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NHS Aylesbury Vale Clinical Commissioning Group

Primary Care Commissioning Committee Meeting Agenda

Thursday 28th April 2016, 8.45am – 10.00am

Aylesbury Vale CCG Board Room, 2nd Floor, the Gateway, Gatehouse Road, Aylesbury, Bucks, HP19 8FF

No	Agenda Item	Desired Outcome(s)	Contributor	Papers/Times
1	**Welcome & Introductions:** **Apologies:**		Graham Smith **CHAIR**	**8.45am – 8.50am**
2	**Declarations of Interest**		Graham Smith **CHAIR**	
2.1	**Questions from members of the public**		Graham Smith **CHAIR**	
3	**Minutes of the March 2016 meeting**		Graham Smith **CHAIR**	
Clinical Commissioning				
4	**Verney Close**	**PAPER:** consider options and agree a way forward.	Nicky Wadely, NHSE Gary Passaway, AVCCG	**8.50am – 9.30am**
5	**Mandeville Surgery**	Verbal Update	Gary Passaway, AVCCG	**9.30am – 9.40am**
6	**PCTF Panel Review**	Verbal Update	Gary Passaway, AVCCG	**9.40am – 9.50am**
AOB				
7	**AOB**		Graham Smith **CHAIR**	**9.50am – 10.00am**

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NHS Aylesbury Vale Clinical Commissioning Group

Primary Care Joint Committee (PCJC)

Thursday 24th March 2016, 9.30am – 11am

AVCCG Boardroom, The Gateway, Gatehouse Road, Aylesbury, Bucks

Present:

Graham Smith, Lay Member for AVCCG	(GS)	**CHAIR**
Richard Corbett, Healthwatch Bucks	(RC)	
Louise Smith, Deputy Director of Operations & Transformation, AVCCG,	(LS)	
Colin Hobbs, NHS England	(CH)	
Louise Patten, Chief Officer AVCCG	(LP)	
Nicky Wadely NHS England	(NW)	
Dr Karen West, AVCCG Clinical Lead for Partnership working	(KW)	
Gary Passaway, AVCCG Primary Care Manager	(GPy)	
Dr Malcolm Jones, GP Clinical Lead AVCCG	(MJ)	
Robert Majilton, AVCCG Chief Finance Officer	(RM)	
Dr Geoff Payne, NHS England	(GPa)	
Colin Seaton, AVCCG Lay member and Co-Chair	(CS)	
Robert Parkes, AVCCG Lay member and Co-Chair	(RP)	
Helen Delaitre, Primary Care Manager, Chiltern CCG	(HD)	
Dr Charles Todd, AVCCG Clinical Lead (joined at 10am for agenda item 7)		(CT)
Vicki Parker- AVCCG (Minute taker)	(VP)	
Kendall Gilmore, NHSE Commissioning Policy Unit	(KG)	
Boskey Amin, NHSE Commissioning Policy Unit	(BA)	

Apologies:

Dr Graham Jackson, Chairman AVCCG	(GJ)
James Drury, Finance Director, NHSE local area team	(JD)
Dr Paul Roblin- Bucks LMC	(PR)

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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 Dr Graham Jackson, James Drury and Dr Paul Roblin.	
2	**Declarations of Interest**. KW declared in items 4, 5 and 7. Members of the committee were in agreement that KW could stay in the room during these discussions. Dr Charles Todd, Central Locality clinical Lead joined the meeting for the Direct Awards discussions and explained he is a GP at the Westongrove Partnership.	
3	**Minutes and Actions of Joint Committee Meeting 14th December 2015** Minutes of 14th December 2015 agreed as a correct record. Action log updated accordingly.	
4	**EoL** LS remained the PCJC members that last year AVCCG proposed a scheme that built on the unplanned admissions DES (DES+). A paper has now gone to the Aylesbury Vale Governing Body highlighting the preliminary results, the training given to practices and support provided with EMIS templates. LS spoke about the data collection and the improvements made. More patients now have planned priorities of care, advanced decision to treat and details of DNCPR. These are elements important for patients on end of life care to have and this will impact on their preferred place of death. LS explained we currently have no data on the impact of emergency admissions. We will not have this data until we get an understanding the death audit data, which comes with a time gap. LS explained the EOL DES+ service went live in August 2015 but the latest data collection was February 2016. LS explained the AVCCG Governing Body felt this service adds value to patients and there is value taking this scheme forward. GPa queried how we are capturing the added value in terms of patient experience. LS explained we are still missing the bereaved carer's survey and details of the patients preferred place of death. GPa offered to put LS in contact with colleagues who can help with this element of evidencing. LS added the clinical template has a link to the quality reporting tool, EQUIP, which will allow clinicians to flag up any concerns which will be picked up by the AVCCG quality team.	

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	NW asked if the one remaining practice who did not sign up in 15/16 will be given the opportunity to commence 16/17. LS confirmed they will be invited to sign up. RM asked when we will know the timeframe for receiving the updated specification of the unplanned admissions. NW explained this is due at the end of the month. Members of the PCJC strongly supported this direction of travel for EOL care.	
5	**Care & Support Planning 16/17** LS explained the 15/16 preparatory year has concluded and the majority of Aylesbury Vale practices (89% of the population) have signed up to the C&SP programme. In 15/16 AVCCG has supported practices with training and EMIS templates. The QoF outcomes have been monitored to ensure they do not fall below standard. 16/17 is about practices having these dialogues with their patients and changing the way they care for their patients. LS explained the AVCCG Governing Body is happy to support this scheme for another year. However they did ask for the finances to be refined so essential key elements were identified. The original finding was for £245k which included a rollover from 15/16. This has now been reduced by £61k. RC explained if this project achieves the culture change it is aiming for, the funding element becomes irrelevant and it was noted that it will take time to quantify the anticipated savings. **Members of the PCJC strongly supported this direction of travel for the Care & Support Specification for 16/17 and agreed to ratify the paper.**	
6	**Delegated commissioning** GPy explained in 2015 AVCCG undertook a membership vote and received 95% in favor to move forward with a delegated commissioning application. GPy explained the delegated agreement was agreed and signed by the Aylesbury Vale Governing Body and the submitted to the NHSE regional team. GPy confirmed we have received a draft letter of support from NHSE detailing the elements of support the CCG's will receive from regional colleagues. NHSE will continue to be key partners as we move forward on 1st April 2016.	
7	**Direct Awards** LS explained the AVCCG Direct Awards have remained unchanged for a number of years. The paper provided to the PCJC highlights a need to move to a new model as the current process is cumbersome and it is felt some practices are under reporting. AVCCG propose a "bundle of services" is offered to practices. AVCCG would like to use the EMIS system in a more proactive way so the CCG can pull off reports and understand activity from the read codes embedded into the templates. We would like our practices to agree to provide all or nothing from the bundle. It is anticipated practices who cannot deliver a certain service are able to	

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	subcontract with colleagues in other practices. We would ask our practices to use the same EMIS templates so the CCG can automatically collect the data and simplify the KPI's to be more indicative to quality rather than process. LS noted it was a challenge to come up with a bundle price. A tabled finance paper was distributed to the members during the meeting. LS would like confirmation from the PCJC that we are heading in the right direction with thoughts given on the funding options. LS explained we need to manage the risk associated with practices providing these services and those that have to subcontract. NW suggested LS speaks to other CCG's who have redesigned their Direct Award schemes. GPa explained some thinking is needed on the benefits from scale that may arise for some of the elements. RM supports this direction of travel but we need to manage the risks in the transition period. As a CCG we need to be clear where the direct awards will be used and be clear within our procurement rules that we are following the correct processes. Clear governance is needed over the payment process and how we evidence what we are paying to practices. LS explained that in 16/17 we would keep the same services already covered by the current direct awards but if we can support practices to get the processes in place, when we start adding additional services they will be better prepared to take these on. CH asked what support have we received from practices? It was explained this has been discussed with the AVCCG Executive membership and the LMC will be consulted. **It was made clear it is not the CCG's intention that practices will not be out of pocket** and it was noted that any other options would be dramatically more expensive than this proposal. GS asked if this is the most clinically efficient way of delivering services and does it make the best use of resources. The answer is "probably" but better evidence collection in terms of quality and patient outcomes is needed. It was agreed the progress of the Direct Awards will be covered in the monthly Primary Care operational meetings. It was agreed the PCJC supports this direction of travel but more work is needed on the financial modelling. LS explained a steering group has been established who meet weekly to continue with the development of the new direct awards proposal.	
8	**Quality Report** GPa provided highlighted the main areas within the quality report. **CQC:** NHSE has learned a lot about the CQC processes so better support has been available to practices. The report picks up some of the outstanding areas from practices which provide a helpful guide to practices needing improvement. **Complaints-** AVCCG has a low number of complaints originating in this area compared to the south central area as a whole. The report highlights the "you said we did" actions which is important to demonstrate patient engagement within a practice. **Safeguarding:** the evidence through CQC inspections is positive and AVCCG has been doing some excellent work in this area.	

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	Child sexual exploitation is an important issue across the whole of Thames Valley. Practices are increasing the reporting of less serious incidents. KW added she has been visiting localities and was asked what should be reported and how. KW will put together a paper to explain these issues so our reporting figures should improve. NW commented all future reports will have complaint data at practice level.	
9	**Finance Report** CH explained there is a variance of £1k in the year to date position but with some variances to plan. Contract payments are in excess of plan due to the growth of the Berryfields Estate. This was estimated correctly by the practice so there will be over-spend on this budget line, offset by underspend in the PCO admin budget. **Premises**: CH explained a correction is needed in the coding error by NHSE Property. This spend appears in the delegated budget and also in another NHSE budget. A correction needs to be made to eliminate the variance. CH explained reserves have been used for cost pressures at Mandeville Practice as the contract has been procured to a new provider. Remaining funds will go back to individual CCG's within their 16/17 allocations. RM asked if we are able to identify the property risks within the budget. CH explained a detailed budget paper for 16/17 will be bought to the next PCJC committee meeting. No further questions raised	
11	**AOB:** LS asked if the Mandeville contract has been signed by the new provider. CH explained concerns were raised by the provider over the income risks which they can earn within the contract. NHSE have drafted a proposal addressing their concerns and are confident these have been identified and responded with a realistic proposal. CH explained the information provided in the invitation to tender was over stared and this genuine error has been made good. Additionally the patient list has reduced from the figure published in the invitation to tender. NHSE have proposed an income guarantee for a period of 6 months from the start of the contract after the patient list reopens. It is hoped the contract will be signed by Tuesday 29th March 2016. GPy advised support from NHSE has been offered to AVCCG to support the process of finding a new provider for the Mandeville surgery ready for 1st April 2017.	

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	Meeting Closed 11.00am	
12	**Date of the next meetings:** **Primary Care Operational Meeting: 7th April 2016, 9.30am – 11.00am** **Primary Care Commissioning Committee: 28th April 2016, 8.45am – 10.00am** **Primary Care Commissioning Committee 2nd June 2016, 3.30pm – 5.00pm**	

Open Action Log – Primary Care meeting

Meeting Date: 24th March 2016

Date	Agenda Item No.	Action	Owner	Open/ Closed
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. **Updated 24.03.16**: No update available. Action Point remains open.	Gary Heneage	**OPEN: 14122015** **Updated 24.03.16**

CLOSED Action Log

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**

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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**
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**
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** **CLOSED: 14.12.15**
24/09/15	11	LS to invite the AHSN onto the Healthy Town Partnership group	Louise Smith	**OPEN: 24092015** **Updated 14.12.2015**

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		Updated 14.12.15: LS has made contact but no reply to date. Action remains open **Updated 24.03.16**: Unfortunately we were not successful with the bid.		**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** **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. **Updated 24.03.16**:Report has been amended accordingly	Nicky Wadely	**OPEN: 14122015** **CLOSED: 24.03.16**
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. Updated 24.03.16: CLOSED	Gary Passaway	**OPEN: 14122015** **CLOSED: 24.03.16**

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NHS Aylesbury Vale Clinical Commissioning Group

Agenda item: 4

Primary Care Commissioning Committee
28th April 2016

Verney Close Surgery Contract

Purpose of Paper
This paper which was originally drafted by NHS England and updated for the purpose of the Primary Care Commissioning Committee sets out the chronology and resolution of a partnership dispute at Verney Close Surgery with a registered patient list of 8,753, and outlines the options for consideration regarding the contract and for a decision to be made by the Primary Care Commissioning Committee following a recommendation made in this paper.

Executive Summary
In March 2015 NHS England was alerted to a partnership dispute at the Verney Close Surgery in Buckingham, one of Aylesbury Clinical Commissioning Group member practices. Due to an ongoing partnership issue, one of the GP partners, had taken action to freeze the bank account which in turn led the remaining partners dissolving the partnership. As there was no immediate resolution to the partnership dispute or agreement for the partner to leave the contract, NHS England took legal advice as to how the primary care services for the registered list could secured during the negotiations to resolve the dispute. The Partnership dispute has now been resolved and there are four options to consider with regard to the future of the contract, each with a varying degree of risk or impact on NHS England and AVCCG: a) Do nothing (and award a continuation of the GMS contract to the re-formed practice partnership) b) Run an open tender c) Run a “closed” tender – i.e. inviting certain potential providers d) Run some form of initial market testing

Actions Required
The Primary Care Commissioning Committee is asked to consider the options available and to make a decision relating to the recommendation made in this paper.

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	√

Prepared by: Nicky Wadely, Programme Manager Co-commissioning, NHs England (South Central)

Updated by Gary Passaway, Primary Care Transformation Manager, AV CCG

1 Background

This paper sets out the chronology and resolution of a partnership dispute at Verney Close Surgery, with a registered patient list of 8,753, and outlines the options for consideration regarding the contract.

2 Introduction

In March 2015 NHS England was alerted to a partnership dispute at the Verney Surgery in Buckingham, one of Aylesbury Clinical Commissioning Group member practices. Due to an ongoing partnership issue, one of the GP partners had taken action to freeze the bank account which in turn led the remaining partners dissolving the partnership. As there was no immediate resolution to the partnership dispute or agreement for the partner to leave the contract, NHS England took legal advice as to how the primary care services for the registered list could be secured during the negotiations to resolve the dispute.

NHS England was advised to put in place a contract with the party who was able to provide services in the interim using the staff and premises employed by the partnership. NHS England was unable to secure any assurance from the doctor regarding his fitness to practice, due to a period of long term sickness, and asked him to clarify his position should he be able to provide primary care services. He did not confirm this to NHS England. Therefore a direct award was made to the remaining GPs to secure services in a timely manner and to protect patients' interests. The interim contract was put in place until end of June 2016.

The advice provided to NHS England at the time was that if the partnership dispute was not resolved, NHS England would need to consider under the Procurement, Patient Choice and Competition Regulations 2013 the requirement "*to commission services from those providers that are most capable of securing the needs of health*

care service users and improving the quality and efficiency of services, and that provide the best value for money in doing so" (Regulation 3(3) of the Procurement, Patient Choice and Competition Regulations) i.e. to undertake a competitive tendering for services. Time line of correspondence and advice is attached to this paper in Appendix 1.

On 12th February 2016, NHS England received confirmation that the partnership dispute had been resolved with the doctor taking retirement from 13th March 2015 and agreeing to withdraw any claim on the contract to provide services to the Verney Close Surgery patients (see appendix 2).

3 Next Steps

As the partnership dispute is now resolved NHS England and Aylesbury Vale CCG need to consider as joint commissioners the contractual arrangements for the future service provision at Verney Close Surgery, taking into account the requirements of the Procurement, Patient Choice and Competition Regulations 2013 and procurement advice should be sought.

4 Options for consideration

e) Do nothing (and award a continuation of the contract to the re-formed practice)
f) Run an open tender
g) Run a "closed" tender – i.e. inviting certain potential providers
h) Run some form of initial market testing

a) Do nothing (and award a continuation of the contract to the re-formed practice)

If this is to be considered further advice should be sought since a clear commitment to tender has been stated in correspondence, and also Regulation 4(2) requires NHS England to advertise on the site maintained by NHS England for that purpose (previously Supply2Health, now Contracts Finder). Therefore, unless the exception in Regulation 5(1) applies (only one possible provider of the services), NHS England would probably be in breach of the 2013 Regulations and vulnerable to a challenge.

Further legal advice has been sought to determine whether on the basis of the practice agreement with Dr X, which back dates the agreement for exit from the partnership prior to the dissolution (13th March 2015) and in addition agreement that Dr Xwill not seek to challenge the award of the contract to the remaining partners, NHS England and the CCG are in a position to reinstate the original GMS contract, held on 13th March 2015.

It must be recognised there is some risk, but this is minimised due to the practice exit agreement and in addition going to the market to undertake a competitive procurement is unlikely to provide best value, as a local procurement has recently demonstrated that APMS contracts cost more than GMS contracts.

b) Run an open tender

This is the option of least risk as it fulfils both NHS England's statutory obligations and the indication given in correspondence that a tender would be held. This complies with the duty to advertise under 4(2) and satisfies the requirement of transparency. However, it is a more costly and resource-intensive option.

c) Run a "closed" tender

This would potentially breach the duty to advertise under Regulation 4(2) unless NHS England are confident that there are only a limited number of potential suppliers in the region and invites them all to tender. The risk would be if there is a potential new entrant to the market who is not invited, but would have been interested in tendering had the contract been advertised.

NHS England could seek to mitigate its risk by following the fourth option, below, before committing to any course of action.

d) Pre-tender market testing

This would entail placing a prior information notice (PIN) in, for example, Contracts Finder or HSJ. The PIN is not an advertisement for a contract and does not commit NHS England to any particular course of action. The PIN invites expressions of interest in providing the services and could (at NHS England's option) ask for basic information around capability and competency.

Based on the response, NHS England could then decide either to follow a closed tender (if there are only a small number of responses) or make a direct award without competition (if there is only one response). The responses to the market test would give NHS England some evidence on which to base the decision.

Any decision to pursue a limited tender or make a direct award will still carry some degree of risk that there may be new entrants or potential providers who missed the initial PIN. Therefore If NHS England does decide to proceed by way of a PIN, the limited tender or direct award should proceed as quickly as possible after that in order to avoid the market moving on and potential new entrants coming on the scene.

The initial advice considered the "least-risk" option would be to run an open-tender, but now the retiring Dr has rescinded his claim this may be less of a risk.

Consideration would need to be given to the capacity of the CCG to undertake a procurement and the additional gain that would be achieved by doing this.

The Joint Commissioning Committee is asked to consider the options with regard to the Verney Close contract and agree a way forward.

Nicola Wadely
March 2016

5 Update: April 2016 for Primary Care Commission Committee

Legal Advice:

The advice provided to NHS England 30th March 2016 "Our advice remains the same and there is a risk in not re-procuring the services or making an interim award. The one point I would want to add would be that the risk of a challenge could come from any possible provider of the services and not just the retiring doctor. "

Current context:

In addition to this potentially disputed contract there is significant population growth anticipated in the local area which will require an increase in primary medical care capacity. There is also a Section 106 commitment for land/funding for new premises which is intended to support the delivery of additional capacity for the benefit of the local population. When considering the next steps for this contract the committee should factor future planning for this increasing population into the discussions regarding this contract decision.

There is a significant development and population increase expected for Buckingham area. It is anticipated that there will be an additional 3,600 dwellings in the Buckingham area as per the preferred options c), d) and e) of the Vale of Aylesbury Local Plan (VALP). However for the Northern area there would be an additional 8,200 (as an average from the three proposed potions) additional dwellings in those surrounding areas meaning the total dwellings for Buckingham and the surround Northern areas would be 11,800.

This could potentially mean a population increase of 29,500 (based on 2.5 people per dwelling calculations) for the whole area over the period 2013 – 2033.

Please see appendix 3 for an indication of expected dwellings as per the VALP.

Current quality and performance indicators:

Please see appendix 4 for background information on current quality and performance indicators for the practice.

Recommendation:

Following consideration and the legal advice received (as above) a recommendation is being made to the board to support an open tender (option b).

Subject to the decision of the Primary Care Commission Committee (PCCC) with respect to the above; considering and taking into account the length of procurement; the current interim contract would require an extension to the existing interim contract by 6 months, to expire on 31st December 2016). This will also require agreement from the PCCC.

Gary Passaway
April 2016

NHS England

NHS Aylesbury Vale Clinical Commissioning Group

Appendix 1. Verney Close Surgery, Buckingham

Timeline of correspondence and actions re continuance of primary medical services during partnership dispute

Abbreviations:
VCS Verney Close Surgery
DR Deborah Ratunabuabua, practice manager, Verney Close Surgery
NW Nicky Wadely, Contracts Manager, NHS England South (South Central)
DX Dr X, Partner at Verney Close Surgery
GH Ginny Hope, Head of Primary Care, NHS England South (South Central)
JN Jessica Newman, Asst Contract Manager, NHS England South (South Central)

Date	Correspondence/Action
11.03.15	DR contacted NW regarding an ongoing partnership dispute. NW email to DR confirming NHS England single operating policy on partnership splits and disputes.
13.03.15	Email from DR to NW informing that partnership to be dissolved in order to expel DX. Letter attached from remaining partners, Dr Mathews, Dr Hens and Dr Banks. New bank account details following freezing current practice account, potentially preventing staff salary payments.
25.03.15	DX email asking for contact on an urgent matter at his practice. NW reply stating NHS England unable to intervene in partnership issues.
31.03.15	Email from Dr Roblin, LMC asking for early intervention to secure services for patients.
13.04.15	GH request for legal advice prior to 15.04.15 meeting.
14.04.15	Advice emailed following telephone call. From Mary Chant, Blake Morgan.
14.04.15	Email from JN to Louise Patten, Chief Officer Aylesbury Vale CCG relaying legal advice.
15.04.15	Action points from meeting at VCS emailed to GH and NW. Present at meeting: JN, DR, Dr Roblin LMC and remaining partners VCS: Dr Mathews, Dr Hens and Dr Banks.
06.05.15	Email from JN to DR asking if DX had responded to letter asking him to sign over contract to Dr Mathews, Dr Hens and Dr Banks. DR confirmed nothing heard.
02.06.15	Email from JN to DR attaching letter (dated 29.05.15) offering interim GMS contract.

02.07.15	Email from DX to NW querying the offer of a contract to the remaining VCS partners. DX advised would take legal advice. Subsequent email from Paul Werrell of DR Solicitors.
10.07.15	NW drafted response sent to Debra Elliott, Director of Commissioning for sign off. Sent to Paul Werrell same day.
14.07.15	Signed and completed interim contract from1st July 2015, ending on 30th June 2016, with remaining partners
31.07.15	Letter from Blake Morgan, Solicitors on behalf of NHS England to DX Solicitors
13.08.15	Response from DX solicitors to Blake Morgan
14.09.15	Response from Blake Morgan to DX Solicitors
21.09.15	Legal advice on procurement should the dispute not be resolved
22.01.16	Correspondence with Blake Morgan regarding potential resolution
11.02.16	Agreement between DX and Verney close partners to agree his retirement

Appendix 2
Extracts from Confidential Partnership contract dated 11th February 2016

2. Dr X must sign and return the contract by 5pm on 12th February 2016, in order to document his retirement from the partnership on 13th March 2015.

3. Dr X will not seek to challenge any decision made by NHS England in relation to any contract held at any time by the Partners, whether jointly or individually, for the provision of healthcare services from Verney Close Surgery, and indemnifies the Partners for any costs they incur to any challenge brought in breach of this agreement.

The agreement also includes a transfer of Dr X share of the premises to the remaining partners within six months of the completion and signing of the agreement.

Dr X signed this agreement on 12th February 2016

Appendix 3
VALP – Settlement dwelling options.

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NHS Aylesbury Vale Clinical Commissioning Group

OPTION	Aylesbury Area		Southern Vale		Buckingham Area		Northern Vale		New Settlement(s)		Total
Sustainable Settlements	14,500	57.1%	4,200	16.5%	3,300	13.2%	3,300	13.2%			25,400
Sustainable Settlements intensification: raise density 20%	15,700	56.8%	4,600	16.6%	3,600	13.0%	3,800	13.6%			27,600
Option A Sustainable Settlements with Milton Keynes / Bletchley Extension	14,500	49.4%	4,200	14.3%	3,300	11.4%	7,300	24.8%			29,300
Option B Sustainable Settlements with one or more new settlements	14,500	49.3%	4,200	14.3%	3,300	11.4%	3,300	11.4%	4,000	13.6%	29,400
Option C Sustainable Settlements with Milton Keynes / Bletchley Extension and New Settlement	14,500	43.5%	4,200	12.6%	3,300	10.1%	7,300	21.8%	4,000	12.0%	33,300
Option D Sustainable Settlements intensification with Milton Keynes / Bletchley Extension + 20% density increase	15,700	48.5%	4,600	14.2%	3,600	11.1%	8,500	26.2%			32,300
Option E Sustainable Settlements Intensification with new settlement + 20% density increase	15,700	49.6%	4,600	14.5%	3,600	11.4%	3,800	11.9%	4,000	12.7%	31,600
Option F Dispersed approach: growth at all settlements, other than the smallest hamlets	13,000	42.0%	5,600	18.0%	3,100	10.0%	9,300	30.0%			31,000
Option G Dispersed approach with extension to Milton Keynes / Bletchley	12,400	40.0%	5,000	16.0%	2,500	8.0%	11,200	36.0%			31,000
Option H Dispersed approach with one or more new settlements	11,800	38.0%	5,000	16.1%	2,200	7.0%	8,100	26.0%	4,000	12.9%	31,000
Option I Dispersed approach with extension to Milton Keynes / Bletchley and new settlement	10,300	33.3%	4,300	14.0%	2,000	6.4%	10,300	33.3%	4,000	12.9%	31,000

NHS England

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Appendix 4

VERNEY CLOSE SURGERY BUCKINGHAM

BACKGROUND INFORMATION

1. National Patient Survey

Practice average across key questions compared to Aylesbury Vale CCG and NHS England averages.

	Satisfaction with Telephone Access				Overall Experience of Making an Appointment				Satisfaction with Opening Hours			
	12/13	13/14	14/15	15/16	12/13	13/14	14/15	15/16	12/13	13/14	14/15	15/16
Verney Close Practice	66%	59%	63%	76%	70%	64%	70%	75%	75%	65%	62%	64%
CCG Average	78%	75%	76%	68%	76%	75%	77%	68%	77%	76%	75%	63%
England Average	75%	73%	72%	70%	76%	75%	74%	73%	80%	77%	76%	75%
	Overall Experience of GP Surgery				**Confidence in GP**				**Confidence in Nurse**			
	12/13	13/14	14/15	15/16	12/13	13/14	14/15	15/16	12/13	13/14	14/15	15/16
Verney Close Practice	80%	75%	81%	85%	90%	89%	91%	96%	91%	82%	87%	91%
CCG Average	94%	94%	94%	84%	89%	87%	87%	79%	83%	82%	83%	72%
England Average	87%	86%	85%	78%	93%	93%	92%	92%	87%	86%	86%	84%

NHS England

NHS Aylesbury Vale Clinical Commissioning Group

2. Friends and Family Test Results

	Verney Close Practice		Aylesbury Vale CCG average		NHS England average	
	% Recommended	% Not Recommended	% Recommended	% Not Recommended	% Recommended	% Not Recommended
January 2015	86%	9%	86%	8%	89%	5%
February 2015	86%	9%	85%	7%	89%	6%
March 2015	100%	0%	87%	6%	88%	6%
April 2015	91%	0%	87%	7%	88%	6%
May 2015	No data		80%	11%	88%	6%
June 2015	No data		85%	9%	88%	6%
July 2015	100%	0%	83%	10%	89%	6%
August 2015	No data		82%	9%	88%	6%
Sept 2015	79%	17%	85%	10%	89%	6%
October 2015	No data		88%	8%	89%	5%
Nov 2015	68%	10%	86%	8%	89%	6%
Dec 2015	13%	0%	88%	7%	88%	6%
January 2016	91%	0%	85%	10%	89%	6%
February 2016	85%	3%	83%	11%	88%	7%

3. CQC

The practice has not been inspected under the new inspection regime but received an inspection on 05.03.14 when they met all the required criteria at the time:

- Treating people with respect and involving them in their care
- Providing care, support and treatment that meets people's needs
- Caring for people safely and protecting them from harm
- Staffing
- Quality and suitability of management.