Seaton, Lay Member for AVCCG | (CS) | **Vice Chair** | **Voting Rights** |
| Louise Patten, Chief Officer AVCCG | (LP) | | **Voting Rights** |
| Nicky Wadely NHS England | (NW) | | |
| Robert Majilton, AVCCG Chief Finance Officer | (RM) | | **Voting Rights** |
| Dr Graham Jackson, AVCCG Clinical Chair | (GJ) | | |
| Helen Delaitre, Chiltern CCG Primary Care Lead | (HD) | | |
| Alan Overton, NHS England | (AO) | | |

Vicki Parker- AVCCG Business Administrator (Minute taker) (VP)

| Item No. | Agenda Item | Lead |
|---|---|---|
| 1 | **Welcome & Apologies**<br><br>Members of the Primary Care Commissioning Committee were welcomed to the meeting and introductions given.<br><br>Apologies were noted from Dr Karen West, Gary Passaway, Robert Parkes and Crystal Oldman. | |
| 2 | **Declarations of Interest**.<br><br>No new declarations. | |
| 3 | **Minutes and Actions of Committee Meeting 28th April 2016**<br><br>Minutes of 28th April 2016 agreed as a correct record. Action log updated accordingly. | |
| 4 | **Additional Portakabin at Berryfields**<br><br>NW explained AVCCG requested additional feedback from Berryfields to establish further details on their application. The cost for this extension is a one off £11,357 with a rental reimbursement of £10,893.00 over the two years (104 weeks). It was noted a permanent solution is approx. 3 years away. LP raised concerns with the practice being housed in a Portakabin for another 3 years as this extension does not solve their capacity issue to take | |

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| | them up to a new build being ready. The extra capacity will give an additional 10 clinical sessions.<br><br>GJ asked if a site has actually been allocated to the practice. This was unsure. It was explained GPy and Paul Rowley have visited the site and LP asks if this extension is going to be enough to sustain the practice until the new build is ready, or is there an alternative mode we can consider. The practice feel the extension will give them clinical capacity for the next 18 months. NW believes a firm site offer has been made and a proposal has been submitted for that build to be funded under the Estates and Transformation fund.<br><br>HD asked if the practice is contributing to any of these costs. NW explained this comes under NHS Property Services rental and the one off cost is fully funded, if accepted, as a discretionary grant.<br><br>LP made it clear patient care is a priority but we need a sensible check on the population trajectory and a check on the proposed estate development which needs to be formatted by the practice into a clearer business case. It was noted the current Practice Manager has now retired and his replacement will be starting end of July. NW explained the group covering the practice does have an Executive Practice Manager who is taking these issues on board until the new PM is in place.<br><br>RM feels the CCG needs to clarify the framework we work to for future decisions so we can assure consistency and transparency for all our practices, which demonstrates an assessment of the need.<br><br>LP requested the PCCC delegate a sub group to make this decision and then reports back to the September 2016 PCCC meeting. It was suggested we ask Paul Rowley to have an input to provide a more detailed business case with more information on the population and capacity in the future. NW explained a Premises Forum is taking place next Thursday and suggests this will be a great place to start the work on this. | |
| **5** | **Verney Close**<br><br>LP asked the PCCC to agree the next stages of further action with the contract of Verney Close. LP explained another GMS provider in Buckingham has expressed an interest to pick up the dispersed list with some provisions, namely keep on the existing building and minimal costs to Partners in terms of staff costs (redundancies etc.) This would mean we would move to disperse the list to the new practice and expect them to have the necessary contractual arrangements in place from 1st July 2016.<br><br>LP asked the PCCC to support the decision to disperse the list to be picked up by another GP provider.<br><br>LP highlighted risks that need to be taken into account. There is an "adjustment factor" in the contract which does not transfer over called "a minimum practice income guarantee". In 2004 practices moved to a new | |

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| | contract and the gap in income was called MPIG which is an additional payment into some practices over a time limited period. Verney Close has a remaining term until 2021 so if a practice were merging, NHSE would merge on GMS value, look at MPIG and do a calculation related to this. As these contacts are not merging the new practice will get an amount per head of population they take on but they would not necessarily be entitled to the MPIG. It was asked how much this could be, and although figures could not be confirmed, it was thought less than £10k.<br><br>LP needs to ensure the new GMS provider would not be financial disadvantaged and therefore the proposal is to guarantee the equivalent MPIG payment to the practice for a set period. For this financial year, the funding is in the budget, however if it is not declared as an MPIG in future budgets, this will provide the CCG with a cost pressure.<br><br>LP asked the PCCC to agree the principle should be there is no difference in the funding from the current GMS contract including the MPIG payment. If the MPIG is not included, LP asked the PCCC for permission to provide an equal payment, accepting this may be a cost pressure in future years. **This was agreed by the PCCC members.**<br><br>LP explained Verney Close is a dispensing practice. Dispensing practices are eligible to dispense within their rural localities to their patients where historically no pharmacists were located. As the number of Pharmacies increased, if a patient lives within 1.6km of a pharmacist a practice cannot dispense to these patients. NW explained the practice boundary for Verney Close contract is different to that of the new practice. The dispensing rights remain with the Verney Close contract which will not exist beyond 1st July 2016. However NW explained while the existing Verney Close site is still there, dispensing rights can still continue. The issue needing further clarification is the part of the practice boundary that sits outside the Swan's boundary.<br><br>LP summarised saying it is looking likely the Verney Close site will still be able to dispense to the majority of eligible patients. Although if the Swan changes its boundary to match that of Verney Close, it was questioned whether they will be able to dispense to patients in the "new" area under their dispensing rights.<br><br>NW explained she will be meeting both practices next week. LP asked NHSE to provide an indication of the income stream.<br>LP asked the PCCC for agreement of the list dispersal, noting the risks and to delegate the management of this process including the agreement of the costs. This was agreed by PCCC members subject to adhering to the general principle that costs are not to exceed what is expected and that the CCG undertake a value of money audit. **This was agreed by the PCCC members.** | |
| **6** | **Mandeville Update**<br><br>It was noted the interim contract is in place until April 2017 and work has | |

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| | started on the procurement of a new permanent provider. A workshop was held last week with many stakeholders to discuss a procurement plan utilising patient engagement and working with the Healthy Living Centre. The patient representatives report stability in the practice and staff seem noticeably less stressed. Contract review update meetings with the provider are scheduled on a monthly basis.<br><br>The Mandeville list is now fully open with the original boundary reinstated. | |
| **7** | **AUA DES+ and QOF Data**<br><br>Throughout 2015/16 AVCCG with NHS England supported the development and implementation of two innovative schemes designed to change the way care is delivered in primary care.<br><br>• Care and Support Planning (CSP) – linked to QOF<br>• Avoiding Unplanned Admissions Direct Enhanced Service Plus (AUA DES+) – focused on the needs of patients at the end of life<br>These two schemes were signed off by the primary care joint committee and Governing Body with the following commitments:<br><br>**Impact on patient care –** It was recognised that the QOF scheme would have minimal impact on direct patient care in the transition year 2015/16. The EoL scheme however had potential to impact patient care within a shorter time period and this required analysis to form the basis of learning and a benchmark for 2016/17.<br><br>**Analysis of impact on QOF** - In addition, due to the proposed changes to QOF there was an expectation set that QOF data would be analysed further to understand the impact of the scheme on this data set.<br><br>**Payment -** At year end the CCG and NHSE would need to be assured of practice delivery in order to authorise the final scheme payment and in the case of the QOF scheme, match fund against 2014/15 service delivery. Practices have had until the end of April to submit their data and evidence of delivery where applicable; therefore the year-end data related to these schemes has only just become accessible. This will be analysed in the coming weeks. Unfortunately this means that a report will not be ready for the June Primary Care Committee. As the CCG has an obligation to make payment to practices by the beginning of July **it is requested that the Primary Care Committee delegate responsibility for sign off of the data for practice payment to the Primary Care Operational Group and a final report come to the next formal committee.**<br><br>RM asked if a sub-committee of the Governing Body should be asked to agree to this and feels this comes under “business as usual” with the appropriate processes and checks in place to sign off any data, reports and invoices and the relevant delegation is in place. | |

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| **8** | **Any Other Business**<br><br>Please note the following received via email from Robert Parkes, AVCCG Lay Member and PCCC Vice Chair:<br>*I read with interest the progress with the Verney practice. It is unfortunate that the members of this practice do not feel they can work with us to achieve an orderly procurement and hand-over, but we cannot change that. I think it is vitally important to act quickly in the patients' interests, to give them all the support they require and minimise any uncertainty. I therefore strongly support the proposal made by Lou Patten to achieve a swift and effective handover. There are some risks, here, but for this very reason, I think it is important that the committee backs Lou to its full extent.*<br><br>*I am happy for you to share my views with the rest of the committee, if you wish.*<br><br>*Regards*<br>*Robert Parkes*<br><br>Meeting Closed: 16.35 | |
| | **Date of the Next Meeting:**<br><br>Primary Care Operational Group:<br>7th July 2016, 3.30pm<br>8th August 2016, 1pm<br><br>Primary Care Commissioning Committee:<br>8th September 2016, 3.30pm | |

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NHS Aylesbury Vale Clinical Commissioning Group

## Open Action Log – Primary Care Commissioning Committee

**Meeting Date: 2nd June 2016**

| Date | Agenda Item No. | Action | Owner | Open/ Closed |
|---|---|---|---|---|
| 020616 | 4 | **Berryfields Portakabin**<br>LP requested the PCCC delegate a sub group to make this decision and then reports back to the September 2016 PCCC meeting. | HD | Open |
| 020616 | 5 | **Verney Close Contract**<br>LP asked NHSE to provide an indication of the income stream in order to undertake a value for money audit on preferred reprovision option. | HD | Open |
| 020616 | 7 | **Avoidable Unplanned Admissions DES+ and QOF**<br><br>The PCCC delegated responsibility for sign off of the data for practice payment to the Primary Care Operational Group and a final report to come to the next formal Committee. | LS | Open |

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## Closed Action Log – Primary Care Commissioning Committee

| Date | Agenda Item No. | Action | Owner | Open/ Closed |
|---|---|---|---|---|
| 09042015 | 4 | Invite LMC, Health-Watch Bucks and the Health and Wellbeing Board to all future meetings | Louise Smith | OPEN 090415 CLOSED 150615 |
| 09042015 | 5 | LS/GH to discuss the membership of the Operational Group | Louise Smith Ginny Hope | OPEN 090415 CLOSED 150615 |
| 09042015 | 5 | LS to amend the TOR to reflect meeting can be held virtually | Louise Smith | OPEN 090415 CLOSED 150615 |
| 09042015 | 7 | The committee need to develop a progression and exit strategy | Louise Smith | OPEN 090415 CLOSED 150615 |
| 09042015 | 7 | GH to sign off the comms message to our members | Ginny Hope | OPEN 090415 CLOSED 150615 |
| 09042015 | 7 | GH to feedback the discussions to Jess Newman | Ginny Hope | OPEN 090415 CLOSED 150615 |
| 09042015 | 7 | LS to produce a 12 month work plan | Louise Smith | OPEN 090415 CLOSED 150615 |
| 09042015 | 7 | LS to produce a FAQ sheet | Louise Smith | OPEN 090415 CLOSED 150615 |
| 15062015 | 4 | LS to add this amendment to the TOR to state GS will appoint a replacement Chair (namely Health-watch Bucks representative) if he is unable to attend future meetings. | Louise Smith | OPEN 15/06/2015 CLOSED 24/09/2015 |
| 15062015 | 7 | LS and CH to hold further discussions on the payment mechanisms needed to implement the C&SP changes MET and had op meetings | Louise Smith Colin Hobbs | OPEN 15/06/2015 CLOSED 24/09/2015 |

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| 15062015 | 8 | It was agreed a delegated group will be established consisting of 2 NHSE reps, GS as chair and LP to sign off AUS DES + once the areas of concern are clarified by NHSE | | OPEN 15/06/2015<br>CLOSED 24/09/2015 |
| 15062015 | 15 | NW to speak to JF to establish practice nurse revalidations<br>NW has flagged to JF who has reported back to LP. | Nicky Wadley | OPEN 15/06/2015<br>CLOSED 24/09/2015 |
| 24/09/15 | 4 | LS to amend the Care & Support Planning Business Case by adding the presentation shown in the meeting as an appendix and provide clarity needed on the business plan for 2016/17 including a value for money assessment and a process for the evaluation framework. | Louise Smith | OPEN: 24092015<br>CLOSED: 14.12.15 |
| 24/09/15 | 11 | LS to invite the AHSN onto the Healthy Town Partnership group<br><br>**Updated 14.12.15:** LS has made contact but no reply to date. Action remains open<br><br>**Updated 24.03.16**: Unfortunately we were not successful with the bid. | Louise Smith | OPEN: 24092015<br><br>Updated 14.12.2015<br><br>CLOSED: 24.03.16 |
| 14/12/15 | 7 | PR asked NHSE if practices have to sign the results of CQRS and if they want to dispute the extraction figures contradicted within first part of the specification, should they sign or hold of signing? NW agreed to raise this question nationally as national guidance is needed to resolve this issue. | Nicky Wadely | OPEN: 14122015<br><br>CLOSED: 24.03.16 |
| 14/12/15 | 8 | LP raised a concern with the lack of safeguarding information in the report. We need this information in the next report. The paper does not reflect the amount of training and support AVCCG gives to practices on safeguarding issues. NW to raise this with the NHSE Quality Team.<br><br>**Updated 24.03.16**:Report has been amended accordingly | Nicky Wadely | OPEN: 14122015<br><br>CLOSED: 24.03.16 |

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| 14/12/15 | 10 | It was agreed a meeting with AVCCG, NHSE and the new provider at Mandeville Surgery will be set in the new year.<br><br>Updated 24.03.16: CLOSED | Gary Passaway | OPEN: 14122015<br><br>CLOSED: 24.03.16 |
| 14/12/15 | 9 | LP advised the CCG has had to fund an administrator in the multi-agency safeguarding hub. GH requested further details to assess if NHSE are able to cover this funding.<br><br>**Updated 24.03.16**: No update available. Action Point remains open.<br><br>**Updated 28.04.16**:NW will chase this up with GH<br><br>**Updated 02.06.16:** NHSE are unable to cover funding. The position is filled by the current workforce | Gary Heneage<br><br>Nicky Wadely | OPEN: 14122015<br><br>Updated 24.03.16<br><br>Updated 28.04.16<br><br>CLOSED 02.06.16 |

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NHS Aylesbury Vale Clinical Commissioning Group

**Agenda Item 5: Paper B**

**Primary Care Commissioning Committee**

**Date** **8th September 2016**

**Title** **Primary Care Commissioning Committee Terms of Reference**

| **Purpose of Paper** |
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| Proposed revisions to the Terms of Reference for the Primary Care Commissioning Committee are attached as a result of changes to the organisational structure for both Aylesbury Vale and Chiltern CCGs that came into effect on 1st July 2016. The Terms of Reference have also been revised to take into account revised guidance on Conflicts of Interest and changes to the CCG Scheme of Delegation. |

| **Executive Summary** |
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| The following amendments are proposed (*text in italics for ease of reference).*<br><br>Page 2- to include Chiltern CCG as an organisation represented on the Committee.<br>Page 5 – under Membership, the Chair of the PCCC should not also chair the Audit Committee.<br>Page 6 - to include Aylesbury Vale/Chiltern CCG Head of Primary Care as a non-voting attendee of the Committee.<br>Page 6 – to include The Committee has delegated authority to take decisions in accordance with standing orders and schemes of delegation.<br>Page 9 – inclusion of Memorandum of Understanding between NHS England and Aylesbury CCG and draft scheme of delegation for primary care. |

| **Actions Required** |
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| The Primary Care Operational Group has already reviewed the proposed revisions and members of the Committee are now asked to approve them. |

| **Objectives supported by this Paper (Please Tick)** | |
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| Support realisation of the primary care strategy | |
| Support delivery of in-year performance and the financial plan | |
| Supports quality agenda | |
| Support development of the CCG to take on the primary care commissioning role | **X** |

# Terms of reference for delegated commissioning arrangements including scheme of delegation and Primary Care Commissioning Committee

## Document Version

| Date | Version Number | Description of Changes | Edited by |
|---|---|---|---|
| 10.03.15 | 2.1 | Watermark added<br>Change to paragraph 13 regarding number of votes | Louise Smith |
| 11.03.15 | 2.2 | Reference to Thames Valley area team removed and replaced with NHS England.<br>Full Acronyms explained<br>Change to secretariat from NHSE to AVCCG<br>Change to membership section to read Chief Officer or Chief Finance Officer | Louise Smith<br><br>Elaine Baldwin |
| 11.03.15 | NOTE | Sent to Graham Jackson for Chairs action and full Governing Body for approval of sign off. Sent to NHS England (South) as final version. | |
| 04.03.16 | 3.0 | Documented updated to delegated commissioning arrangements including scheme of delegation and Primary Care Commissioning Committee. | Elaine Baldwin |

**Introduction**
Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

1. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS **Aylesbury Vale** CCG. The delegation is set out in Schedule 1.

2. The CCG has established the **Aylesbury Vale** CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

3. It is a committee comprising representatives of the following organisations:

    - **Aylesbury Vale CCG**
    - **NHS England**
    - **Health watch**
    - **LMC**
    - **Lay Chair**
    - **Lay member**
    - **Health and Well Being representative**

**Statutory Framework**
4. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

5. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

6. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

    a) Management of conflicts of interest (section 14O);
    b) Duty to promote the NHS Constitution (section 14P);
    c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
    d) Duty as to improvement in quality of services (section 14R);
    e) Duty in relation to quality of primary medical services (section 14S);
    f) Duties as to reducing inequalities (section 14T);
    g) Duty to promote the involvement of each patient (section 14U);
    h) Duty as to patient choice (section 14V);

i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2).

7. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

8. The Committee is established as a committee of the **Governing Body** of **NHS Aylesbury Vale CCG** in accordance with Schedule 1A of the "NHS Act".

9. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

**Role of the Committee**

10. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in **Aylesbury Vale** under delegated authority from NHS England.

11. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Aylesbury Vale CCG, which will sit alongside the delegation and terms of reference.

12. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

13. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

14. This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

15. The CCG will also carry out the following activities:

**a) To plan, including needs assessment, primary care services in Aylesbury Vale**
**b) To undertake reviews of primary care services in Aylesbury Vale**
**c) To co-ordinate a common approach to the commissioning of primary care services generally;**

**d) To manage the budget for commissioning of primary care services in the Aylesbury Vale area.**

**e) To assist and support NHS England in discharging its duty under section13E of the NHS Act 2006 (as amended by the Health and Social Care Act2012) so far as relating to securing continuous improvement in the quality of primary medical services.**

**f) To undertake and deliver an estates strategy across the Aylesbury Vale area.**

**Geographical coverage**

16. The Committee will comprise Aylesbury Vale CCG. It will undertake the function of AVCCG commissioning primary medical services for the Aylesbury Vale area, as defined within the Constitution.

**Membership**

17. The Primary Care Commissioning Committee shall consist of:

- Lay member, AVCCG (Chair)
- Lay member, AVCCG (Vice Chair)
- Chief Officer
- Chief Finance Officer
- Director of Operations & Performance
- Governing Body Chief Nurse or Public health representative
- Quality Lead
- Clinical Chair

If GP members need to withdraw from decision making for conflicts of interest reasons, the committee would still be quorate with a lay and executive majority.

**Other non-voting attendees:**

- Invitation to a Health Watch representative
- Invitation to a Health and Wellbeing Board representative
- Local Medical Committee representative
- NHS England
- Aylesbury Vale Primary Care Transformation Manager
- Non-conflicted GPs from other CCGs
- Additional Lay members
- Subject Matter experts (e.g. premises, workforce)

Provision could be made for the committee to have the ability to call on additional lay members or CCG members when required, for example where the committee would not be quorate because of a conflict of interest. It could also include GP representatives from other CCG areas and non-GP clinical representatives (such as the CCGs secondary care specialist)

- The Chair of the Joint Committee shall be a Lay member of the AVCCG Governing Body
- The Vice Chair of the Joint Committee shall be the lay member of the AVCCG governing body and agreed by the Governing Body.

**Meetings and Voting**

18. The Committee will operate in accordance with the CCG's Constitution, Standing Orders and Prime Financial Policies. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than **5** days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

19. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible. **[Reconsider voting procedures following a decision on the make-up of the committee].**

**Quorum**

20. Five members of the Committee must be present for the quorum to be established including:

- At least two lay members or the Governing Body Registered Nurse;

And

- Either the Accountable Officer (AO) or the Chief Finance Officer (DoF).

**Frequency of meetings**

21. Meetings will take place in public on a monthly basis for the first four meetings followed by bi- monthly meetings thereafter.

22. Meetings of the Committee shall:

a) be held in public, subject to the application of 25(b);
b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

23. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

24. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest..

25. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

26. Members of the Committee shall respect confidentiality requirements as set out in the CCG's **Constitution and relevant policies**

27. The Committee will present its minutes to **NHS England** and to the governing body of Aylesbury Vale CCG each month for information.

28. The CCG will also comply with any reporting requirements set out in its constitution.

29. The terms of reference will be reviewed at least annually with final approval being sought from **Aylesbury Vale CCG** Amendments will be made, where appropriate, to reflect any updated national model terms of reference and local need.

**Accountability of the Committee**

30. The Committee to have delegated authority from Aylesbury Vale CCG governing body:

- To carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act
- To assist and support NHS England in discharging its duty under section
- 13E of the NHS Act 2006 (as amended by the Health and Social Care Act
- 2012) so far as relating to securing continuous improvement in the quality of primary medical services.
- To work with NHS England to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF, and IT intra-operability.
- To comply with public procurement regulations and with statutory guidance on conflicts of interest
- To consult with Local Medical Committee and demonstrate improved outcomes reduced inequalities and value for money when developing a local QOF scheme or DES.
- To approve the arrangements for discharging the group's statutory duties associated with its GP practice commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.

**Procurement of Agreed Services**

*The below is taken from the Next Steps in primary care co-commissioning document for further guidance on this please see link below.*
*https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf*

31. The committee must comply with public procurement regulations and with statutory guidance on conflicts of interest. The committee may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances. If the committee fails to secure an adequate supply of high quality primary medical care, NHS England may direct the CCG to act.

32. If the Committee are found to have breached public procurement regulations and/or statutory guidance on conflicts of interest, Monitor may direct the CCG or to act. NHS England may, ultimately, revoke the CCG's delegation. Any proposed new incentive schemes should be subject to consultation with the Local Medical Committee and be able to demonstrate improved outcomes, reduced inequalities and value for money.

Consistent with the NHS Five Year Forward View and working with CCGs, NHS England reserves the right to establish new national approaches and rules on expanding primary care provision – for example to tackle health inequalities.

**Review of Terms of Reference**

33. These terms of reference will be formally reviewed by NHS England and Aylesbury Vale CCG in April of each year, following the year in which the joint committee is created, and may be amended by mutual agreement between NHS England and Aylesbury Vale CCG at any time to reflect changes in circumstances which may arise.

34. The Committee will make decisions within the bounds of its remit.

35. The decisions of the Committee shall be binding on NHS England and **Aylesbury Vale CCG** within the scope of these TOR and the CCG's Standing Orders. .

36. The Committee will produce the minutes which will provide the update and agenda items provide any decisions for the Governing Body. This information will then be shared with the **NHS England** and the governing body of **Aylesbury Vale** of the CCG.

**[Signature provisions]**
**[Schedule 1 – Delegation-to be added when final arrangements confirmed]**
**[Schedule 2 – Delegated functions-to be added when final arrangements confirmed]**
**[Schedule 3 - List of Members-to be added when confirmed]**
**[Schedule 4 – Primary Care Commissioning Committee Guidance]**

**Schedule 3**

| ROLE | Lay | CCG | NHS England | VOTING RIGHTS |
|---|---|---|---|---|
| Chief Officer AVCCG | | x | | YES |
| Director of Operations and Performance | | x | | YES |
| Lay Member (Vice chair) AVCCG | | | | YES |
| Lay Member (Chair) AVCCG | x | | | YES |
| Governing Body Chief Nurse or secondary care consultant Member AVCCG | | x | | YES |
| Local Medical Committee representative | | | | No |
| Clinical Chair AVCCG | | X | | NO |
| Chief Finance Officer AVCCG | | X | | YES |
| Quality Lead AVCCG | | X | | NO |
| Primary Care Transformation Manager | | x | | NO |
| Health & Well Being Board representation | | | | NO |
| Health Watch Bucks representation | | | | NO |
| Non-conflicted GP's from other CCG's | | | | NO |
| NHS England | | | x | NO |
| Additional Lay members | | | | NO |
| Subject Matter experts (e.g. premises, workforce) | | | | NO |
| Additional input as required (e.g. Data analyst, contracting etc.) non-voting | | | | NO |

**Schedule 4**

*Membership of CCG primary care commissioning committees*
*Guidance below –*

*It is for CCGs to agree the full membership of their primary care commissioning committee. CCGs will be required to ensure that it is chaired by a lay member and have a lay and executive majority. Furthermore, in the interest of transparency and the mitigation of conflicts of interest, a local Health Watch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the delegated committee as non-voting attendees. Health Watch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system. CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. Furthermore, it will be important to retain clinical involvement in a delegated committee arrangement to ensure the unique benefits of clinical commissioning are retained.*

**Agenda item: 6 – Paper C**

**Primary Care Commissioning Committee**
**8th September 2016**

# Mandeville Practice Procurement and The Practice Group APMS Contract

## Purpose of Paper

To provide the Primary Care Commissioning Committee with a brief update on the Mandeville procurement process and to ask for a decision on the future timeline of the project which has an impact on the current interim contract holders.

The paper also summarises the timeline for procurement.

## Executive Summary

Aylesbury Vale CCG had anticipated that the timeline for the procurement and mobilisation of primary care services to the Mandeville population would be one year in duration starting April 2016. Since this decision was made, it has become clear that if the CCG is to maximise the contribution of patients, the community, providers and primary care vanguards it would be worthwhile slowing down the procurement process.

This slowdown of the process would require an extension to the current interim APMS contract and to the lease on the premises. This has now been discussed with the provider.

Given agreement in principle to an extension to the contract, the CCG has worked with the CSU to review options for length of extension and to draw up the timeline for the proposed procurement.

## Actions Required

It is requested that the Primary Care Commissioning Committee agree to a slowdown in the pace of procurement for the Mandeville site APMS contract, with a view to having a new provider in place starting April 2018. As a consequence it will also be necessary for the Committee to agree to a twelve month extension to The Practice Group APMS contract for services at the Mandeville site, subject to approval of the single tender waiver application.

The Committee is also asked to review and approve the timeline for the procurement process.

| Objectives supported by this Paper (Please Tick) | |
|---|---|
| Support realisation of the primary care strategy | **x** |
| Support delivery of in-year performance and the financial plan | |
| Supports quality agenda | **x** |
| Support development of the CCG to take on the primary care commissioning role | **x** |

**Introduction**
The Practice Group was awarded an interim APMS contract for the provision of services at the Mandeville Practice following resignation by the previous contract holders in October 2015. The interim contract term offered was 12 months starting 1st April 2016, with an option to extend for a further 6 months.

By the very nature of how this service was procured using a standard APMS contract and a shortened process to meet the deadline to get a service in place, this interim solution did not meet the full needs of the local population and further work was expected to procure a longer term contract which responds to both the health needs of this population and the principles of innovation seen in many of the new models of care.

**Original Procurement Plans**
Following the successful mobilisation of the service by the required deadline, Aylesbury Vale CCG under delegated commissioning arrangements, started working with the CSU procurement team to progress a second procurement in order to ensure the tender and service mobilisation was completed by 1st April 2017.

The new procurement had a very positive start with the following activities having taken place:

- Project team established
- CSU procurement timetable generated
- Patient engagement activities including paper surveys, community forums, stakeholder events planned
- Visits to sites with alternative models of primary care including critique of these models and the relevance of application at the Mandeville site
- Public health needs analysis of the population served by Mandeville including comparisons to local and national data.

Despite this positive start it soon became apparent that additional time would be required to gain the level of community and provider engagement that the CCG was looking for in order to make the most of the opportunity to commission an innovative service which draws on best practice and meets the needs of this unique population.

Therefore, a revised proposal was taken to the Primary Care Operational Group in July 2016.

**Subsequent Procurement Proposal**
Given the ambition and challenges described above it was proposed to slow down the procurement by either 6 or 12 months. The added value of utilising an extension to the procurement timeline being that it would enable the following:

- Identify CCG project support to take responsibility for the procurement working alongside the CSU but directly to the Head of Primary Care
- Population needs assessment to be fully analysed
- Full engagement with potential service users
- Thorough community engagement with local and hard to reach groups
- Considered and informative provider event designed to gain the maximum value from this knowledge group
- Further visits to review other primary care services demonstrating innovation in their approach to care delivery including access models, alternative skill mix etc.

In slowing down the procurement process to ensure it is resourced appropriately and that the service specification is provided with the greatest level of input, there is a risk that the timelines for service mobilisation would not be met. Rather that accepting this risk and managing it though the year by shortening the time input at other stages of the process, the Operational Group opted to recommend extending the interim APMS contract extension with The Practice Group by a further 12 months. The decision to extend by 12 rather than 6 months was based on the inherent risk of a new provider taking on the contract starting 1st October (the start of the busiest time of the year in general practice).

Action taken now to extend the interim contract with The Practice Group not only provides the contractor with as much notice as possible but supports the principle of service continuity and time for wider public engagement.

**Varying the Interim APMS Contract**

The current APMS contract allows for a maximum 6 month extension only and therefore a single tender waiver application will be submitted to the Audit Committee on 28th September 2016 to extend the contract by a further 6 months.

**Revised Procurement Timelines**
Assuming the Committee approves the extension to the current interim contract, and the single tender waiver is also approved, the proposal is that the CCG would work towards appointing their preferred provider by August/September 2017. The procurement project plan will be divided into the following project phases and timelines:

Phase 1 – Pre-procurement (September – February 2017)
Phase 2 – Procurement (March 2017 – July 2017)
Phase 3 – Contract award (August – September 2017)
Phase 4 – Mobilisation (October 2017 – March 2018)

The first step in reinstating the procurement process will be to re-establish the Project Group, made up of the following members:

Louise Smith, Associate Director Commissioning and Locality Delivery
Dr Charles Todd, Lead GP for Central Aylesbury Locality
Helen Delaitre, Head of Primary Care
Jessica Newman, Assistant Contracts Manager, NHS England
Vicki Parker, Business Support Manager for Central Aylesbury Locality
Alan Cadman, Deputy Chief Finance Officer
Sarah Mahoney, Procurement Lead CSU

**Recommendation and Actions**

Subject to the approval of a single tender waiver application by the Audit Committee, the Primary Care Commissioning Committee is asked to approve the recommendation made by the Primary Care Operational Group that the Mandeville Practice interim APMS contract with The Practice Group is extended by a further 12 months. This will provide more time to run a comprehensive stakeholder engagement process and explore alternative models of primary care. In so doing it is anticipated that the longer term contract that is commissioned will respond both the health needs of this population and meet the principles of innovation seen in many of the new models of care.

Helen Delaitre
2nd September 2016

**Agenda Item 7: Paper D**

**Primary Care Commissioning Committee**

**Date** **8th September 2016**

**Title** **Vulnerable Practice Scheme / General Practice Resilience Programme**

| **Purpose of Paper** |
|---|
| The purpose of this paper is to:<br>• Report to Committee on the proposed process for identifying vulnerable practices, assessing their needs and allocating funding.<br>• Update the Committee on the launch of the General Practice Resilience Programme, including suggested proposal on effective use of these funds going forward.<br>• Provide a briefing paper for information, prepared by NHS England on *General Practice Forward View* Supporting Programmes issued in August 2016. |

| **Executive Summary** |
|---|
| In December 2015, a programme was announced by NHS England to secure improvements in vulnerable GP practices to help build resilience in primary care and to support delivery of new models of care and the sum of £35,000 was awarded to each CCG in the Thames Valley area.<br><br>The CCG has drawn up a policy based on guidance from NHSE that outlines the criteria for identifying vulnerable practices and allocating funding to same. The policy also builds on the work that Dr Karen West has done to establish a Primary Care Dashboard.<br><br>The policy has been shared with Clinical Locality Leads (CLL) and was discussed at the Primary Care Operational Group (PCOG) in August 2016. Helpful comments were gathered from both the CLLs and the PCOG, particularly regarding the criteria which need to be flexible and take more account of local intelligence.<br><br>The allocations for both CCGs have already been transferred from NHSE to the CCG. Activity and financial expenditure for the Vulnerable Practice Scheme will be monitored by NHS England on a monthly basis.<br><br>The recently publicised GP Resilience Programme further builds on the ideas and criteria of the Vulnerable Practice Scheme and makes available an additional £48,000 to Aylesbury practices. The GP Resilience Programme is designed to enable support for practices before they become vulnerable and funding has been identified for the next four years to |

help struggling practices under this scheme.

NHS England is now asking CCGs for a summary of their proposed local approach to resilience planning by 19th September 2016.

The PCOG has acknowledged that practices can become vulnerable and / or improve their position quickly and so the list of practices deemed as vulnerable can change frequently. Therefore, "vulnerable practices" will become a standing item on the agenda of forthcoming Primary Care Operational Groups.

The PCOG will also be responsible for monitoring roll out of other supporting schemes under the *GP Forward View* banner, as summarised in the Briefing Paper attached as Appendix 2.

| **Actions Required** |
|---|
| Committee is asked to approve the process for identifying vulnerable practices, assessing their needs and allocating funding.<br><br>The Committee is also asked to comment and/or agree suggestions put forward for the use of GP Resilience Programme Funding. Summary proposals to be submitted to NHS England by 19th September 2016. |

| **Objectives supported by this Paper (Please Tick)** | |
|---|---|
| Support realisation of the primary care strategy | **X** |
| Support delivery of in-year performance and the financial plan | |
| Supports quality agenda | **X** |
| Support development of the CCG to take on the primary care commissioning role | **X** |

## Vulnerable Practice Scheme/General Practice Resilience Programme

### Vulnerable Practice Scheme

In December 2015, a programme was announced by NHS England to secure improvements in vulnerable GP practices to help build resilience in primary care and to support delivery of new models of care and the sum of £35,000 was awarded to each CCG in the Thames Valley area.

So that this funding can be accessed in a consistent, transparent manner, the CCG has drawn up a policy based on guidance from NHSE that outlines the criteria for identifying vulnerable practices and the process for allocating funding to same. The policy also builds on the work that Dr Karen West has done to establish a Primary Care Dashboard.

The policy has been shared with Clinical Locality Leads (CLL) and was discussed at the Primary Care Operational Group (PCOG) in August 2016. Helpful comments were gathered from both the CLLs and the PCOG, particularly regarding the criteria which need to be flexible and take more account of local intelligence.

The allocations for both CCGs have already been transferred from NHSE to the CCG. Activity and financial expenditure for the Vulnerable Practice Scheme will be monitored by NHS England on a monthly basis.

The policy is attached at Appendix 1.

### General Practice Resilience Programme

The recently publicised GP Resilience Programme further builds on the ideas and criteria of the Vulnerable Practice Scheme and makes available an additional £48,000 to Aylesbury practices. The GP Resilience Programme is designed to enable support for practices before they become vulnerable and funding has been identified for the next four years to help struggling practices under this scheme.

In short the funding can be used to build on work underway through the vulnerable practice scheme. The programme allows a wider range of support to be delivered, ranging from help for practices with urgent pressures to transformation support to move to more sustainable future models of care. NHS England has produced guidance[1] that offers a menu of support for which this funding can be used. The menu of support includes:

- Diagnostic services to quickly identify areas for improvement support
- Specialist advice and guidance e.g. Operational HR, IT, Management and Finance
- Coaching/Supervision/Mentorship as appropriate to identified needs
- Practice management capacity support
- Rapid intervention and management support for practices at risk of closure
- Co-ordinated support to help practices struggling with workforce issues
- Change management and improvement support to individual practices or groups of practices
- Supporting primary care resilience in the longer term through transformational change.

[1] https://www.england.nhs.uk/wp-content/uploads/2016/07/gp-resilience-prog.pdf

This year, earlier work to identify vulnerable practices can be used to select practices for support under this new programme e.g. funding could be used to support even more practices including those less vulnerable but GP practices will need to have agreed to this support and any offer of funding will be conditional upon a matched commitment from the practice, evidenced through an agreed action plan.
NHS England is now asking CCGs for a summary of their proposed local approach to resilience planning by 19th September 2016.

**Suggested Local Approach**
There are many definitions of struggling practices in need of support to become more sustainable and resilient, and this view is reflected in the comments received from Clinical Locality Leads. However, there appeared to be a consensus on the type of schemes that would be of most benefit to primary care teams locally:

- **Rapid intervention and management support for practices at risk of closure.** Rapid intervention where support can be provided quickly to secure any immediate management capacity needs, assuring and supporting continued day to day operations within primary care.
- **Co-ordinated support to help practices struggling with workforce issues.** Maintaining clinical sessions is a priority for practices struggling with workforce issues (e.g. sudden critical vacancies, sickness, and long term vacancies) and increasing competition for a diminishing workforce has escalated the problems experienced locally.

The preferred proposal therefore would be to:

- Continue to use the vulnerable practice scheme to support practices identified as being vulnerable;
- Use a proportion of the General Practice Resilience Programme (GPRP) funding to be able to provide rapid intervention for practices needing immediate support;
- Use a proportion of the GPRP funding to develop a GP locum bank and encourage newly qualified GPs and recent retirees to join.

Further details of this proposal will be worked up and shared with CLLs in advance of submitting to NHS England by the due date.

**Summary**
The Committee is asked to:

- approve the process for identifying vulnerable practices, assessing their needs and allocating funding – see Appendix 1
- comment and/or agree suggestions put forward for the use of GP Resilience Programme Funding. Summary proposals to be submitted to NHS England by 19th September 2016.

Helen Delaitre
2nd September 2016

**Appendix 1**

# Chiltern and Aylesbury Vale CCGs Vulnerable Practice Scheme

August 2016

# Vulnerable Practice Scheme

## Background

In December 2015, a programme was announced by NHS England to secure improvements in vulnerable GP practices to help build resilience in primary care and to support delivery of new models of care. This scheme is intended to provide support to practices under pressure ensuring patients have continued access to high quality care.

NHS England has therefore been allocated the sum of £34,538 each for both Chiltern and Aylesbury Vale CCGs from the Vulnerable Practice programme for use in 2016/17.

Support to practices is to be provided by external providers and is in addition to, not instead of, the existing flexibilities available to commissioners under Section 96 of the 2006 NHS Act. This funding is also in addition to the recently announced *General Practice Resilience Programme* (GPRP), which will be making £40m available nationally over the next 4 years.

This means that in the medium term, the CCG will be able to provide a range of support activities to primary care that are fully funded using either Vulnerable Practice or GPRP funding.

## NHS England criteria to identify vulnerable GP practices

Potentially, notification that a practice is getting into difficulty may come from a variety of routes: locality leads, commissioning colleagues, NHS England or the practice themselves.

To encourage a standardised approach, a national procedure to determine the overall vulnerability of a practice has been drawn up.

The criteria seek to chart a middle route between those aspects that are measurable and those less tangible issues which can have a significant impact on the operation of a practice.

| Domain | Criteria | Description and rationale for inclusion |
|---|---|---|
| **Safety** | | |
| 1. | CQC rating – inadequate | A practice rated as inadequate by the CQC is already directed to the RCGP scheme which is analogous to the proposed approach. It is not proposed that this is changed but is included within the criteria for the sake of completeness. |
| 2. | CQC rating - requires improvement | A practice rated as requiring improvement where there is greatest concern (e.g. just short of inadequate) should be offered support. Issues will be more intractable or have significant impact on the operation of the practice. This also applies to any patient safety issues identified as requiring improvement. |
| 3. | Individual professional performance issues | This reflects that sometimes practices where a professional is having performance issues can have an impact on the overall performance of the practice. |
| **Workforce** | | |
| 4. | Number of patients per WTE GP | This criteria is to reflect the significant workload facing a practice in this situation, which of itself is not an indicator of a vulnerable practice as this may be ameliorated by a significant number of practice nurses or nurse practitioners. |

| | | |
|---|---|---|
| 5. | Percentage of GP sessions not routinely filled (include long term illness) | This is a key indicator of a practice that is vulnerable. |
| **Efficiency** | | |
| 6. | QOF % achievement | This is often used as a short hand measure of how well a practice is operated.<br>The vast majority of practices score well above 90% with average 94% achievement. Just 500 practices score under 80% achievement, 100 practices score under 65% achievement. 21 practices achieve a score which is half of England average achievement (47%). |
| 7. | Referral or prescribing performance compared to CCG average | It is proposed that this is flagged as a risk where a practice is in the upper quartile for aggregate prescribing performance compared to the CCG average and the same measure for GP referrals. |
| **Patient Experience/ access** | | |
| 8. | List closure (including application to close list) | This criteria is akin to the practice self-declaring that they have a problem. It is a crude 'measure' however in that the practice may be struggling to meet an increase in demand or it may be a struggling practice unable to managing its current demand. It will be important to consider the reasons for list closure. |
| 9. | GP Patient Survey - Would you recommend your GP surgery to someone who has just moved to your local area? (% no). | This is one of a set of patient experience criteria that could be usefully included. Patient advocacy is known to correlate with good quality care. |
| 10. | GP Patient Survey – ease of getting through by phone (% not at all easy). | Could be usefully included in that it provides an early indication where problems with matching capacity and demand are starting to be reflected in the results. |
| **Organisational Issues** | | |
| 11. | Practice leadership issues (partner relationships) | This is a key criteria but difficult to define so will be for local commissioners to reflect a risk rating against this and provide justification. |
| 12. | Significant practice changes | It is self-evident that this increases the vulnerability of the practice where a practice is splitting, less so for a practice merging which may be to for positive reasons and may make local practices stronger and more resilient. |
| 13. | Professional isolation | This is a self-evident criteria, but there are many resilient single handed practices that continue to operate successfully. However by definition a single handed practice has less resilience than a larger practice. Again it would be for local commissioners to reflect a risk rating against this. |
| **External perspective** | | |
| 14. | Other external perspectives not | This is a key criteria. The risk score increases dependent upon how many local external bodies have significant |

| | | |
|---|---|---|
| | covered in the above criteria, for example significant concerns from LMC, CCG or NHS England | concerns. |
| 15. | Primary Care Web Tool – negative triggers | Using this tool and in particular those practices that trigger 5/6 or more negative indicators provides an indication of some issues in a practice. |

The range of criteria will be used as a screening tool to identify practices that could potentially become a cause for concern and would benefit from additional support. A standard risk matrix will then be applied to the assessment to determine the impact and likelihood of vulnerability (see Appendix A).

The outcome of the review process will be recorded and signed off by the Primary Care Commissioning Operational Group GP Lead for Quality.

### Types of support available

The aim of this scheme is to assess and treat the causes of vulnerability, securing practice improvement and building longer term resilience rather than deliver short term quick fixes and therefore support may include:

- Diagnostic services so improvements can be identified and understood
- Specialist advice and guidance e.g. HR, management, finance, IT
- Coaching, supervision or mentorship
- Practice management capacity and support.
-

NHS England are working to deliver a sustainability and resilience procurement framework for primary care by October 2016, which is not mandatory but will speed up local ability to secure support from a range of providers. In the meantime, once support packages are identified and agreed, NHS England has published a list of potential sources of support that the CCG can access (see Appendix B).

### Developing a support package

Where a practice has been deemed to be vulnerable and agrees to participate in the scheme, the practice will work with the CCG/NHSE to complete an Improvement Plan[2].

The principle of the Vulnerable Practice Scheme is that practices should be co-investors in their future and therefore in the first instance, practices will need to agree with the package of support offered and demonstrate their commitment to the scheme and match any financial contribution from the CCG with a contribution “in kind”. Practices can opt to commit to the process by agreeing for staff to be released to attend courses or agreeing to fund venues for training. However, it is up to the practice and the CCG/NHSE to agree the type and level of contribution.

Once agreed, the plan will be assessed to identify actions that could be supported using the Vulnerable Practice Scheme and the practice will be asked to approve the actions and submit their proposals for matching in kind.

[2] NHSE has compiled a useful step by step guide to support practices in developing their improvement plan.

### Support package approval process

For Aylesbury Vale CCG, the CCG's Primary Care Commissioning Committee will approve/sign off support packages. It is likely that the Committee will delegate responsibility for this function to the Operational Group.

For Chiltern CCG, the NHS England Primary Care Commissioning Quality Group will approve/sign off support packages.

### How to access the funding

Once the support package has been approved, the CCG/NHSE will source/contact potential providers of support, brief and obtain quotations for services and select a provider. External providers of support services will invoice the CCG direct for services provided.

### Monitoring

CCGs will be required to report support activity and financial expenditure to NHS England on a monthly basis using the template provided. Progress will also be monitored at the Primary Care Commissioning Operational Group.

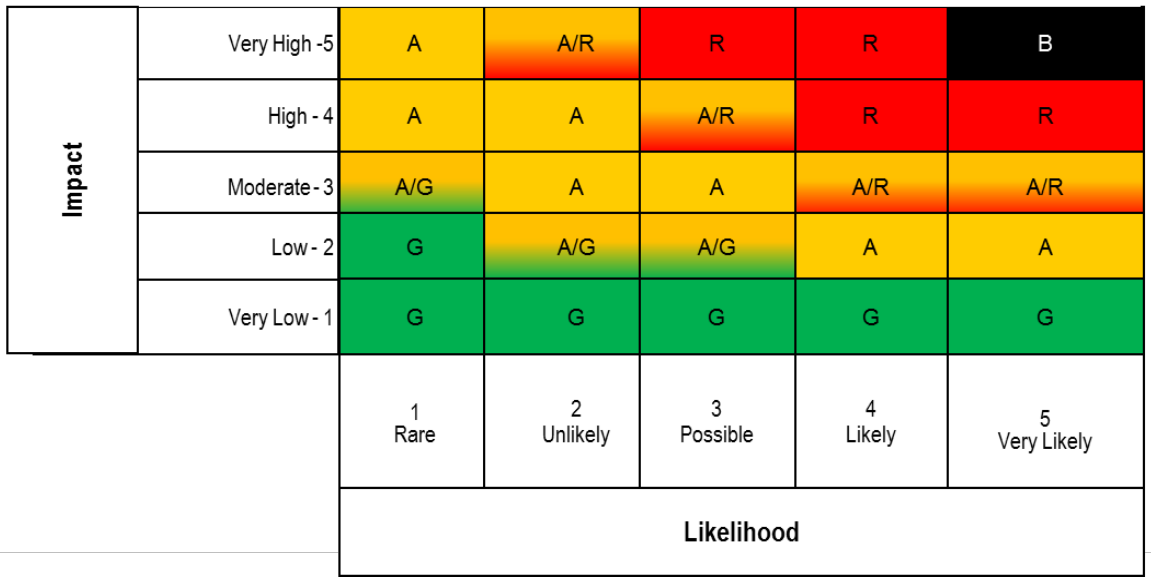
Appendix A

## Vulnerability Risk Matrix

1. Following assessment using the criteria, practices can be scored using the vulnerability risk matrix.

2. Practices should be scored between 1-5 for both likelihood of vulnerability and impact of vulnerability. Descriptions of likelihood and impact scoring are provided.

3. The outcome and rationale behind the score should be recorded for each practice.




## Risk Matrix Description: likelihood scoring

| **Category** | **Likelihood Scoring** | | | | |
|---|---|---|---|---|---|
| **Likelihood Score** | 1 | 2 | 3 | 4 | 5 |
| **Descriptor** | Rare | Unlikely | Possible | Likely | Very Likely |
| Frequency/what is the likelihood of the practice falling into significant difficulties | This probably will never happen/ recur | Do not expect it to happen / recur, but it is possible it may do so | Might happen or recur occasionally | Will probably happen/recur, but it is not a persisting issue or circumstance | Very likely to happen/recur; possibly frequently. |

### Risk Matrix Description: impact scoring

| **Category** | **Impact Scoring** | | | | |
|---|---|---|---|---|---|
| **Likelihood Score** | 1 | 2 | 3 | 4 | 5 |
| **Descriptor** | Very Low | Low | Moderate | High | Very High |
| How serious are the practice difficulties? | - Minor difficulties<br><br>- No or minimal effect for patients<br><br>- No or minimal effect for staff | - single difficulty<br><br>- low effect for a small number of patients if unresolved<br><br>- low effect on practice and staff | - repeated difficulties<br><br>- moderate effect for multiple patients if unresolved<br><br>- moderate effect for practice and staff in unresolved | - ongoing serious difficulties<br><br>- significant effect for numerous patients if unresolved<br><br>- significant effect for practice and staff if unresolved | - difficulties leading to failure to meet national standards with unacceptable levels of quality of treatment or service<br><br>- very significant effect for a large number of patients if unresolved<br><br>- very significant effect for practice and staff if unresolved. |

Appendix B

# Potential sources of support

This list is intended to help inform decisions about securing support to improve. Entry on the list does not constitute a recommendation or commitment to provide funding.

Practices may benefit from the support of a wide variety of people and organisations. In many cases, they will want to seek others' input to help compile a coherent package of support, while, in others, a more piecemeal approach will be appropriate. CCGs have a significant role to play in stimulating the development of support offers to help practices innovate and improve. These may combine in-house and external resources, depending on local circumstances. Some CCGs have already contributed to the creation of locally based expert teams and systems for sharing experience between practices. Others are beginning to work with national organisations to support practices directly or build local capabilities. It is likely that every CCG will need access to both local and wider expertise to help all practices improve quality and transform services for the future, and development of the right capacity and capabilities this will need to be an area for detailed planning and investment over coming years.

### Local sources of support

| Organisation | Expectations |
|---|---|
| Local Medical Committee | Provide professional leadership, promoting the identification of solutions which put the needs of local patients first.<br><br>Support the identification of solutions and sources of support for the practice. Provide support and mentoring to leaders of the practice.<br><br>Offer brokerage of discussions between local practices about solutions involving collaborations. |
| Other local practices, including networks or federations where relevant | Identify how they can support the practice, working with NHS England/CCG - for example by sharing practice management, practice nurse or other expertise.<br><br>Seek to build collaboration in the best interests of local patients. |
| Health Education England | Offer personal mentoring schemes to support quality improvement. |
| RCGP Faculty | Offer personal mentoring schemes to support quality improvement. |

| | |
|---|---|
| Health and Wellbeing Board | Potentially contribute to discussions about the future of local community based health services, where practice performance issues raise these.<br><br>Contribute to discussions about new premises solutions. |
| Local authority | Provide advice and support to improve services they have commissioned from the practice, where relevant. |
| Patients and the public | Can contribute ideas and practical support, and are often very keen to champion their practice. |

### National & commercial sources of support (listed alphabetically)

| Organisation/company | What they can help with | Further details |
|---|---|---|
| CHEC | Practice development support, for example root cause analysis, improvement development plans, education and training, mentoring, and facilitated away days. | www.chec.org.uk |
| GP Access | Redesigning GP access using the Stour Access model | www.gpaccess.uk |
| Health and Social Care Information Centre | A suite of resources and guidance about effective governance and systems, especially around records. | www.hscic.gov.uk/standards |
| Third sector organisations | A number of third sector organisations offer resources such as best practice guidance and staff training on specific issues. | |
| Medical indemnity providers | The indemnity providers are able to provide a range of services, including advice on best practice and staff training. | |
| NHS Employers | Resources to support workforce planning and best practice in HR. | www.nhsemployers.org |
| National Association of Patient Participation | Support for PPGs which could contribute to improvement plan and deliver perspective on performance | www.napp.org.uk |

| | | |
|---|---|---|
| National Care Forum | Providing links to various organisations that can provide toolkits for working with patients (hard to reach/marginalised groups etc.) | www.nationalcareforum.org.uk |
| NCAS | Expert advice and support, clinical assessment and training for staff who give cause for concern. | www.ncas.nhs.uk |
| NHS England | 'Releasing Capacity in General Practice' which may provide some additional models to consider for sustainability. | https://www.england.nhs.uk/ourwork/qual-clin-lead/pressure-in-gp/case-studies/ |
| NHS Improving Quality | Productive General Practice. A guided practice development programme focusing on teamwork and service redesign using Lean principles. | www.nhsiq.nhs.uk |
| Personal Strengths Ltd | Team development, conflict resolution, leadership development | www.personalstrengthsuk.com |
| PCC | Access to interim practice management/business management. Facilitation for planning and direct support. Free best practice resources. Training workshops, events and e-learning. | www.pcc-cic.org.uk |
| Practice Management Network | A national community run by practice managers for practice managers. The Network offers support and opportunities to share, develop and influence. | www.practicemanagement.org.uk |
| Primary Care Foundation | Support to measure and understand urgent workload. | www.primarycarefoundation.co.uk |
| Productive Primary Care | Redesigning GP access using the Stour Access model ('Doctor First' programme) | www.productiveprimarycare.co.uk |

## Appendix 2

**BRIEFING PAPER**

**General Practice Forward View – Supporting Programmes**

General Practice Forward View was published in April 2016 recognising that general practice is under increasing pressure and it outlined a number of programmes to support general practice to become sustainable and provide enablers so primary care is better able to play its part of the transformation of health and social care system.

At the July 2016 NHS England Board meeting the details, funding and timetable for implementation of these programme was announced and these are now published on the NHS England website https://www.england.nhs.uk/ourwork/gpfv/ . This briefing paper provides the headlines for each of the programmes and the actions required, enabling funding to flow through to practices to support them now and in the future.

**A. General Practice Resilience** https://www.england.nhs.uk/ourwork/gpfv/resilience/

Funding has been identified for the next four years to help struggling practices under the General Practice Resilience Programme. Nationally this is £16m, £1.05m for South Central for 16/17. The programme aims to provide support for struggling practices by delivering local resources, which may include local resilience teams or pools of experienced GPs and other practice staff, to help with practice management, recruitment issues, and capacity. A menu of supporting organisations is being developed as a part of a national call off framework, which should be available in the autumn, but in the meantime we need to identify which practices need support and what that support consists of to help plan and implement changes that will support practices become more sustainable and resilient. This builds on the work CCGs and NHS England have developed under the Vulnerable Practice scheme.

**Key Actions and Timelines**

1. Named contact to be identified as the lead for your CCG
2. Commitment to report monthly on progress as per timetable for Vulnerable practices and key milestones below:
   a) **By 19th August** – proposals for how NHSE/CCG intend to deliver the menu of support will be developed and shared with CCGs, LMCs and RCGP leads. Essentially this will be an outline of your proposals for going further faster with your current plans with vulnerable practices, identify other practices who may need support or how you will add/or replace these arrangements to secure the wider menu for practices.

   b) **By 19th September** – decided on your local approach, practices selected for support and offers made to them.

c) **By mid-October** – any practices in urgent need not receiving support via vulnerable practice scheme should have begun to receive support (this could include Section 96 funding ahead of your delivery arrangements being in place).

d) **By 10th October** – confirmation that practices needing support in 16/17 have an agreed offer and the budget is fully committed to individual practices.

e) **By end of December** – evidence of spend and outcomes from commitments to individual practices.

In addition to the resilience programme for practices there is the procurement for **NHS GP Health service** https://www.england.nhs.uk/ourwork/gpfv/resilience/gp-health/ will improve access to mental health support for general practitioners and trainee GPs who may be suffering from mental ill-health including stress and burnout. Once the service is procured it is expected to be available by the end of 2016.

**B. General Practice Development Programme** https://www.england.nhs.uk/ourwork/gpfv/gpdp/

This programme will support practices to manage their workload differently, freeing up time – **Time for Care** – for GPs and improving care for patients. This will help practices implement proven innovations, including **online consultations,** that others have already found useful and that we have expressed as 10 High Impact Actions. In turn, this will help practices lay the foundations for new models of integrated care, and play their part in delivering a sustainable and high quality NHS as part of the STP process in which general practice has a key role.

The menu of support from this programme

1. **Releasing time for care.** National resources and expertise will help groups of practices plan their own Time for Care programme. This will help you use proven innovations from the Ten High Impact Actions quickly, safely and sustainably. Your programme can be tailored to meet local interests and plans.
2. **Building capability for improvement.** Free training and coaching will be provided for clinicians and managers to grow confidence and skills in using improvement science and leading change. In addition, we will support a new national primary care improvement community, spreading and accelerating innovation, improvement and transformation.
3. **Training for reception and clerical staff.** The programme is providing funding via CCGs towards training for receptionists to play a greater role in active signposting and for clerical staff to manage more incoming correspondence. Over the next five years, a typical 10,000 patient practice could receive around £7,500 towards training and backfill costs.

4. **Practice manager development.** Working with practice manager leaders, the programme will support networking between managers at a local and national level, to share successful ways of managing workload and provide peer-to-peer encouragement and support.
5. **Online consultation systems.** From April 2017 the programme will provide funding via CCGs towards the cost for practices to install an online consultation system, helping GPs spend more time doing what only they can do.

In terms of actions CCGs may wish to consider a state of readiness assessment and then submit an expression of interest which can be found on the website, these can be submitted through to August 2018. Go to https://www.england.nhs.uk/ourwork/gpfv/gpdp/releasing-time/ and there is a page which covers actions that the CCG can take https://www.england.nhs.uk/ourwork/gpfv/gpdp/ccg-help/

There are also a number of webinars which will provide further details about the programmes and opportunity to hear more about how a Time for Care programme can benefit your practices and federation; what each component of the programme is; how to prepare for success and how your development advisor can work with you to design a tailored programme. You will also have the chance to learn about the General Practice Improvement Leader Programme and how it could benefit clinicians and managers in your area

- Monday 8 August 2 – 3pm
- Monday 22 August 1 – 2pm
- Monday 5 September 7 – 8pm
- Monday 26 September 6 – 7pm
- Monday 10 October 7 – 8pm
- Monday 31 October 1 – 2pm

Nicky Wadely
Programme Manager Co-commissioning
NHS England (South Central)

August 2016

**Agenda item 9: Paper E**

## Primary Care Commissioning Committee

**Date:** 8 September 2016

**Title:** Quality Report - Primary Care Safeguarding

| **Purpose of Paper** |
|---|
| To inform the Primary Care Commissioning Group on current primary care focused safeguarding assurance, challenges and developments in the Buckinghamshire area. This is a themed update produced by the NHS England South Central Nursing Team. |

| **Executive Summary** |
|---|
| **Key areas to highlight:**<br>• All key Buckinghamshire health safeguarding posts are in place and well established<br>• Recent primary care safeguarding audit received a response rate of 34 out of 53 practices, a 64% return with good assurance achieved<br>• CQC inspections of primary care have a focus on safeguarding practice<br>• The Ofsted inspection 2014 identified Buckinghamshire children's services and the Safeguarding Children Board as Inadequate<br>• There is a strong health Network in place for safeguarding professionals in the Buckinghamshire health community<br>• There are a range of health focussed safeguarding developments/training events being delivered in 2016/17<br><br>**Assurance**<br>This paper provides assurance that Primary Care focused health services are discharging their duties in relation to safeguarding children and vulnerable adults at risk. The Ofsted inadequate judgement is of note though there is good assurance that remedial action is being taken.<br><br>**Improvements/Developments**<br>• Identified development work arising from the Ofsted Inspection, Primary Care CQC inspections and local audit as described within this paper<br>• Addressing identified challenges around improving communication with local authority services and primary care, embedding adult safeguarding requirements as per the Care Act 2014 |

| **Actions Required** |
| --- |
| For information / assurance |

| **Objectives supported by this Paper (Please Tick)** | |
| --- | --- |
| Support realisation of the primary care strategy | **X** |
| Support delivery of in-year performance and the financial plan | |
| Supports quality agenda | **X** |
| Support development of the CCG to take on the primary care commissioning role | **X** |

# Joint Primary Care Co-Commissioning Group Quality Report – Primary Care Safeguarding

# NHS Aylesbury Vale and Chiltern CCGs Quarter 2 2016/17

## EXECUTIVE SUMMARY

This report informs the Joint Primary Care Co-Commissioning Group (JPCCC) on current primary care focussed safeguarding assurance, challenges and developments in the Buckinghamshire area. This is a themed update produced by the NHS England South Central Nursing Team.

### Key areas to highlight:

- All key Buckinghamshire health safeguarding posts are in place and well established

- Recent primary care safeguarding audit received a response rate of 34 out of 53 practices, a 64% return with good assurance achieved

- CQC inspections of primary care have a focus on safeguarding practice

- The Ofsted inspection 2014 identified Buckinghamshire children's services and the Safeguarding Children Board as Inadequate

- There is a strong health Network in place for safeguarding professionals in the Buckinghamshire health community

- There are a range of health focussed safeguarding developments/training events being delivered in 2016/17

### Assurance

This paper provides assurance that Primary Care focused health services are discharging their duties in relation to safeguarding children and vulnerable adults at risk. The Ofsted inadequate judgement is of note though there is good assurance that remedial action is being taken.

### Improvements/Developments

- Identified development work arising from the Ofsted Inspection, Primary Care CQC inspections and local audit as described within this paper

- Addressing identified challenges around improving communication with local authority services and primary care, embedding adult safeguarding requirements as per the Care Act 2014

**Introduction & Context**

1.1 The purpose of this report is to inform the Joint Primary Care Commissioning Committee (JPCCC) and or Primary Care Operational Group (PCOG) on current primary care focussed safeguarding assurance, challenges and development in the Buckinghamshire area. This is a themed update produced by the NHS England South Central Nursing Team.

1.2 NHS England, as with all other NHS bodies has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children, young people, and vulnerable adults. From a safeguarding assurance responsibility perspective, the NHS England South Central team ensures it is appropriately engaged in the Local Safeguarding Boards and any local arrangements for safeguarding both adults and children, including effective mechanisms for Local Safeguarding Children Boards (LSCBs), Safeguarding Adult Boards (SABs) and Health and Wellbeing Boards to raise concerns about the engagement and leadership of the local NHS if indicated.

1.3 The South Central team approach is in line with the duties and approach set out within the NHS England Safeguarding Policy (2015) and NHS England Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (2015).

1.4 Safeguarding is a complex area for health with a wide scope of challenges and emerging needs. Alongside general safeguarding requirements the following areas are current priorities for NHS England and health partners:

- Children's Sexual Exploitation related safeguarding
- Awareness of and statutory reporting of Female Genital Mutilation
- Awareness and reporting of PREVENT (anti radicalisation) related information
- Implementation of Adult safeguarding requirements as mandated in the Care Act 2014
- Modern Slavery/Human Trafficking
- Looked after Children

**2. Current safeguarding infrastructure in Buckinghamshire**

2.1 The list below details the key safeguarding roles in terms of named individuals/functions within the local health community, Clinical Commissioning Groups (CCGs) and the independently chaired multi agency safeguarding adult and safeguarding children boards that they participate in:

- Designated Nurse CCGs (Adults/Children) – Tania Atcheson
- Designated Doctor - Dr Lesley Ray
- Named GPs - Dr Nicola Widginton and Dr Sarah Abbas
- Child Death Overview Panel (CDOP) officer – Hilary Walker
- CCGs Safeguarding Adults manager – Vikki Gray

- LSCB Buckinghamshire Safeguarding Children Board Chair - Fran Gosling - Thomas

- LSAB Buckinghamshire Safeguarding Adult Board Chair – Marie Seaton

The above list of professionals gives good assurance in that there are no vacant or interim posts for these important safeguarding roles.

2.2 CCG directors of nursing/quality take executive leadership for safeguarding. Primary care is approached as a shared responsibility alongside CCG leads with the NHS England South Central quality team. In the Thames Valley area John Trevains Assistant Director of Nursing and Sheila Jenkins lead nurse for safeguarding (supported by Helen Chrystal for Bath & North East Somerset, Gloucester, Swindon and Wiltshire) support CCG leads, provide advice and oversight to primary care colleagues inclusive of disseminating learning from serious case reviews (or similar investigations).

2.3 It is important to note that all allegation management issues regarding Primary Care in Buckinghamshire are managed via the NHSE South Central team. This is completed in conjunction with the NHSE South Central Medical Director and the Primary Care Commissioning team. This includes allegations about medical and practice staff.

2.4 Complaints that are reported to NHSE are screened locally for potential safeguarding issues and are managed accordingly.

**3. Primary care responsibilities**

3.1 All health practitioners have a duty under *Working together to safeguard children* (2015) to participate in effective safeguarding of children at risk of harm or abuse. The relatively recent introduction of the Care Act (2014) in April 2015 has also made it a statutory duty for health services inclusive of primary care to be actively involved and mindful of safeguarding adult's requirements.

3.2 GP practices with regard to safeguarding are a partner agency of their local authority and are a key contact between the local authority children, young people adults who are at risk of harm. They therefore have an important role in safeguarding. Practices have a legal duty to:

- Work in a way that safeguards children and vulnerable adults

- Ensure GPs and other practice staff understand how important it is to identify at the earliest possible stage, children and vulnerable adults in need of safeguarding
- Ensure that suspicions or allegations of harm are dealt with appropriately
- Work effectively with multi-agency partners

An informative and useful guide to the role and responsibilities of safeguarding and general practice produced by the *Family Doctor Association (2016)* is attached in **Annex 1** of this paper. The NHSE South Central team is using this document in its safeguarding promotion activities with General Practice.

3.3 Alongside General Practice a wide range of health professionals have a critical role to play in safeguarding and promoting the welfare of children and adults inclusive of Dentistry, Pharmacy, Optometry and other primary care based health professionals.

**4. Primary Care Assurance information**

4.1 The following section details safeguarding related quality assurance data available for Buckinghamshire. This consists of the Care Quality Commission (CQC) inspection information, audit data obtained by the joint NHSE and Buckinghamshire CCG Primary Care safeguarding audit and the joint Ofsted inspection of children's service in 2014.

4.2 The Care Quality Commission (CQC) regulates primary care services inclusive of GP practices. There is a programme of CQC inspection of practices. Safeguarding related compliance is included as part of the CQC inspection process. This information is used as part of the NHSE quality monitoring of primary care.

4.3 **CQC Inspections Buckinghamshire August 2015 – July 2016**

The following information is the themed feedback from CQC inspections in the previous 12 month period. A total of **25** practices have been inspected in this period out of a total of 53 practices in Buckinghamshire.

<u>Safeguarding related good practice</u>

- Staff are actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place.
- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements, and policies were accessible to all staff.
- The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.
- There was a lead member of staff for safeguarding. GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.
- Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- Safeguarding related themes where improvement is needed
- The practice had in place ways to raise safeguarding issues and discuss these at staff meetings however these were not always followed-up and there was a lack of trend analysis, leading to a lack of learning from investigations.
- Most staff had received relevant role specific training on safeguarding with the exception of a few clinical staff.
- Not all staff undertaking chaperoning duties had undergone a DBS check.

Where remedial action is required this is included within the practice action plan for completion.

4.4 **NHSE South Central and Buckinghamshire CCG Primary Care audit**
The Aylesbury Vale and Chiltern CCGs and NHSE safeguarding team have been working with primary care practices to develop an understanding of safeguarding needs and issues. To achieve this, a self-assessment audit of safeguarding practice has been undertaken in CCGs across the South Central region in 2016 inclusive of Thames Valley.

4.5 The aim of the audit was to assess safeguarding practice for adults and children, based on section 11 of the Children Act and the Care Act 2014 and to identify areas for development. An audit tool was designed by a team of Named GPs in the Thames Valley Safeguarding Network, supported by NHS England. Practices were asked to assess themselves and rate their practice under the safeguarding standards statements as red, amber or green (RAG rating); and to identify evidence demonstrating compliance and areas for development with a timeframe for achieving this. Analysis is underway across South Central to identify areas in which practices need continued support and to identify training needs.

4.6 Responses were received from 33 out of 53 practices, a 64% return which is considered a reasonable response rate. The overall result was that all participating practices were able to present evidence of compliance and good practice in each of the standards. Within the sub sections there were identified areas for improved and further development. The following section details the themes from the analysis of the audit data.

**Themes from the analysis:**

***Training needs:***
In general, practice self-assessment of training levels was good in core safeguarding knowledge. The issues raised and the areas for development were focused on requiring further training in specific areas of safeguarding knowledge (PREVENT strategy, child sexual exploitation, female genital mutilation, Mental Capacity Act, and Deprivation of Liberty Safeguards). These are emerging areas of knowledge development required because of local and national strategic drivers. Practice safeguarding leads identified that they would benefit from support to disseminate training to all practice staff, including non-clinical staff.

***Policy development*:**
Safeguarding leads highlighted the need for more rigorous practice policies in some areas, particularly adult safeguarding, and policies around practice members contributing to case conferences. The Children Act identifies seeking feedback from children and young people as good practice, and several practices identified a need to help develop this, as it is not generally embedded in GP practice culture.

***Record keeping:***
Issues related to the complexity of record keeping in safeguarding situations, for example how to minute all safeguarding discussions and case reviews, and a need for clearer guidance around record keeping and information sharing in split families.

***Discussion on audit data:***
This was a self-assessment exercise. The RAG rating, while helpful for practices to define areas where they would like to improve, is very subjective. It is evident that there is wide variation in safeguarding need across different practices in the county, and some practices have very much more developed systems in place. It was felt that some practices assessed their own performance harshly.

***Actions taken by the CCG as a result of this audit:***

- CCG lead will discuss main audit themes at the next Practice Safeguarding Leads training sessions in the Autumn and continue to offer support to individual practices where the audit or CQC inspection report indicates further help is required

- CCG is in the early stages of developing a safeguarding training programme with BHT that will enable health professionals from different providers including GPs to understand how by working closely together they can improve outcomes for children, families and the more vulnerable adult population

- The CCG has made improvements in the information sharing between social care and GP practices and the escalation process is working well to address individual practice issues. We now are going to improve the GP contribution to child protection conferences through appropriate reporting

4.7 **Ofsted Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board**

Between 3 June 2014 and 25 June 2014, Ofsted inspectors looked closely at the experiences of children and young people who had needed, or still needed help, protection, or both of these. This included children and young people who were looked after and young people who were leaving care and starting their lives as young adults.

4.8 The overall judgement made was that both the Buckinghamshire children's services and the LSCB were inadequate. The report identified key areas for improvement and an Improvement plan for both children's services and the LSCB continues to be monitored by the Ofsted Improvement Board which initially met monthly and now meets bi monthly. Further work has been undertaken to understand the impact that the Improvement Board and the Improvement Plan has had on safeguarding children.

4.9 This has led to improvements in multi-agency working and in service delivery which aims to ensure that children in Buckinghamshire are adequately safeguarded. Health partners in the CCG and in provider services have worked with the Local Authority and the safeguarding board to improve the services provided for example in the Multi agency safeguarding hub and have been involved in the development of the Swan Unit. Health staff are active and committed members of the safeguarding board.

4.10 Key areas of focus for health going forward following Ofsted learning have been improving the knowledge of multiagency thresholds for intervention, the quality of health referrals to the Local Authority and greater participation in Early Help interventions.

**5**. **Safeguarding Networks – Buckinghamshire & Thames Valley**

5.1 NHS England South Central facilitates a safeguarding network for named and designated safeguarding professionals from CCGs across the Thames Valley region. The Network is well attended by Buckinghamshire health professionals. This forum's focus is on:

- Sharing strategic safeguarding concerns
- Identify common themes, trends and early warnings
- Identify safeguarding concerns that may need to be escalated
- Identify areas of work that could benefit from regional or national input
- Provide a forum where professionals can share good practice, developments and experiences
- Share lessons learnt from Serious Incidents, Serious Case Reviews, Independent and Multi-Agency Investigations
- Provide up to date information and guidance from a national and regional perspective.
- Promote clearer partnership working
- Support localities across the region to achieve the key standards and embed new NHS policies and Government guidance

5.2 Within Buckinghamshire a Countywide health group meets quarterly and brings together all named professionals for safeguarding and children looked after. This group is facilitated by the designated professionals to share good practice, develop shared procedures and raise issues and concerns that require joint health actions. Strategic issues from this group are then escalated and operational ones disseminated creating a good level of health communication within the safeguarding network. Primary care issues are brought by the named GPs who have heard the issues and concerns through their networks and at their regular locality based safeguarding leads meetings.

5.3 The CCGs oversee both adult and child safeguarding activity in health services in Buckinghamshire via a Strategic Safeguarding Steering Group which meets monthly with quarterly attendance by health partners. This group has noted a significant improvement in partnership working, clinical collaboration and leading to better outcomes for the child.

**6. Key Challenges for Safeguarding in Buckinghamshire**

6.1 Safeguarding will remain a complex and challenging area for primary care services. Within Buckinghamshire issues around embedding the practical

requirements of adult safeguarding in primary care have been identified as a challenge, further work is required on this for example in the areas of self-neglect and mental capacity assessments and dementia awareness

6.2 From discussions with Buckinghamshire colleagues further work is required on improving communication between GP practices and Local Authority children's services to improve shared understanding of roles and responsibilities once assessments have been completed and action plans created.

6.3 The BSCB currently has one Serious Case review completed but not yet published, a second in progress to go to the Board in October and a third recently commissioned to be started. The BSAB currently has one safeguarding adult review underway and a Domestic Homicide review underway. Primary Care reviews for Serious Case Reviews are written by the named GPs and the action plans are monitored by the CCG Designated nurse and the NHS England safeguarding lead. Learning is disseminated through the safeguarding leads meetings and at learning events.

6.4 Working with children's services and a safeguarding board which require improvement continues to be a challenge, but one to which health staff have shown commitment and the drive to improve outcomes for children.

6.5 The Safeguarding Adults Board has a new chair and currently no business manager which may have an effect on the efficient running of the Board.

**7. Future Plans and actions**

7.1 As previously reported in this briefing work is be actioned in response to the learning and issues identified within the assurance information from primary care CQC inspections, audit and Ofsted related actions.

7.2 To support the above the NHSE team will continue to work alongside Buckinghamshire CCG colleagues. This will include activity via the Thames Valley Health professional safeguarding Network. There will also be more work directed to wider primary care professionals to offer training opportunities for pharmacy, dental and optometry. It is planned to repeat the Primary Care Audit seeking engagement from practices that did not participate previously.

7.3 NHSE South Central has a programme of safeguarding training and development initiatives for 2016/2017. This is utilising national NHSE safeguarding development funding. For Buckinghamshire development funding will be providing and supporting:

- CSE workshops provided by an award winning national group
- Designated doctor/nurse Safeguarding investigation report writing training
- Level 4 Children's/Adults Safeguarding Training Days

**8. References**

NHS England (2015) *Safeguarding Policy*

NHS England (2015) ***Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework.***

Intercollegiate Document (2014**)** ***Safeguarding Children and Young people: roles and competences for health care staff***

Family Doctor Association (2016) ***Member Fact Sheet No. 42 Safeguarding in GP practices***

NHS
Aylesbury Vale
Clinical Commissioning Group

| **Purpose of Paper** |
|---|
| To update the committee on the financial position for month 4 of 2016/17 for the delegated Primary Care Services joint commissioning budget of Aylesbury Vale CCG. |

| **Executive Summary** |
|---|
| The position at month 4 is a favourable variance of £72k against plan. |


| **Executive Summary** |
|---|
| The position at month 4 is a favourable variance of £72k against plan. |


| **Objectives supported by this Paper (Please Tick)** | |
|---|---|
| Support realisation of the primary care strategy | |
| Support delivery of in-year performance and the financial plan | |
| Supports quality agenda | |
| Support development of the CCG to take on the primary care commissioning role | ✓ |

NHS England

# Joint Commissioning Primary Medical Services Committee

**Report to the Primary Care Commissioning Committee – Aylesbury Vale CCG**

**Prepared by:** Alan Overton, NHS England South (South Central), Finance Analyst

**Classification:** OFFICIAL

The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

## 1. Introduction

1.1. This paper sets out the financial position for month 4 of 2016/17 for the delegated primary care services joint commissioning budget of Aylesbury Vale CCG.

| Aylesbury Vale CCG | Month 4 | | | Year to Date | | | Full Year | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **GP Services 16/17** | Plan | Actual | Variance | Plan | Actual | Variance | Plan | FOT | Variance | Prior yr |
| | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k |
| GP Contract payment | 1,346 | 1,400 | (55) | 5,382 | 5,445 | (63) | 16,147 | 16,147 | 0 | 0 |
| QOF payments | 194 | 194 | (0) | 776 | 776 | (0) | 2,328 | 2,328 | 0 | 0 |
| GP Seniority and Locums | 46 | 39 | 7 | 183 | 182 | 1 | 550 | 550 | 0 | 0 |
| GP Drug payments | 146 | 67 | 80 | 586 | 566 | 20 | 1,758 | 1,758 | 0 | 0 |
| GP Premises | 229 | 233 | (3) | 917 | 883 | 34 | 2,752 | 2,752 | 0 | 0 |
| GP Enhanced Services | 106 | 110 | (3) | 425 | 390 | 35 | 1,275 | 1,275 | 0 | 0 |
| GP Other Items | 3 | 3 | 0 | 11 | 11 | 0 | 33 | 33 | 0 | 0 |
| CCG Prescribing | 0 | (38) | 38 | 0 | (38) | 38 | 0 | 0 | 0 | 0 |
| Collaborative Fees | 5 | 5 | 0 | 20 | 20 | 0 | 60 | 60 | 0 | 0 |
| GP Premises other | 19 | 17 | 2 | 76 | 69 | 7 | 229 | 229 | 0 | 0 |
| GP General Reserves | 0 | 0 | 0 | 0 | 0 | 0 | 762 | 762 | 0 | 0 |
| **Total** | **2,094** | **2,030** | **64** | **8,376** | **8,304** | **72** | **25,893** | **25,893** | **0** | **0** |

## 2.0 Month Position

The position for month 4 is a favourable variance of £64k.

## 2.1 Year to Date Position

Overall the YTD position is a favourable variance of £72k.

- GP Enhanced Services £35k favourable due to not all practices are signed up to the extended hours service.
- GP Contracts £63k adverse due to unbudgeted MPIG.
- GP Drug payments £20k favourable due to a seasonal variation of costs received which will smooth out during the year when cost change during the autumn/winter flu campaign.
- CCG prescribing £38k favourable due to dispensing practices patients charge income received. It is anticipated that the budget is within CCG Prescribing and this will be transferred during the year.
- GP Premises £30k favourable due to timing of payments and no costs shown for clinical waste. The clinical waste costs have been paid by NHS England so will be recharged to the CCG.

## 2.2 Forecast Outturn

The actual FOT is on plan.

## 3.0 Assumptions on reporting

The figures have been prepared in accordance with the following national guidance:

- Prior year balances/costs will remain with NHS England.
- Accruals will be as per accounting standards and will be to the expected year end outturn position.

## 4.0 Contracting and procurement activity

Mandeville Surgery, Aylesbury - New provider commenced 1st April 2016
Verney Close, Buckingham – Current provider is operating under a temporary contract until 30th September 2016.

NHS England

NHS Aylesbury Vale Clinical Commissioning Group

**Agenda item: Paper G**

# Primary Care Commissioning Committee

**Date** 8 September 2016

**Title** Report from the Primary Care Operational Group

| **Purpose of Paper** |
|---|
| To provide the Primary Care Commissioning Committee with an update from the Primary Care Commissioning Operational Group (PCOG) meetings held on 7 July 2016 and 11 August 2016. |

| **Executive Summary** |
|---|
| **Vulnerable Practice Scheme**<br>The draft policy outlining the criteria for identifying vulnerable practices and allocating funding to these practices was presented to the Group. The funding available for vulnerable practices within Aylesbury Vale CCG will be transferred from NHS England (NHSE) to the CCG for allocation. The CCG will be required to report activity and financial expenditure to NHSE on a monthly basis. Standing agenda item for the Operational Group to ensure a contemporary vulnerable patient list. The PCOG agreed the policy.<br><br>**Terms of Reference**<br>The Terms of Reference were reviewed and updated to include Chiltern CCG. It was noted that the Group will be accountable to the Aylesbury Vale Primary Care Commissioning Committee for matters concerning Aylesbury Vale CCG and to the Federated CCGs Executive Committee and NHSE for matters concerning Chiltern CCG.<br><br>**Delegated Commissioning for Chiltern CCG**<br>Membership engagement has commenced. So far the feedback from members has been largely positive and the CCG expects to seek a members mandate to apply to NHSE for delegated commissioning status in the forthcoming weeks.<br><br>**Application to Establish a Community Education Provider Network (CEPN)**<br>Thames Valley Health Education England (TVHEE) has invited CCGs and GP Federations to express an interest to establish local CEPNs (also known as Training Hubs). Chiltern CCG and Aylesbury Vale CCG have worked closely with FedBucks and TVHEE to submit a formal application. The CCGs expects to hear the result of the formal application during September 2016. If the application is successful a CEPN Board will be established. |

**Releasing Time for Care**
This is a new initiative announced by NHSE following the publication of the General Practice Forward View and is being offered to all practices. The central team will help practices to identify areas of pressure and to look at case studies and solutions adopted in other areas. The aim is to reduce the demand on GP consultations and improve the morale of colleagues working in primary care.

**Estates and Technology Transformation Fund (ETTF)**
NHSE reported that applications for ETTF have been oversubscribed. CCGs priority lists have been passed to the national team for consideration. Feedback from national team expected in September 2016.

**Remedial Notices**
Remedial notices will be issued by NHSE to 2 practices within Bucks who have not completed the required complaints survey. The notices will inform the practices that they have 28 days to complete and return the survey manually.

**Mandeville Procurement**
The Operational Group agreed in principle to recommend extension to the current temporary contract with TPG to enable robust patient / public consultation. TPG have been notified and were agreeable to an extension of the temporary contract based on no changes being made to the existing terms and conditions. The Operational Group will consider new models of care and present a recommendation to the Primary Care Commissioning Committee. CSWCSU to work with the CCG on the procurement process. Further update to be provided to the Primary Care Commissioning Committee at meeting on 8 September 2016.

**Verney Close Surgery / The Swan Practice Update**
A “bridging arrangement” remains in place until the end of September 2016 to ensure that patients are safely managed during the transition period. Verney Close Surgery’s financial arrangements will transfer to The Swan Practice on 1 October 2016. PCSE have been given early notification of the forthcoming bulk transfer of patients.

**Additional Portakabin at Berryfields Medical Centre**
Members of Operational Group recommended that a final decision regarding the additional portakabin at Berryfields Medical Centre is delayed until the outcome of the ETTF process is announced.

| **Actions Required** |
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| For information |

| **Objectives supported by this Paper (Please Tick)** | |
|---|---|
| Support realisation of the primary care strategy | **X** |
| Support delivery of in-year performance and the financial plan | |
| Supports quality agenda | **X** |
| Support development of the CCG to take on the primary care commissioning role | **X** |