NHS England

NHS Aylesbury Vale Clinical Commissioning Group

Primary Care Joint Committee Meeting
Agenda

Monday 14th December 2015, 3.30pm – 5.00pm
Aylesbury Vale CCG Boardroom, 2nd Floor, The Gateway, Gatehouse Road, Aylesbury, Bucks, HP19 8FF

No	Agenda Item	Desired Outcome(s)	Contributor	Papers
1	**Welcome & Apologies**		Graham Smith CHAIR	
2	**Declarations of Interest**		Graham Smith CHAIR	
	Corporate and Governance			
3	**Minutes and Actions Joint Committee Meeting 24th September 2015**	Agreement	Graham Smith CHAIR	PAPER
	Clinical Commissioning			
4	**Care & Support Planning / EoL DES+ progress update**	Information	Louise Smith, AVCCG Locality Business Manager	VERBAL
5	**Care & Support Planning 16/17 Discussion Paper**	Discussion	Louise Smith, AVCCG Locality Business Manager	**PAPER**
6	**Delegated commissioning**	Information	Louise Smith, AVCCG Locality Business Manager	VERBAL
	Operational			
7	**AUA DES+ payment concerns**	Update	Nicky Wadely, Primary Care NHS England South (South Central)	
	Quality & Performance			
8	**Quality Report**	Information	Jan Fowler, NHSE Director of Nursing	PAPER
	Finance			
9	**Finance report**	Information	Colin Hobbs, Assistant Head of Finance (Primary Care), NHS	PAPER

			England South (South Central)	
Infrastructure Development				
10	**Infrastructure report**	Information	Louise Smith, AVCCG Locality Business Manager	**PAPER**

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Primary Care Joint Committee (PCJC)

Thursday 24th September 2015
10.00am – 11.30am
AVCCG Boardroom, The Gateway, Gatehouse Road, Aylesbury, Bucks

Present:

Richard Corbett, Healthwatch Bucks	(RC) **CHAIR**
Dr Graham Jackson, Chairman AVCCG	(GJ)
David Lunn, Lay Member, AVCCG	(DL)
Louise Smith, Locality Business Manager AVCCG	(LS)
Dr Malcolm Jones, GP Clinical Lead AVCCG	(MJ)
Colin Hobbs, NHS England	(CH)
Alison Foster, Director of Quality, AVCCG	(AF)
Ginny Hope NHS England	(GHo)
Gary Passaway, AVCCG Primary Care Manager	(GPy)
James Drury, NHSE Finance Director	(JD)
Dr Stuart Logan- GP Clinical Lead AVCCG	(SL)
Louise Patten, Chief Officer AVCCG	(LP)
Vicki Parker- AVCCG (Minute taker)	(VP)
Dr Paul Roblin- Bucks LMC	(PR)
Dr Rodger Dickson- GP Clinical Lead AVCCG	(RD)
Julie Orrey- C&SP Project Manager AVCCG	(JO)
Jessica Newman- NHSE	(JN)

Apologies:

Jan Fowler, NHS England	(JF)
Robert Majilton, Chief Finance Officer	(RM)
Gary Heneage, NHS England	(GHe)
Katie MacDonald, Health & Well Being Board	(KMc)
Nicky Wadely NHSE	(NW)
Rebecca Tyrell NHSE	(RT
Graham Smith, Lay Member for AVCCG	(GS)
Geoff Payne, NHS England	(GPa)
Debra Elliott, NHS England	(DE)

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Item No.	Agenda Item	Lead
1	**Welcome & Apologies** Members of the Primary Care Joint Committee were welcomed to the meeting and introductions given. Apologies were noted from Jan Fowler, Debra Elliott, Robert Majilton, Gary Heneage, Katie MacDonald, Nicky Wadely, Rebecca Tyrell, Graham Smith and Alan Cadman. The meeting would be chaired by Richard Corbett in Graham Smiths absence. It was agreed that David Lunn would be able to vote in Graham's absence although his position as audit chair was noted.	
2	**Declarations of Interest**. No new declarations were declared from the meeting of 15th June 2015 however, GJ reminded the group he is a GP at Whitehill Surgery SL added he is a GP at Trinity Practice in Brill RD added he is a GP at Norden House in Winslow	
3	**Minutes and Actions of Inaugural Joint Committee Meeting 15th June 2015** Minutes of 15th June agreed as a correct record.	
4	**Care & Support Planning Business Case** LS explained the Care & Support Business Case has been further developed to cover the areas believed by NHSE as needing further clarification. LS explained the concept behind care planning. The first year is about establishing processes and systems and working with patients to understand this new format for general practice consultations. From 16/17 it is anticipated that we will increase the breadth of the scheme to include more LTC's and practice sign up. In AVCCG we have 14 out of 19 practices wanting to do this initiative which covers 150,000 of our 200,000 registered patient numbers. LS explained the specifics of the areas for which NHSE had asked for further clarification: **Stakeholder Involvement**: Patients and Carers have been involved in the set-up of our model. Practices will be expected to get PPG involvement in the programme. We plan to recruit patient champions which will be taken forward when the scheme is fully	

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endorsed. In addition we will use “crowdicity” which is an online forum for patients to use to discuss.

Scheme Evaluation: The first year is about embedding processes like training, engaging PPG’s and amending appointment systems etc. In 2016/17 we will be expecting to see better health outcomes, improvement in QOF outcomes, less exception reporting and an improvement in self-care behaviour. The patient experience will be evaluated via a survey sent through the PPG’s. LS explained how Tower Hamlets had evaluated a reduction in health inequalities by encouraging BME communities to engage with their own health.

Finance- Practices will still work through CQRS and QoF and the templates will have the coding built in to automatically draw out the reports. We will shadow monitor quality through EMIS enterprise. We have looked at other models and Somerset has seen a 5% reduction in their QoF explained as a natural progression when you take away the link between reporting and payment. Through 16/17, if we were to change QoF, it would be through our Diabetes re-design work and we will be looking at what measures make a difference. AVCCG feels this is a minimal spend for good outcomes and change of behavior in General Practice. Once the transition year is over it and practices are implementing it will be cost neutral for practices. AVCCG has committed £350k of funding and there is no additional spend to NHSE under their QoF budget.

Management of Risk: LS explained we have controls in place to reduce the risks, namely:

- Practices have to complete a state of readiness and will be visited by a member of the CCG.
- EMIS enterprise will monitor quality outcomes
- AVCCG risk management system
- Care &Support steering group
- Oversight by the Primary Care Joint Committee

LS asked the membership if they had further questions. LP asked if we can use metrics of population numbers when we talk about numbers of practices/practice take up. SL added 75% of our population has signed up to this.

LP asked about the unknown unknowns? Can we have something in the evaluation about how this will affect GP practice time? LS explained the template has a link to the Quality Reporting Tool which will help flag these changes in behavior.

GHo explained the NHSE Team which covers Somerset has commissioned an evaluation which would be useful to review. This is currently going through their Governance procedures before it can be made public.

MJ asked what the degree of leniency of QoF is and has this been worked out? LS explained this has not made explicit to practices and we will look at the data through CQRS and EMIS. If we decide practices are more comfortable with an arbitrator figure we can run with a figure between 5% or 10%. It was suggested that if this was the case practices would like to know this before-hand and we need to set some tolerance levels around this. GJ feels this system would discourage practices from exempting patients from QoF. SL explained we would be looking for outliners where a gentle approach would be taken to establish why there are these dips in performance instead.

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	CH asked within this year, are practices going to maintain their patient disease registers so the national prevalence adjustment isn't affected? LS explained prevalence registers will be maintained in 15/16. CH asked in 16/17 is the CCG working on a payment mechanism as an alternative outside of CQRS? LS explained not at the moment but this will be worked up in the business planning for 2015/16 through the Diabetes redesign. AF asked about the level of patient involvement in the C&SP steering group? It was explained that the group were struggling to find the right person and was hoping Healthwatch Bucks would be able to sit on the steering group. There was a clear commitment to get patient representation and the ccg had been very focused on the patient side of things. JO added we will be inviting representation from the local voluntary sector organisations for the specific LTC's we are working on within C&SP. LP added the PCJC should monitor the level of patient engagement and our new Lay member will be able to help with this. RC commented there is a lot of work put on the PPG's and they are all at different levels but noted this could be a process to help practices work closer with their PPGs. JD feels the presentation shown in the meeting is a step further from the business case and suggests the presentation is made as an appendix to the business case. It was also asked for more clarity on the deliverables and the timescales. LP explained we are using this time to set a robust evaluation framework ready to commence 1/4/2016. The work with the Healthcare Foundation is going to be influential with our evaluation. SL wished to clarify the Business Case presented is for 15/16 and the evaluation is about the readiness of the practice to start delivering the support. There will be a new Business Case to support the 16/17 agenda which will cover the complex evaluations and the health outcomes which will come to the PCJC when ready. JD asked about value for money. In terms of the business case, how does Tower Hamlets compare to Aylesbury Vale and what would the potential saving be if we delivered similar outcomes to our practice population? LP explained this evaluation will be part of next years' business plan. LS explained this is about moving to supported self-management and Tower Hamlets is one of the only examples available to evaluate against. LP explained these schemes often take years to embed and change cultures, so if this did not create any financial savings but works to achieve the CCGs primary care strategic goals, the ccg would view this positively. LP asked how NHSE would feel if this was the case? JD said the concern would be there is a lot of investment in hospital strategy and CCGs may over extend themselves. This is a risk in all system transformation and this risk needs to be a key focus throughout this process. LP explained we do need to see a reduction in A&E attendance and a move to patient supported self-management. The Primary Care Joint Committee and NHSE agreed the Business Case, subject to the presentation shown in the meeting being embedded as an appendix, clarity needed on the business plan for 2016/17 including a value for money assessment and a process for the evaluation framework and a description of the QoF leniency.	**Action:** LS to amend the business case to reflect the comments from NHSE
5	**EoL DES+ update** LS provided an update on the EoL DES+. We have had 18 out of 19 practices take up the DES+ scheme. Practices have trialed an EMIS template which will pull out the EoL data and care plans for the patients. SL added he presented at the SCN EoL Commissioners forum which was positively received.	

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	GHo asked what encouragement is being done to get the last practice to engage? GJ contacted them to discuss but for them it was a capacity issue and they did not have the headroom to do anything else. PR asked for clarification on the DES+. The + part had received additional funding by NHSE as a pilot scheme. PR feels an alert is needed to these supplementary funding streams to the LMC. It was explained this was a one-off not recurrent funding for a pilot.	
6	**Delegated commissioning** GPy went through the highlights of the paper and explained AVCCG is currently undergoing engagement with the membership through meetings and webinars which are well attended and constructive. We have also involved stakeholder partners in these discussions (The LMC and Healthwatch Bucks). The engagement is on-going GPy explained the timeline for practices to make a decision. Communication out to practices is planned for 2nd October with voting to end on 8th October 2015. We need 70% of our practices to agree a yes vote for us to proceed. We will then have 4 weeks to officially submit an interest to NHSE. GPy explained a SWOT analysis has been compiled highlighting the concerns raised by practices. GPy has also met with colleagues in Gloucester who are happy to share their learning after going fully delegated earlier this year. We will be working on our own due-diligence and other key elements of the application process including finance. LP asked how NHSE are getting sighted on the work we are doing? GPy has jointly set up fortnightly meetings with NW. LP asked what will this do to us as a potential resource drain and what else is happening in Thames Valley? A lot of this work will be transactional, resource and legacy work. GHo feels we can gain a lot of learning from Gloucester and DE will be speaking at the Accountable Officers forum about how this will work going forward and touching on resources. PR commented that the obligations that come with delegated commissioning need to be matched by resources. It was queried how a practice can make a decision unless they have some knowledge of the resource available? LP explained conversations are needed with NHSE on how the transactional stuff will be resourced. Across TV, most of the CCG's want to keep this resource together and the anticipation is there would be no change to this. The rest is for the CCG to balance as we can shift the investment into out of hospital work.	
7	**NHSE Decision Making Document** GHo explained this document was discussed in the last meeting. It is a stepping stone where most CCGs are in the joint commissioning role. The framework explains how we work together on joint decision making requirements. GHo asked if the PCJC are happy to continue under this basis until such point at which the CCG switch to delegated. GHo explained nothing has changed in the document since it was last distributed and clarified urgent decisions can be made virtually (via email/telephone calls etc) and then ratified at the next PCJC.	

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	LP asked that as a standing agenda item at every PCJC we state what decision, if any, were made outside of the meeting which need ratifying by the committee.	
8	**Quality Report** The Quality Report was presented for information and explained as a work in progress. AF explained the safeguarding report is available on a monthly basis and feels a priority is the lack of any incident reporting.	
9	**CQC** GHo explained this framework has been submitted for information to all PCJCs. The framework clarifies the processes going forward for NHSE South Central and formalises who has the responsibility for picking up triggers from CQC inspections. Within NHSE, the Nursing and Quality team receive the information from the cqc and inform the CCG about the subsequent actions that need to take place for oversight and assurance. JF is in liaison with the Directors of Nursing within the CCG's to ensure this process is embedded.	
10	**Finance Report** CH went through the financial monthly report explaining Page 1 reiterates the basis on which the budget is set. Page 2 gives a further breakdown in the budget into spend and the level of risk reserves available. The NHSE Held Investment is for premises developments and is yet to be allocated. A central reserve is held on behalf of the National Team for general NHS pressures which currently cannot be committed. Each CCG has a capitation share of the risk reserves for in year pressures (£450k for AV) PR asked what is the plan for the PMS review which has to be completed by April 2016. CH explained there is a premium element planned for AV PMS practices and there is need to plan for the investment involved. LS explained there are two practices within AVCCG with PMS contracts. Westongrove have held discussions about their PMS and the value of funding is very small. PR feels the mandated process of a PMS still needs attention and documentation. It was noted this was discussed at the last PJCC and noted in the minutes. LP queried the risk reserve and asked is this based on population growth? CH advised yes it is. CH advised that the overall position is favorable and we are planning to break even against plan anticipating that we will not need to use reserves for any in year pressures. LP expressed some concerns with the transfer of information between us and NHSE and what should be in the public domain. Can we be explicit with information that is not for FOI requests? We need to be clear how we manage practice level data with our providers. JD explained there is a process issue with the data that impacts the timing of financial information available.	

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11	**Infrastructure Report** LS spoke about the Primary care infrastructure fund. AVCCG had 2 practices apply for funds and neither was successful. We have now commissioned Paul Rowley to work with the practices to think about where they want to go with their estates etc. Paul has visited half of AV practices and will meet with the CCG in October to discuss what we are able to support in terms of our wider strategy. In June 2015 AVCCG was sent a document about local estates strategies and this will inform what we will do going forward. GHo asked if LS has spoken to James Page? LS had not but RM and PR had. GHo also advised NHSE have commissioned workshops on premises issues and the dates have been released. GHo will resend the information again so we can get staff booked onto the courses. LP asked about the local estate strategies and feels there are real inconsistencies in terms of what we are proposing against the Councils local plans and big provisos are needed around this when it comes in to action. LS explained we have had an expression of interest in the Healthy Towns Partnership which is led by the Public Health Team at BCC. We have asked them to engage with patients to establish what they want. It was noted the AHSN should be part of the partnership which LS will take forward. GHo added Bicester was identified in the 5 year forward view as a healthy new town and took the initiative forward to work with the developers at the Eco Town, so it might be worth investigating if there's a developer to link in to this? LS asked for further thoughts on how we can improve this and asked for the support of the group to proceed- this was agreed by the PCJC.	
13	**AOB:** None	
	Date of the next meeting: 14th December 2015, 3.30pm – 5.00pm	

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New Action Log – Primary Care meeting

Meeting Date: 24th September 2015

Date	Agenda Item No.	Action	Owner	Open/ Closed
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**

24/09/15	11	LS to invite the AHSN onto the Healthy Town Partnership group	Louise Smith	**OPEN: 24092015**

CLOSED Action Log – Primary Care meeting of 9th April 2015 and 15th June 2015

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**

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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**
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 **CLOSED 24/09/2015**
15062015	15	NW to speak to JF to establish practice nurse revalidations NW has flagged to JF who has reported back to LP.	Nicky Wadley	OPEN 15/06/2015 **CLOSED 24/09/2015**

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Purpose of Paper

During 15/16 Aylesbury Vale Clinical Commissioning Group (AVCCG) implemented the first stage (set up phase) of an innovative scheme to introduce Care and Support Planning (CSP) in general practice. The discussion paper below relates to stage two of the scheme, implementation, which covers the financial year 16/17. The paper is designed to generate discussion between NHS England (NHSE) and clinical commissioners in support of the final business case.

Executive Summary

In line with national guidance, the CSP scheme will provide more personalised support to patients with LTCs to help them better manage their health. It will also provide an opportunity to understand the patient journey, see how care could be improved and link this to future commissioning intentions for those with LTCs as per the house of care framework.

The core aims of the CSP scheme are:

- To maximise the opportunity to improve care aligned to the needs of the AVCCG local population afforded to us through jointly commissioning primary care services
- Stage 1 - during 15/16, adopt and embed care and support planning to deliver good quality, patient-centred care
- Stage 2 - from April 2016, improve patient reported outcomes for those with priority long term conditions; this may include the inclusion of alternative quality markers.

During the set-up phase, 15/16, the CCG introduced its innovative CSP scheme across Aylesbury Vale. Significant uptake so far means that 89% of the CCG population is covered by the scheme. However, some practices have opted for the lower levels of engagement, meaning not all clinical areas are covered.

The objectives for Stage 2 are defined as:

- encouraging those practices who have up until now not engaged with the scheme
- bringing those working at lower levels up to include additional clinical areas
- introducing patient activation or similar measures
- embedding sustainability into the scheme.

In order to deliver on stage 2 it is requested from the CCG that the underspend in 15/16 is carried forward into 16/17 and at least an additional 60K is allocated. It is also considered that the QOF scheme seen in stage 1 is rolled over into 16/17 to allow further headroom to develop.

In order to inform the full business case the committee is requested to discuss the following key points and form a view to support the general direction of travel

- That the practice funding not yet claimed, alongside any underspend in the central resource, be rolled over into the financial year for 2016/17 to enable remaining practices to set up the scheme and/or progress to level 3.
- That the QOF leniency applied in stage 1 is applied to a second year and no more
- The set of outcome measures shown in appendix B which are cost neutral are sufficient
- The timelines for sign off of year 2 business case and service specifications are appropriate.

Actions Required
The NHSE and AVCCG primary care joint committee are asked to approve the direction of travel for CSP prior to the completion of the Stage2 business case. This includes the rollover and consideration of additional funds to support CSP in general practice and the continuation of the QOF arrangement for a second year.

Objectives supported by this Paper (Please indicate)	
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**

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Discussion Paper Title:	Adoption of Care & Support Planning (CSP) in Primary Care Stage 2: Spread and sustainability

Author:	Julie Orrey / Louise Smith	**Clinical Lead:**	Dr Stuart Logan
Date Created:	8 December 2015	**Date Approved by Clinical Lead:**	

1. Background and progress so far

Background

Aylesbury Vale Clinical Commissioning Group (AVCCG) believes the introduction of Care and Support Planning (CSP) in general practice to be an essential step towards the delivery of the Buckinghamshire wide primary care strategy and also forms part of the ambition to develop new models of care across the system as per the Five Year Forward View. The introduction of the CSP concept aims to increase supported self-care for those with long term conditions (LTCs) and represents a significant change to practice consultations and culture within a practice. For these reasons the CCG recognised that any associated delivery programme designed to implement the intervention would need to be at least two years in duration.

As a consequence of the above during 15/16 (year 1) under joint commissioning arrangements with NHS England (NHSE), AVCCG implemented an innovative scheme to encourage general practice to move to a CSP approach using the year of care partnership model (YoC) in the care of their patients with long-term conditions. GP practices were able to choose varying degrees of commitment to the scheme which were linked to QOF domains that represented priority areas for our locality populations - diabetes, dementia and respiratory conditions. For these particular domains the link between reporting QOF data fields and payment was disassociated and instead annual payment was guaranteed based on 14/15 achievement. It was intended that this would provide practices with the headroom to adopt and embed CSP enabling them to develop the infrastructure and shift practice culture to make this a part of 'normal' care for those with LTCs. For full details of the original scheme the 15/16 Business case and service specification are available.

15/16 Progress

During 15/16 practices wishing to participate in the scheme were expected to demonstrate adequate preparedness to progress to YoC 'go live' from 1st April 2016. This included changes to practice appointment systems, clinical system templates, patient information, healthcare professional (HCP) skill mix and training. 15 out of our 19 practices committed to this set up phase of CSP known as Stage 1. This translated as 89% of the AVCCG population potentially being covered by the CSP scheme - Table 1 below demonstrates the level of commitment of each practice to the scheme.

Table 1: Care and Support Planning Project - Practice involvement

GP Practice	Level 1 Diabetes	Level 2 Diabetes & Dementia	Level 3 Diabetes, Dementia & Respiratory	Population
Swan Surgery				18,637
Whitchurch Surgery	Not yet participating			4,136
Norden House Surgery				9,418

Ashcroft Surgery				4,110
Verney Close Surgery	Not yet participating			8,635
Wing Surgery	Not yet participating			4,874
Edlesborough Surgery				7,388
Oakfield Surgery				5,005
Meadowcroft Surgery				13,562
The Mandeville Practice				16,833
Poplar Grove Surgery				17,800
Whitehill Surgery				13,045
Westongrove Partnership				27,548
Berryfields Medical Centre				4,282
Cross Keys Surgery				14,559
Haddenham Medical Centre				7,878
Wellington House Surgery				9,065
Trinity Health				11,254
Waddesdon Surgery	Not yet participating			5,273
Practice engagement totals	**5**	**2**	**8**	
Total Population				**203,302**
Percentage take up of CSP				**89%**

15/16 Assurance

Due to the fact that practices participating in the scheme receive income associated with 14/15 QOF achievement and delivery of CSP process measures as opposed to the actual QOF achievement during the 15/16 financial year it was necessary to shadow monitor QOF through EMIS web. This has enabled the CCG team to identify any outliers in terms of performance associated with these indicators and investigate accordingly. Current data suggests that there has not been any significant drop and this will continue to be monitored (Data available).

15/16 Forecast spend against budget

Appendix A shows the current expected spend for the project during 15/16. It is therefore estimated that there will be a £140k underspend and it is anticipated that this would be rolled over into 16/17.

2. Proposed next phase (*including health benefits/outcomes*)

The key objectives for the next phase of delivery during 16/17 are:

- encouraging those practices who have up until now not engaged with the scheme
- bringing those working at lower levels up to include additional clinical areas
- introducing patient activation or similar measures
- embedding sustainability into the scheme.

The CCG will facilitate this by continuing to work alongside NHSE within the boundaries and expectations set by the national team for similar schemes which alter the national QOF requirement. As a CCG waiting for confirmation of approval for the full delegation of primary care commissioning AVCCG would have the scope to continue and build upon the current model. There is a shared expectation that any scheme and its changes would still need to be sense checked by NHSE but that this would not be an approvals process. However once the scheme is up and running further scrutiny would continue to be applied through the NHSE assurance process.

Continuation of stage 1

It will be possible for practices that made the decision not to embark on the scheme during 15/16 to join it. This will be on the same funding and service specification as that offered to practices in 15/16. Of the remaining four practices, three have currently indicated that they anticipate commencing the stage 1 during 16/17.

Alongside increasing practice take-up for those not yet involved, for those practices who were 'early adopters' and have already implemented the CSP approach for levels 1-3, we anticipate extending clinical coverage into other LTC areas in alignment with the CCG's strategy for 16/17. There is currently expected to be a focus on cancer survivorship and heart disease.

Roll out of stage 2

For practices who have completed stage 1 (set up) during 15/16, stage 2 (implementation) will be from 1st April 2016. The stage 2 implementation will be aligned to the level of commitment originally chosen by the practice therefore if the practice chose to deliver level 1 (diabetes) then they will be expected to offer CSP to all patients with diabetes and if they choose level 3 (diabetes, dementia and respiratory) to all patients with those conditions. A service specification for 16/17 will be issued to practices covering the implementation phase of the scheme.

It is proposed that for the practices in the implementation phase that headroom continues to be facilitated by the current principle of QOF leniency. Our early adopters who are rolling out CSP to a number of long term conditions not just diabetes are finding that implementation is not straight forward and that skills and competencies to carry it out effectively continue to need to be developed. It is therefore recommended that stage 2 continues to provide the additional headroom in the same way as described in stage 1 by associating QOF payment with previous delivery aligned to 14/15.

Cost

It is currently estimated that there is a £140k underspend in 15/16 and that this should be rolled forward for practices in 16/17. In addition to this £140k it is currently expected that there will be a requirement for an additional 60k which will be used to ensure that all practices reach the same level of achievement, utilise further training, networks of support, project management and clinical champions (appendix A). This funding will be requested directly from the CCG accompanied by a full business case and detailed costings.

Evaluation

The aim of the CSP scheme is to improve the quality of long term conditions care by embedding care planning as the care delivery vehicle. The CCG needs to be assured that quality care planning is being delivered and that patient and carer experience is improving. The following principles will be applied to measurement

- Care quality will be evaluated by the patients and carers – this will be by patient experience survey during 15/16
- The experiences of healthcare professionals will be used in the evaluation
- Quantitative proxy measures of quality (QOF) will be used as well as qualitative measures
- Data collection methods will make maximum use of routinely collected data to ensure the burden of data collection is minimised.
- Process measures such as monitoring of the care planning processes and consultation quality will be used in addition to outcomes.

A full list of measures are provided in Appendix B

CSP Development during 16/17

Activation - Engaged, informed patients make up the left wall of the House of Care model, and supporting patients to take a greater role in managing their health is a core element of current health and public health agendas. Certainly CSP is a tool to support this process but as we have developed the scheme through the set up process, we have come to realise we need a way to measure what we mean by engaged or activated. In terms of measuring impact of CSP activity, beyond the range of success measures and outcomes already listed in this paper, patient activation is seen as something that could have a positive impact. Patient centred outcome measures (PCOM) and patient activation (PAM) are just two of the evaluation tools that the CSP steering group will now consider during 16/17 to understand any potential added value to the project. For now it is expected that the PAM will be trialled through the Live Well, Stay Well project.

Social prescribing – It is aimed that the CSP steering group will look at strengthening integration with non NHS providers/agencies including third sector to establish a robust social prescribing model.

Future commissioning needs – Gaps in services will be identified through the CSP monitoring process to inform future commissioning intentions

Assistive technology's – The use of assistive technologies to support the CSP model will be investigated further, building on FLO or MJOG type models.

Skill mix and workforce development – Training needs for HCAs have already been identified and suitable training started to be developed. The CSP steering group aim to identify a workforce model for successful delivery of CSP, including skill mix and competencies and new roles such as that of the health coach is also being explored

Timeframe for development

It is proposed that the timelines below will be used to progress and finalise the 16/17 scheme and aims to meet the NHSE guidance for agreement of such schemes. It is expected that should the scheme require funding in addition to any which is rolled over from 15/16 that this request goes to the CCG governing body.

Document	Meeting	Date
Discussion paper	Primary Care Joint Committee	14 December 2015
Business case	CSP Steering Group	14 January 2016
Business case	Governing Body	11th February 2016
Business case	Primary Care Joint Committee	24 March 2016

3. Supporting Papers

The following is recommended reading and provides an overview of the model and its impact nationally, alongside NHS guidance on adopting care and support planning and person-centred care for LTCs:

Angela Coulter, Sue Roberts, Anna Dixon (October 2013) Kings Fund - Delivering better services for people with long-term conditions, Building the house of care
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

National Voices (2013) - A Narrative for Person-Centred Coordinated Care
Available at: http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf (accessed on 9 January 2015).

Year of Care Partnerships – Impacts and benefits
http://www.yearofcare.co.uk/impact-and-benefits

NHS England (January 2015) - Personalised Care and Support Planning Handbook
Available at: http://www.england.nhs.uk/wp-content/uploads/2015/01/pers-care-guid-core-guid.pdf (accessed 12 August 2015)

NHS England (September 2015) - Our Declaration: Person-centred care for long-term conditions. Available at https://www.england.nhs.uk/wp-content/uploads/2015/09/ltc-our-declaration.pdf (accessed 3 November 2015)

NHS England (November 2015) - Independent evaluation of the feasibility of using the Patient Activation Measure in the NHS in England - Early Findings. Available at https://www.england.nhs.uk/wp-content/uploads/2015/11/pam-evaluation.pdf (accessed 8 December 2015)

Kings Fund (May 2014) - Supporting people to manage their health: An introduction to patient activation. Available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf (accessed 8 December 2015)

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Appendix A

Budget requirement		15/16 Budget	15/16 Forecast Spend	15/16 Rollover	16/17 Budget Requirement	Comments
Care planning training	Taster sessions,	0	0	0	0	SCN Provided in 15/16
	Teaching sessions	50,000	0	50000	14000	SCN Provided in 15/16, Cost for remaining practices in 16/17
	Train the trainer	0	0	0	30000	SCN Provided in 15/16, Focus on sustainability building a CSP team in AV / Bucks
Project Management	Senior project manager	100000	68000	32000		Senior project management required in early stages - ceased Jan 16
	Junior project manager	0	8000	-8000	50000	Junior project manager recruited from February 16
Care planning champions	GP	15600	1200	14400	15600	
	Nursing	10400	800	9600	10400	
	Administration	7800	600	7200	7800	
EMIS	EMIS Template design	10000	8900	1100	0	
Communications	Envisage video	0	420	-420	0	
Set up in practice	15/16 Stage 1 QOF Scheme	150000	114,000	36000	36000	
Implementation in practice	15/16 Stage 2 QOF Scheme	NA	NA	NA	tbc	
	Total Expenditure	**343800**	**201920**	**141880**	**163800**	

Appendix B

Metric	Method of measurement	What this measure will demonstrate	Baseline data available (years)
Patient care measures			
Maintain register (in order to record prevalence)	QOF read codes (through EMIS template)	Number of people on with relevant LTC, in order to record prevalence	2014-15
CSP consultations/ reviews completed for relevant LTCs	QOF read codes and CSP data (through EMIS template)	Number of CSP consultations carried out Clinical measures recorded and shared with patient CSP outcomes recorded and shared with patient	2014-15 (QOF annual reviews only)
Patient and carer experience	Patient questionnaire / Carer questionnaire	To establish patient and carer satisfaction and views on the CSP process Patient Q includes: A measure of the consultation itself • Consultation Quality Index (CQI) • Patient Enablement Index (PEI) • Consultation and Relational Empathy (CARE) measure A measure of key aspects of the support and care over the past 12 months • The LTC6 A measure of quality of life • EQ5D	2015-16 (baseline survey pre CSP activity)
Patient 'journey'	To be defined		
Organisational measures			
Evidence of meeting YOC Quality Assurance outcomes	Year of Care CSP Self Assessment / Quality Mark	CSP quality standards assessment to show progress of team, and areas for improvement. Aiming to reach 'exemplar' practice status	n/a
Fidelity of CSP process	Year of Care CSP Fidelity Processes Checklist	To ensure high quality CSP is taking place	n/a
Staff satisfaction survey	Year of Care questionnaire	Assessment of staff job satisfaction and views on the CSP process	2015-16 (baseline survey pre CSP activity)

Approved

NHS
Aylesbury Vale
Clinical Commissioning Group

Agenda item: 8

Primary Care Joint Committee
14 December 2015

Quality Pack December 2105

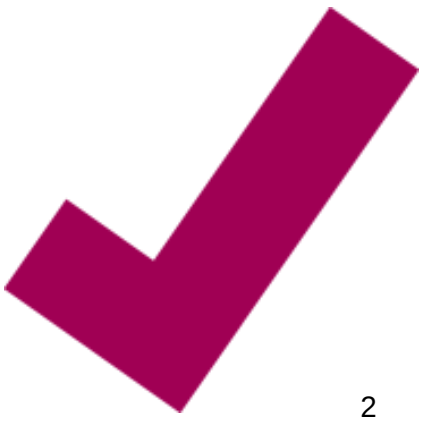
Purpose of Paper
To provide to the committee the NHS England South (South Central) Quality Pack information for December 2015.

Executive Summary
CQC ratings: 10 practices have had an inspection report published, including 2 practices where they have been re inspected. Overall ratings for November are: 7 were rated as good (2 previous practices 'required improvement'), 3 'require improvement'. 4 out of the 7 practices rated overall 'good' still 'required improvement' in the 'safe' domain. Complaints: For the period 1st August 2015 to 31st August 2015, South Central received 26 complaints, 2 of which were in relation to practices in Aylesbury. FFT: It is a mandatory requirement that practices report data to NHS England every month, as well as publishing their own results locally. Safeguarding: Information currently not available for this report. Incidents: No serious incidents reported for August 2015.

Actions Required
To note.

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	✓

Joint Commissioning Primary Medical Services Committee



Report to the Joint Primary Care Co-Commissioning Joint Committee – Aylesbury Vale CCG 14 December 2015

Prepared by: Ginny Davies, Quality Safety Lead and Rebecca Tyrell, Quality Improvement Manager, NHS England South (South Central)

Lead Director: Jan Fowler Director of Nursing, NHS England South (South Central).

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.

NHS England South (South Central)

NHS Aylesbury Vale CCG

Primary Care Joint Co Commissioning Meeting
Quality Pack
December 2015

Contents

1. Introduction and Context – NHS Aylesbury CCG

22 GP Practices	
CQC new inspection regime since October 2014	
FFT since Dec 14	
2 practices have taken part in NHS England Thames Valley Patient Safety Project	

2. Summary

CQC ratings	10 practices have had an inspection report published, including 2 practices where they have been re inspected. Overall ratings for November are: 7 were rated as good (2 previous practices 'required improvement'), 3 'require improvement'. 4 out of the 7 practices rated overall 'good' still 'required improvement' in the 'safe' domain.
Complaints	For the period 1st August 2015 to 31st August 2015, South Central received 26 complaints, 2 of which were in relation to practices in Aylesbury.
FFT	It is a mandatory requirement that practices report data to NHS England every month, as well as publishing their own results locally.
Safeguarding	Information currently not available for this report.
Incidents	No serious incidents reported for August 2015.

3. Care Quality Commission (CQC) GP Inspections

The following table shows when inspections by the CQC have taken place and practices rated as overall 'good' including 2 practices which have had re inspections.

Practice Name	**Oakfield (Zaib)**		**Meadowcroft (Tinnion & Partners)**	**Haddenham Medical Centre**	**Wellington House**	**Westongrove (Wendover Health Centre)**	**Berryfields Medical Centre**
Date of Inspection report published	Re inspection 01/10/15	23/04/15	24/09/15	19/02/15	31/03/15	19/03/15	19/03/15
Rating	**Good Previous**	**Requires Improvement**	**Good**	**Good**	**Good**	**Good**	**Good**
Safe	Good	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Effective	Require Improvement	Good	Good	Good	Good	Good	Good
Caring	Good	Good	Good	Good	Good	Good	Good
Responsive	Good	Good	Good	Good	Good	Good	Good
Well Led	Good	Requires Improvement	Good	Good	Good	Good	Good

Practice Name	**Waddesdon Surgery**	
Date of Inspection report published	Re Inspection 29/10/15	19/03/15
Rating	**Good**	**Requires Improvement**
Safe	Good	Inadequate
Effective	Good	Good
Caring	Good	Good
Responsive	Good	Requires Improvement
Well Led	Good	Requires Improvement

The following table shows when inspections by the CQC have taken place and practices rated as overall 'requiring improvement', which regulatory standards were not being met.

Practice Name	Cross Keys	Dr Dickson & Partners (Norden)	The Mandeville Practice
Date of Inspection report published	26/03/15	31/03/15	27/08/15
Rating	**Requires Improvement**	**Requires Improvement**	**Requires Improvement**
Safe	Requires Improvement	Requires Improvement	Good
Effective	Requires Improvement	Good	Requires Improvement
Caring	Good	Good	Good
Responsive	Requires Improvement	Good	Good
Well Led	Requires Improvement	Requires Improvement	Requires Improvement

4. Patient Experience

a) Complaints

As of 17th September 2015 NHS England South South Central had 46 active cases. Of these cases two were concerns and two were with the Health Service Ombudsman.

For the period 1st August 2015 to 31st August 2015, South Central received 26 complaints, 2 of which were in relation to practices in Aylesbury.

b) Friends and Family Test (August 2015 Results)

Name	Address	Postcode	Practice List Size	Total Responses	Percentage Recommended	Percentage Not Recommended
		England	56,973,815	137,885	88%	6%
	Selection (excluding	pressed da	206,951	554	82%	9%
ASHCROFT SURGERY	STEWKLEY ROAD, WING, LEIGH	LU7 0NE	4,012	2	*	*
BERRYFIELDS MEDICAL CENTRE	COLONEL GRANTHAM AVENUI	HP19 9AP	5,277	no data		
EDLESBOROUGH SURGERY	11 COW LANE,EDLESBOROUGH	LU6 2HT	7,490	8	100%	0%
HADDENHAM MEDICAL CENTRE	STANBRIDGE RD, HADDENHAN	HP17 8JX	7,982	65	69%	17%
MEADOWCROFT SURGERY	JACKSON ROAD, AYLESBURY, E	HP19 9EX	14,179	no data		
NORDEN HOUSE SURGERY	AVENUE ROAD, WINSLOW, BU	MK18 3DW	9,447	43	93%	7%
OAKFIELD SURGERY	OAKFIELD ROAD, AYLESBURY,	HP20 1LJ	4,995	5	100%	0%
POPLAR GROVE PRACTICE	MEADOW WAY, AYLESBURY, B	HP20 1XB	18,244	no data		
STEWKLEY ROAD SURGERY	THE SURGERY, 46 STEWKLEY RO	LU7 0NE	4,946	39	90%	10%
THE CROSS KEYS PRACTICE	60 HIGH STREET, PRINCES RISB	HP27 0AX	14,440	4	*	*
THE MANDEVILLE PRACTICE	HANNON ROAD, AYLESBURY, E	HP21 8TR	16,763	7	29%	43%
THE SWAN PRACTICE	HIGH STREET, BUCKINGHAM, E	MK18 1NU	19,383	85	88%	11%
TRINITY HEALTH	HIGH STREET, LONG CRENDON	HP18 9AF	11,422	no data		
VERNEY CLOSE SURGERY	VERNEY CLOSE FAMILY PRACT,	MK18 1JP	8,769	no data		
WADDESDON SURGERY	GOSS AVENUE, WADDESDON,	HP18 0LY	5,298	no data		
WELLINGTON HOUSE SURGERY	WELLINGTON HOUSE PRACTIC	HP27 9AX	9,122	47	96%	4%
WESTONGROVE PARTNERSHIP	BEDGROVE SURGERY, BRENTW	HP21 7TL	27,730	110	83%	6%
WHITCHURCH SURGERY	49 OVING ROAD, WHITCHURCI	HP22 4JF	4,129	34	97%	3%
WHITEHILL SURGERY	WHITEHILL LANE, OXFORD RD,	HP19 8EN	13,323	105	67%	10%

5. Incidents

As NHS England South South Central we are actively encouraging GP practices to report incidents as part of an improving patient safety culture -for openness and honesty to learn from incidents.

a) Serious Incidents

There have been no serious incidents reported during September and or October 2015.

b) Non Serious Incidents

There have been 2 non serious incidents reported for GP practices in September 2015, 'Tests – failure/delay to undertake' and one 'Medication'.

c) Incident reporting to National Reporting and Learning System (NRLS)

NRLS is now the preferred method for reporting incidents to the Quality Team.

6. Safeguarding

Information currently not available for this months report.

7. GP, Nurse and staff appraisals carried out

Number of GP Appraisals for month of August 2015 in area (Locums which are appraised in this patch are included in the figures).

Aug-15	Bucks
Due	8
Completed	6
Overdue	2
Postponed	0

Compiled by Ginny Davies, Assistant Quality & Safety Manager, NHS England South South Central

NHS
Aylesbury Vale
Clinical Commissioning Group

Agenda item: 9

Primary Care Joint Committee

Financial Report for month 7

Purpose of Paper
To update the committee on the financial position for month 7 of 2015/16 for the Primary Care Services joint commissioning budget of Aylesbury Vale CCG.

Executive Summary
The year to date position at month 7 is a favourable variance of £43k with the annual forecast as plan.

Actions Required
To note the financial position for month 7.

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	✓

Joint Commissioning Primary Medical Services Committee

Report to the Joint Primary Care Co-Commissioning Committee Operational Group – 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 7 of 2015/16 for the primary care services joint commissioning budget of Aylesbury Vale CCG.

Co-Commissioning Expenditure Report

Month	7
CCG Code	10Y
CCG Name	NHS AYLESBURY VALE CCG

	Month			Year to Date			Forecast		
GP Services 15/16	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£k	£k	£k	£k	£k	£k	£k	£k	£k
GP Contract payment	1,257	1,272	(16)	8,796	8,866	(71)	15,078	15,078	0
QOF payments	190	189	0	1,327	1,326	1	2,274	2,274	0
PCO Admin	61	43	18	426	362	64	731	731	0
GP Drug payments	150	159	(10)	1,048	1,048	(0)	1,796	1,796	0
GP Premises	217	158	59	1,521	1,475	46	2,608	2,608	0
GP Enhanced Services	118	75	43	828	812	16	1,421	1,421	0
GP Other Items	12	13	(1)	82	116	(34)	141	141	(0)
CCG Prescribing	0	(0)	0	0	(0)	0	0	0	0
Collaborative Fees	7	4	2	46	42	3	78	78	0
GP IT									
GP Premises other	2	0	2	13	(4)	16	22	22	0
GP General Reserves	33	33	0	228	228	0	390	390	0
Total	**2,045**	**1,947**	**98**	**14,314**	**14,272**	**43**	**24,540**	**24,540**	**(0)**

() Negative value equates to Overspend against plan

2.0 Month Position

The position for month 7 is a favourable variance of £98k with main variances explained below:

- Enhanced Services £43k favourable due to timing of payments.
- GP Premises £59k favourable due to timing of quarterly rent payments not matching the budget profile in equal 12ths.

2.1 Year to Date Position

Overall the YTD position is a favourable variance of £43k with main variances explained below:

- GP Contract payments £71k adverse due to higher than planned list growth
- PCO Admin £64k favourable due to list growth reserve held
- GP Premises £46k favourable due to timing of payments

2.2 Forecast Outturn

Current FOT is as plan.

A review of the commitment of general reserves is completed and will be reported at the next meeting.

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.
- Individual CCG cost pressures for primary care services will (where possible) be managed at NHS England level (whilst joint commissioning arrangements are in place).

4.0 Contracting and procurement activity

Mandeville Surgery, Aylesbury
Verney Close, Buckingham

5.0 Direct Awards (Local Enhanced Services)

The CCG has individual contracts covering Direct Awards with GP practices covering the following services:

Care Homes
Depot Neuroleptics
H – pylori testing
Insulin Initiation
Near Patient Testing
Phlebotomy
Suture Removal
Wound Care

The budget allocated to these services from the CCG's Programme Budget is £660k and is based on prior year spends against the schemes.

The information is based on Q2 budget and costs – (the Direct Awards are paid at the end of each quarter).

Ditrect Awards (Enhanced Services 15/16)
Budgets based on 14/15 actuals

	Annual Budget £000's	YTD Budget £000's	YTD Actuals £000's	YTD Variance £000's	Full Year Forecast £000's	Full year Variance £000's
Direct Awards (Local Enhanced Service).	**Total**					
C&M-GMS LES Depot Neuroleptics	**8**	**4**	**3**	**2**	**5**	**3**
C&M-GMS LES Anti-coagulation	**86**	**86**	**86**	**0**	**86**	**0**
C&M-GMS LES Care Home/Nursing Home	**150**	**75**	**71**	**4**	**155**	**-5**
C&M-GMS LES Complex Wound Care/Suture Removal	**136**	**68**	**69**	**-1**	**138**	**-1**
C&M-GMS LES Diabetes-Insulin (GTT)	**11**	**5**	**4**	**2**	**7**	**4**
C&M-GMS LES H Pylori	**4**	**2**	**2**	**0**	**4**	**0**
C&M-GMS LES Near Patient Testing	**158**	**79**	**77**	**2**	**154**	**3**
C&M-GMS LES Phlebotomy	**107**	**53**	**57**	**-4**	**109**	**-2**
Grand Total	**660**	**373**	**368**	**5**	**658**	**2**

Year to Date position

Overall the YTD position is a favourable variance of £5k represented by small under/over spends against each line, Care homes being the highest underspend off set against an overspend for Phlebotomy.

Forecast Outturn

Current FOT is a small underspend of £2k.

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Strategic Estates Plan (SEP)

Briefing Paper for the Primary Care Joint Committee

Purpose of paper:
To provide a brief update to the Primary Care Joint Committee on the progress made with the Aylesbury Vale CCG strategic estates plan (SEP) and identify the key actions and milestones going forward.

Executive summary
This SEP sets out the context of the community estate associated with Aylesbury Vale (AVCCG) as at December 2015. For the CCG the primary driver is to ensure that Primary Care is delivered through appropriate and 'right sized' estate that enables health economy integrated care and also meets anticipated population growth and housing growth in the coming years.

Actions Required
The Primary Care Joint Committee is asked to note and support the approach described as the SEP and future delivery plan as being essential to managing the changes needed to achieve the implementation of the primary care strategy.

Objectives supported by this Paper (Please indicate)	
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**

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The CCG in Aylesbury Vale as part of its overall role as health systems leaders, has the responsibility to establish a working document that sets out the Estate Strategy which will support their commissioning and clinical strategy.

AVCCG has been working with an NHS Property Services (NHSPS) Estates Strategy expert to develop a high level Estate Strategy for the end of December 2015 and a full Estate Strategy and delivery plan by mid-2016. In order to support this local work the CCG has also secured the services of an additional subject matter expert to work closely with the team. This has enabled access to estates information and subject matter knowledge which has informed the process.

The document itself aims to cover and address as primary drivers:

1) The five year forward view
2) The Buckinghamshire Primary Care strategy
3) Primary Care Transformation Fund (PCTF)
4) Proposed future housing development of Aylesbury Vale and the implications and impact to the healthcare economy

Part of the estates strategy work has included a "stock check" of current Primary Care facilities and sites in order to develop an informed view on the services provided from each site, the quality of the space, its condition and the overall space utilisation against list size. The CCG is also seeking funding from the Primary Care Transformation Fund (PCIF) for a 6 facet survey to be completed on the GP estate. It is anticipated that this will identify a number of strategic property initiatives to support integrated primary care. The CCG also aims to fully understand the aspirations of the practice leaders to improve their facilities in pursuit of the primary care objectives.

<u>Key Messages</u>

1) <u>Understand the current role of the Buckinghamshire estate forum and maximise the opportunity for partnership working on estates across the healthcare system</u>

These forums currently exist and have representation from Commissioners, Providers and other stakeholders. Their role is to establish future estate requirements for CCG and NHS commissioned services. These forums have the potential to act as the steering group to the CCG primary care committee with the estates workload being shared by others including specialists.

Area for development – ownership of this forum by the CCG as system leaders. It is recognised that this forum represents the key opportunity for debate and system development of estate, see point below. The key to this work will be "engagement"

and in order to achieve this it is recommended that AV and Chiltern CCGs reviews the current Estates Forum including membership and leadership.

2) Confirm the Current Estate

The CCG Estate Forum will be provided with a comprehensive list of estate that delivers CCG and NHS Commissioned Services. For the larger estate i.e. Community Hospitals and NHSPS owned Health Centres an explanation of services provided from each site will be provided 'The Forum will be asked to approve the list'.

3) Undertake Options Appraisal (Future Estate)

This will be at Strategic and not Business case level. The options appraised will be facilitated by NHSPS and other specialists with the scoring process being undertaken by the Estate Forums and invited stakeholders.

4) Develop the Strategic Estate Plan

The SEP will flow from the options appraisal and will set out the 5 – 10 year estate rationalisation plan. Once approved by the CCG Board, the Plan will give legitimacy to proceed to scheme specific outline and then full business cases. This will also take into account the future housing development proposals that have been outlined by Aylesbury Vale District Council.

5) Collaborative working with Chiltern CCG

Each CCG both AV and Chiltern will have their own SEP which will allow each CCG to have a strategy that fits their commissioning intentions, to choose their own priorities and work at a pace that does not disadvantage them with regard the strategies being developed in the other CCG. However it is recognised that as a system they share many of the same larger healthcare providers and estate priorities and will therefore need to work collaboratively.

NHS England

NHS Aylesbury Vale Clinical Commissioning Group

MILESTONES 2015/2016 FOR THE STRATEGIC ESTATES PLAN AYLESBURY VALE CCG

1. Stock Check of the Current Estate This will include location, size activity (clinical & non clinical) for the whole of the CCG	End December
2. Review Current Estate Forum Review terms of reference and ensure this is chaired by the CCG and will include CCG, Primary Care, Acute, Mental Health and Community providers.	End January 2016
3. Future Estate Need This is to include, the high level strategic view of location, size, activity (clinical & non clinical for each CCG area), for CCG and involving Primary Care, Acute, Community and Mental Health stakeholders. This will be a gap analysis taking into account population growth, changing needs of population (such as care of the elderly), moving more to out of hospital care.	End February 2016
4. PCTF Prioritisation of bids received from each General Practice in Aylesbury Vale including submission to NHSE.	End February 2016
5. Options Appraisal This will be a complex piece of work leading to a full options appraisal process involving a range of stakeholders, and which may reflect the localities, CCG's, Providers, NHS England, and HOSC's.	Early March 2016
6. The Estates Delivery Plan This will be the plan that enables individual business cases to proceed i.e. Estate investment, Disinvestment business plans at all the main sites:- Primary, Secondary, Acute, Community, L.A and Voluntary Sector	June 2016