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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on
Tuesday, 25th November, 2014 at 10.00 am

(A pre-meeting will take place for ALL Members of the Board at 9.30 a.m.)

MEMBERSHIP

Councillors

J Akhtar - Hyde Park and Woodhouse;
D Coupar (Chair) - Cross Gates and Whinmoor;
B Flynn - Adel and Wharfedale;
G Hussain - Roundhay;
P Latty - Guiseley and Rawdon;
S Lay - Otley and Yeadon;
J Lewis - Kippax and Methley;
K Maqsood - Gipton and Harehills;
E Taylor - Chapel Allerton;
S Varley - Morley South;
J Walker - Headingley;

Co-optees

Dr J Beal - HealthWatch Leeds

Please note: Certain or all items on this agenda may be recorded

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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Head of Governance Services at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND THE PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows: **No exempt items have been identified.**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES - 30 SEPTEMBER AND 28 OCTOBER 2014** To confirm as a correct record, the minutes of the meetings held on 30 September and 28 October 2014.	1 - 16
7			**CHAIR'S UPDATE REPORT (NOVEMBER 2014)** To receive a report from the Head of Scrutiny and Member Development providing an update on some of the areas of work and activity of the Chair of the Scrutiny Board since the Scrutiny Board meeting in October 2014.	17 - 18
8			**PRIMARY CARE SERVICES IN LEEDS** To receive a report from the Head of Scrutiny and Member Development providing an overview of Primary Care Services in Leeds and on-going developments.	19 - 160

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**WORK SCHEDULE** To consider the Scrutiny Board's work schedule for the 2014/15 municipal year.	161 - 172
10			**DATE AND TIME OF THE NEXT MEETING** Tuesday, 16 December 2014 at 10.00am in the Civic Hall, Leeds (Pre-meeting for all Board Members at 9.30am) **THIRD PARTY RECORDING** Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda. Use of Recordings by Third Parties– code of practice a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title. b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.	

SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

TUESDAY, 30TH SEPTEMBER, 2014

PRESENT: Councillor D Coupar in the Chair

Councillors J Akhtar, B Flynn, G Hussain, P Latty, J Lewis, K Maqsood, E Taylor, S Varley and J Walker

Non-voting co-opted member: J Beal (HealthWatch Leeds)

15 Chair's Opening Remarks

The Chair welcomed everyone to the September meeting of the Scrutiny Board (Health and Well-Being and Adult Social Care).

In particular, the Chair welcomed Dr John Beal to his first meeting of the Scrutiny Board. It was noted that Dr Beal had been nominated as a non-voting co-opted member of the Scrutiny Board, representing HealthWatch Leeds.

16 Late Items

In accordance with powers under Section 100B(4)(b) of the Local Government Act 1972, the Chair agreed to accept the following late information:

- Leeds Teaching Hospitals NHS Trust (LTHT) updated 'SHOULD' improve action plan (minute 21 refers).

The above information was not available at the time of agenda despatch and was subsequently made available on the Council's website.

17 Declaration of Disclosable Pecuniary Interests

There were no disclosable pecuniary interests declared to the meeting.

18 Apologies for Absence and Notification of Substitutes

An apology for absence was submitted by Councillor Lay. No substitute members were in attendance.

19 Minutes - 15 July 2014

RESOLVED – That the minutes of the meeting held on 15 July 2014 be approved as a correct record.

20 Chairs Update Report - September 2014

The Head of Scrutiny and Member Development submitted a report that provided an outline of activity undertaken since the Board's meeting in July 2014, which included:

- Commissioning of Specialised Services;
- Developments in the commissioning/ provision of Children's Epilepsy Surgery;
- Commissioning arrangements on a West Yorkshire footprint – work of the 10 CC Group
- Commissioning / provision of Personality Disorder Services in Leeds;
- Discussions with Leeds Local Medical Committee (LMC);
- Maternity Services provision in Leeds;
- Care Ring services;
- Work of the West Yorkshire Area Team (NHS England);
- Forthcoming Care Quality Commission (CQC) inspections;
- Work of the Joint Health Overview and Scrutiny Committee (JHOSC);
- NHS England's ongoing review of services Children's Cardiac Surgery Services at LTHT (following the temporary suspension of services in March/ April 2013).

The Chair provided a verbal report at the meeting, drawing particular attention to the discussions with Leeds' Local Medical Committee around GPs awareness and understanding of the Council's Choice Based Lettings process.

Members requested they be provided with details of Leeds' Local Medical Committee.

RESOLVED – To note the report and update provided at the meeting.

21 Leeds Teaching Hospitals NHS Trust: Care Quality Commission - Hospitals Inspection Outcome and Action Plan

The Head of Scrutiny and Member Development submitted a report that presented a summary of the outcome of the Care Quality Commission (CQC) hospital inspection of services provided by Leeds Teaching Hospitals NHS Trust (LTHT), alongside the Trust's associated action plans.

The following representatives were in attendance:

- Professor Suzanne Hinchliffe – Chief Nurse and Interim Chief Operating Officer, Leeds Teaching Hospitals NHS Trust
- Craig Brigg – Director of Quality, Leeds Teaching Hospitals NHS Trust
- Russell Hart-Davies – Head of Quality, Leeds' Clinical Commissioning Groups

The Chief Nurse and Director of Quality gave a brief outline of the inspection, publishing the reports and the process for developing the Trust's action plan. As part of the introduction, a number of points were highlighted, including:

- The Trust felt the reports reflected the position of the organisation and had highlighted areas already identified by senior management.
- The CQC reports did not present any 'surprises'.
- The CQC highlighted a number of areas the Trust 'must' improve and additional areas it 'should' improve.
- The initial action plan to address the areas of improvement was briefly discussed at a Quality Summit meeting in July 2014.
- Progress against the action plan was monitored through the Trust's Quality Committee. The Trust also met monthly with Clinical Commissioning Groups (CCGs) to review progress. It was also noted that NHS Trust Development Authority maintained overall oversight of progress.

Members of the Scrutiny Board reflected on the verbal introduction and discussed the details presented on the agenda. Members raised a number of specific matters including:

- Accountability of the current and previous members of the Trust Board.
- Why earlier action had not been taken if the CQC report did not raise any 'new' issues / areas for improvement.
- Confirmation of the processes for monitoring progress against the action plans – both internally and externally.
- Noting with concern that of the 6 areas of assessment, the CQC had identified that 4 areas required improvement.
- Given the Trust's current financial position, the financial implications of addressing the areas for improvement – particularly in relation to staffing shortages.
- Availability of suitably qualified staff and the Trust's ability to attract high calibre individuals.
- Concern around the staff training and low level of appraisals highlighted by the CQC.
- Quality assurance roles and responsibilities (in general) across NHS/ health services in Leeds.
- Concern that the flow of the improvement plans did not follow a similar format to that of the inspection reports and areas of assessment: Making it difficult to identify and track improvement activity against the original findings and areas of assessment.

In response, the Trust noted the comments made by the Scrutiny Board and outlined progress against the issues identified by the CQC and detailed within the Trust's action plans. The Trust also stated that the CQC's overall 'requires improvement' assessment was comparable with other Teaching Hospitals in England and that the inspection had not identified any critical issues.

The Scrutiny Board also discussed:

- Issues associated with the release of deceased relatives to aid timely burials across the Muslim community.
- The reuse, refurbishment and recycling of hospitals equipment.

The Board requested that the Trust provide further details of its activity and future plans in respect of the above matters.

RESOLVED –

(a) To note the report and the information presented and discussed at the meeting.
(b) To receive a further progress update from Leeds Teaching Hospitals NHS Trust against its action plans at the Scrutiny Board meeting in December 2014.
(c) To consider quality assurance processes, including roles and responsibilities, across NHS/ health services in Leeds.

22 Consultation, Engagement and Communication Strategy for the Care Act (2014)

The Director of Adult Social Services submitted a report presenting the Consultation, Engagement and Communication Strategy in respect of the Care Act (2014).

The following representatives were in attendance:

- Councillor Adam Ogilvie (Executive Board Member for Adult Social Services) – Leeds City Council
- Dennis Holmes (Deputy Director, Adult Social Services) – Leeds City Council
- Sukhdev Dosanjh (Chief Officer, Adult Social Care Reforms) – Leeds City Council

The Executive Board Member and officers present gave a brief introduction to the report, highlighting a number of issues in relation to the Care Act (2014), including:

- The Act represented the biggest change to the Adult Social Care landscape in 60 years.
- The Act placed the wellbeing of individuals at the heart of all activity.
- The Act presented a series of challenges for the Council, with issues associated with carers representing a significant pressure.
- National guidance was expected 13 October 2014 and consideration about 'the Leeds offer' was needed.
- There was potentially a big risk associated with a significant increase in demand for services in the context of the current public sector financial environment.

Members of the Scrutiny Board reflected on the verbal introduction and discussed the details presented on the agenda. Members raised a number of specific matters including:

- How to effectively engage/ communicate with service users across different communities.
- Responsibilities regarding the needs of offenders.
- The pressures/ challenges faced by the Council in responding to the requirements of the Care Act 2014.
- Concern about the timing of the release/ availability of national guidance in relation to the requirements of the Care Act 2014.

The Board requested that Councillor Ghulam Hussain be involved in discussions around engagement with communities.

RESOLVED –

(a) To note the report and the information presented and discussed at the meeting.
(b) To refer the matter, including monitoring of the proposed action plan, to the Adult Social Care Working Group.

23 Better Care Fund Overview

The Head of Scrutiny and Member Development submitted a report providing an overview of how the national Better Care Fund (BCF) was being implemented in Leeds, including:

- The context of plans for a sustainable health and social care system in the city;
- The financial challenge facing the health and social care economy in Leeds;
- Progress on implementation of the BCF since it was announced in 2013;
- The individual BCF project areas;
- The allocated budget and projected savings for each project;
- The timescales and management / governance arrangements.

The following representatives were in attendance:

- Councillor Lisa Mulherin (Executive Board Member for Health and Wellbeing) – Leeds City Council
- Councillor Adam Ogilvie (Executive Board Member for Adult Social Services) – Leeds City Council
- Dennis Holmes (Deputy Director, Adult Social Services) – Leeds City Council
- Matt Ward (Chief Operating Officer) – Leeds South & East Clinical Commissioning Group

The representative present gave a brief introduction to the report and information provided, reiterating the significant challenges posed across the health and social care landscape in Leeds. There was also an

acknowledgement of the significant work undertaken to date and genuine approach to partnership working to meet the challenges ahead.

Members of the Scrutiny Board reflected on the verbal introduction and discussed the details presented on the agenda. Members raised a number of specific matters including:

- Processes for managing and sharing financial risks across health and social care organisations in Leeds.
- Governance arrangements and the respective roles of Leeds' Health and Wellbeing Board and NHS England.
- Queries about deliverability and whether or not the scheme would make a significant difference to service users.
- Some concern that, predominantly, the proposals seemed an extension of existing schemes already underway.
- The extent to which all GPs in Leeds were on board with the proposals.
- Workforce issues associated with delivering 7-day, 24hr services.

RESOLVED –

(a) To note the report and the information presented and discussed at the meeting.
(b) That the respective roles of the Health and Wellbeing Board and the Scrutiny Board, insofar as they relate to the Better Care Fund, be subject to further discussions between the respective Chair of those Boards.
(c) That the outcome of those discussions (in (b) above) be reported to a future meeting of the Scrutiny Board.

(Councillor James Lewis left the meeting at 12:10pm during consideration of this item)

24 Work Schedule - September 2014

The Head of Scrutiny and Member Development submitted a report setting out the progress and ongoing development of the Scrutiny Board's work schedule for the current municipal year, which included a particular focus around the provision of Child and Adolescent Mental Health Services (CAMHS) in Leeds.

The report also outlined:

- Progress of the Scrutiny Board's two working groups and outlined some proposed changes to provide the Board with greater flexibility and capacity.
- Working arrangements with other Scrutiny Boards.

Members discussed the issues presented in the report and outlined at the meeting.

RESOLVED –

(a) To note the content of the report and its appendices.
(b) To establish the 'Adult Social Care Working Group', to cover general issues relating to Adult Social Care.
(c) To note that the work of the current 'Homecare Working Group' will form part of the activity undertaken by the 'Adult Social care Working Group' (referred to in (b) above).
(d) To nominate Councillor E Taylor as the Board's representative on the Sport and Active Lifestyles Working Group, established by the Scrutiny Board (Sustainable Economy and Culture).

25 Date and Time of the Next Meeting

RESOLVED – To note the date and time of the next meeting as Tuesday, 28 October 2014 at 10:00am (with a pre-meeting for members of the Scrutiny Board from 9:30am).

(The meeting concluded at 12:25pm)

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SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

TUESDAY, 28TH OCTOBER, 2014

PRESENT: Councillor D Coupar in the Chair

Councillors J Akhtar, B Flynn, G Hussain, P Latty, S Lay, J Lewis, K Maqsood, E Taylor, S Varley and J Walker

Non-voting co-opted member: J Beal (HealthWatch Leeds)

26 Chair's Opening Remarks

The Chair welcomed everyone to the October meeting of the Scrutiny Board (Health and Well-Being and Adult Social Care).

In particular, the Chair welcomed Councillor Judith Chapman (Chair, Scrutiny Board (Children and Families)), specifically attending in relation to the mental health framework (minute no. 32 refers) and the provision of mental health services and support for children and young people (minute no. 33 refers).

27 Late Items

There were no late items; however members of the Scrutiny Board received a set of presentation in relation to Leeds' Mental Health Framework (minute no. 32 refers). The presentation did not provide any new/ additional information and summarised the information already presented in the report.

28 Declaration of Disclosable Pecuniary Interests

There were no disclosable pecuniary interests declared to the meeting, however in relation to agenda item 9, Child and Adolescent Mental Health Services (CAMHS), Mr J Beal drew the Board's attention to the fact that a close family member was a CAMHS practitioner. As this was not a pecuniary interest, Mr J Beal remained in the meeting for that part of the discussion (minute no. 33 refers).

29 Apologies for Absence and Notification of Substitutes

There were no apologies for absence and no substitute members were in attendance.

30 Minutes - 30 September 2014

RESOLVED – The draft minutes from the meeting held on 30 September 2014 be deferred until the next meeting (25 November 2014).

31 Chair's Update Report - October 2014

The Head of Scrutiny and Member Development submitted a report that provided an outline of the Chair's activity since the Board's meeting in September 2014.

The Chair provided a verbal report at the meeting, drawing particular attention to the discussions / activity around the following matters:

- Work of the Joint Health Overview and Scrutiny Committee (JHOSC) – particularly relating to the new congenital heart disease (CHD) review;
- NHS England's ongoing review of services Children's Cardiac Surgery Services at LTHT (following the temporary suspension of services in March/ April 2013);
- Meeting a range of stakeholders in relation to Swillington GP Surgery; and,
- The availability of healthy food options at health care establishments across the City.

Members discussed the information provided, in particular the availability of healthy food options at health care establishments across the City – and requested an overall position statement. Members also suggested this should be extended to include Leeds City Council Sports establishments.

Progress against previous matters highlighted at the Scrutiny Board was also discussed – in particular issues associated with the release of deceased relatives to aid timely burials across the Muslim community

RESOLVED –

(a) To note the report and update provided at the meeting.
(b) To request an overall position statement in relation to the availability and provision of healthy food options at health care establishments across the City.
(c) To expand the request in (b) above, to include Leeds City Council Sports establishments.

32 Leeds' Mental Health Framework

The Head of Scrutiny and Member Development submitted a report introducing a summary paper in relation to Leeds' Mental Health Framework (2014 – 2017).

The following representatives were in attendance:

- Liane Langdon (Director of Commissioning and Strategic Development) – NHS Leeds North CCG
- Jane Williams (Strategic Commissioning Lead – Mental Health) – NHS Leeds North CCG
- Victoria Eaton (Consultant in Public Health) – Leeds City Council

- Mick Ward (Head of Commissioning (Adult Social Care) – Leeds City Council)

The Director of Commissioning and Strategic Development gave a brief outline of the report and the process for developing the draft framework to date. As part of the introduction, a number of points were highlighted, including:

- The role of the Mental Health Partnership Board in developing the draft framework.
- One of the aims of the Mental Health Framework was to help inform the transformation over the coming 12 months.
- A significant challenge was around parity of esteem between mental health and physical needs/ care.
- Recent planning guidance from NHS England had identified 'parity of esteem' in relation to mental health services. In response, contracts were being developed to include clauses to ensure NHS service providers adopted the principles of parity of esteem.

Members of the Scrutiny Board reflected on the details presented and raised a number of specific matters, including:

- The mental health needs (including transition) of Children and Young People insufficiently reflected in the framework;
- Leeds Mental Health Needs Assessment highlighted that 50% of mental health issues occur before 14 years of age.
- Partnership arrangements and associated governance.
- Wider determinants / contributors of mental ill-health.
- Despite an increased focus on improving mental health, demand for services appeared to be rising.
- Current baseline information in order to help identify the direction of travel and impact of the Mental Health Framework sometime in the future.
- Relationships with Community Committees and identified priority areas.
- Personalised health budgets – specifically in relation to helping to address mental health needs.
- The work and role of Third Sector organisations.
- Waiting times for diagnosis and treatment, including how these related/ compared to physical health needs.
- Prevalence of mental ill-health across different communities.
- The likely reduction in the bed-base to reflect the shift in the model of care (i.e. a greater focus of recovery and rehabilitation).
- How Leeds' draft framework reflected the detail of the 'Closing the Gap' report (published January 2014).

Through the discussion and responses provided, members identified a range of additional information to be provided, including:

- A copy of the 'Whole Life Course' (covering children and adults), presented to the Health and Wellbeing Board.
- Details of the Mental Health Partnership Board and its associated governance arrangements.
- Details of current performance (including referral / waiting times) associated with mental health service provision.
- Associated action plans to support the delivery of the Leeds Mental Health Framework.

RESOLVED –

(a) To note the report and the information presented and discussed at the meeting.
(b) To request the additional information (noted above) identified during the discussion.
(c) To give further consideration to the Mental Health Framework, with a particular focus on supporting action plans, at the Scrutiny Board meeting in January 2015.

In conclusion, the Chair thanked those in attendance for their contribution to the discussion.

33 Leeds' Child and Adolescent Mental Health Services and Targeted Mental Health in Schools

The Head of Scrutiny and Member Development submitted a report introducing a summary paper in relation to Leeds' Child and Adolescent Mental Health Services (CAMHS) and Targeted Mental Health in Schools (TaMHS).

The following representatives were in attendance:

- Matt Ward (Chief Operating Officer) – NHS Leeds South & East CCG
- Jane Mischenko (Commissioning Lead – Children and Maternity Services) – NHS Leeds CCGs
- Paul Bollom (Head of Commissioning and Market Management) - Children's Services, Leeds City Council

Those in attendance gave a brief introduction and outline of the report. As part of the introduction, a number of points were highlighted, including:

- There were significant concerns about access to CAMHS, nationally. This was also reflected regionally and locally.
- There was a level of unmet demand for services, which was reflected by feedback from stakeholders.
- A review of service provision had recently started and this was the highest priority area for Children's Commissioning. The report and recommendations to be reported to the Integrated Commissioning Executive (ICE) by March 2015.

- Support and services for children were provided through a mixture of provision.
- There was a complexity to the commissioning and provision of services, but recognition that changes are needed around access to emotional and mental health services.
- There were a number of challenges, including:
  Providing the same level of access to services for children and young people, when compared to services for adults.
  The need for early interventions and support, i.e. upstreaming services.
  Significant demand and capacity issues.
  Recognition that the review may not resolve all the current issues.
- The use of seed-funding to support Targeted Mental Health in Schools (TaMHS) was seen as a particular strength in Leeds.
- The review would seek to build on current strengths and consider the challenges facing the City. The review would include:
  Refreshing the local health needs assessment (currently 2 years old), with the backdrop of the national prevalence information being based on 2004 data and updated national prevalence information unlikely to be available until 2016/17.
  Modelling current patient flows across the system.
  Benchmarking activity, looking at key performance data such as activity, waiting times, turnover etc.

Members of the Scrutiny Board reflected on the details presented and raised a number of specific matters, including:

- The need for a clearer overall spending/ funding analysis across CAMHS and TaMHS, including the different tiers of provision.
- Saddened that, excluding dementia, 50% of mental illnesses in adult life start before age 15 and 75% by age 18. There appeared to be a clear need to focus on early interventions and appropriate access to such services.
- The involvement of children and families in the design of services was crucial.
- Notwithstanding attempts to understand local needs, concern in relation to, what appeared to be, out of date national prevalence data.
- Concern there may be inconsistent TaMHS provision across the City due to different arrangements and priorities within school clusters. The Scrutiny Board should reflect on the School Clusters enquiry report produced by the Scrutiny Board (Children and Families).
- The relationship between emotional wellbeing and attendance and behaviour in Leeds.
- The relative protected nature of schools budgets (when compared to other public services) and the challenge/ opportunity for NHS commissioners to work more closely with the school community.
- The need for the Scrutiny Board to consider the evaluation reports in relation to TaMHS services.
- Queries around whether there had been any analysis of current provision against national / local policies.

- The transition between child and adult services.
- Some concern about the lack of clarity and transparency around the role of the Integrated Commissioning Executive (ICE).
- The need to have access to the full report recently presented to the ICE.
- The need to provide data around the level of current provision and existing/ future demand for services.

In summing up the discussion, the Chair confirmed the Board's intention to invite contributions from a range of stakeholders and it was hoped that the Scrutiny Board's inquiry would feed into the review reporting in March 2015 (as discussed during the meeting).

The Chair also confirmed the need for a range of information to be made available to the Scrutiny Board, including:

- Performance data in relation to access, waiting times and outcomes.
- Information around demand for services and current capacity.
- A copy of the full report recently presented to the Integrated Commissioning Executive (ICE).
- Information regarding the consistency of TaMHS provision across the City
- Relevant details from the School Clusters enquiry report produced by the Scrutiny Board (Children and Families)
- A clearer overall spending/ funding analysis for CAMHS and TaMHS services across the City, including the different tiers of provision.

RESOLVED –

(a) To note the report and information presented and discussed at the meeting.
(b) That the additional information requested at the meeting (as detailed above) be provided and presented to the Scrutiny Board, ideally at its meeting in December 2014.

On conclusion of the discussion, the Chair thanked those in attendance for their open contributions to the discussion.

(Councillor James Lewis left the meeting at 12:00 noon during consideration of this item).

34 Work Schedule

The Head of Scrutiny and Member Development submitted a report setting out the progress and ongoing development of the Scrutiny Board's work schedule for the current municipal year, which included a particular focus around Mental Health and the provision of Child and Adolescent Mental Health Services (CAMHS) in Leeds.

Members discussed the issues presented in the report and raised a number of matters at the meeting, including:

- The Director of Public Health's Annual Report and requested that this be presented to the Scrutiny Board for consideration (including progress on previous reports/ recommendations).
- Equality Impact Assessments associated with the provision of mental health services in Leeds.
- The 'Due North' report highlighted in the minutes from the Executive Board meeting held on 15 November 2014. The Scrutiny Board noted the referral to the Health and Wellbeing Board and requested the outcome of such consideration be reported to a future meeting of the Scrutiny Board.
- Members noted that, earlier that morning, NHS England had published the final two reports following the temporary suspension of children's cardiac surgery services at Leeds Teaching Hospitals NHS Trust in March/ April 2013.

RESOLVED –

(a) To note the content of the report and its appendices.
(b) To amend the work schedule presented to reflect the discussion and outcomes of the meeting.

35 Date and Time of the Next Meeting

Tuesday, 25 November 2014 at 10:00am (with a pre-meeting for members of the Scrutiny Board from 9:30am).

(The meeting concluded at 12:10pm)

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 25 November 2014

Subject: Chairs Update Report – November 2014

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to outline some of the areas of work and activity of the Chair of the Scrutiny Board since the Scrutiny Board meeting in October 2014.

2 Main issues

2.1 Invariably, scrutiny activity often takes place outside of the formal monthly Scrutiny Board meetings. Such activity can take the form of working groups (as detailed in the work schedule report, elsewhere on the agenda), but can also take the form of specific activity and actions of the Chair of the Scrutiny Board.

2.2 The purpose of this report is to provide an opportunity to formally update the Scrutiny Board on activity since the last meeting, including any specific outcomes. It also provides an opportunity for members of the Scrutiny Board to identify and agree any further scrutiny activity that may be necessary.

2.3 Since the last Scrutiny Board meeting, the Chair and Principal Scrutiny Adviser have been involved in a series of meetings and/or discussions covering a wide range of issues/ areas, including:

- Provision of healthy food at Leeds' health care establishments and Leeds City Council's sports establishments.
- Muslim burials – release of deceased relatives.
- Work of the Joint Health Overview and Scrutiny Committee (JHOSC) for Yorkshire and the Humber.

- Progress of the Care Quality Commission's inspection of Leeds and York Partnership NHS Foundation Trust.
- West Yorkshire Health Scrutiny Chairs – commissioning services across a wider area.

2.4 The Chair and Principal Scrutiny Adviser will provide a verbal update at the Scrutiny Board meeting, as required.

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and the verbal update provided at the meeting.
b) Identify any specific matters that may require further scrutiny input/ activity.

4. Background papers[1]

4.1 None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 25 November 2014

Subject: Primary Care Services in Leeds

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to provide the Scrutiny Board with an overview of Primary Care Services in Leeds and on-going developments.

2 Main issues

2.1 Primary Care was identified as an area for consideration as part of the Scrutiny Board's discussion around its work programme earlier in the municipal year. Therefore the purpose of this report is to provide an overview of Primary Care Services in Leeds and on-going developments.

2.2 Primary Care Commissioning was the subject of a report to the Health and Wellbeing Board at its meeting on 22 October 2014. The report prepared and presented to the Health and Wellbeing Board by NHS England (West Yorkshire Area Team) is appended to this report. The relevant extract from the minutes of the Health and Wellbeing Board meeting as detailed below:

> *Further to Minute 7 of the meeting held 18 June 2014, Moira Dumma, NHS England, West Yorkshire, presented a report on the NHS England commissioning approach and plans for primary care services in Leeds for 2014-2016, covering the major commissioning areas of General Practice, Dental Services, Community Pharmacy and Community Optometry.*
>
> *A revised version of the appendix to the report had been circulated prior to the meeting.*

The Chair reported that she had responded on behalf of HWB to NHS England's request for comments on co-commissioning by welcoming the move to more local decision making and seeking a role for the HWB.

In considering the report, the following matters were highlighted:

- *Co-commissioning – noted the development work being undertaken across the CCGs in readiness for implementation in April 2015. Updates would be provided as plans emerged*
- *Oral health - noted the progress made by Leeds and that the Oral Health Strategy would be presented to HWB early next year*
- *Links and monitoring - the need to ensure that issues raised in various partner meetings were fed into the co-commissioning plans and that monitoring of the new working arrangements would ensure progression*
- *Ambitions – commented that the plans did not reference co-commissioning as an ambition for Primary Care and that additional narrative on how patient feedback shaped service provision was required in order to meet the criteria of the JHWS*
- *Recognition of the need to discuss how change will be instigated and delivered, and the external factors which might affect delivery.*
- *Existing practice - recognised that some existing practices had grown out of immediate service need rather than an overview of provision being taken.*

HWB discussed examples –

- *HWB discussed the example of child mental health which was dependant on individual teachers and cluster organisations taking a role and required behavioural changes in adults to recognise children in difficulty. Noted the comment that Clusters should be involved in service planning for this issue*

- *deprivation and it's influence on provision, noting that individual former PCTs would have had regard to the deprivation indexes and shaped provision accordingly although it could be said that those indicators were now out of date. A workshop scheduled for the New Year would consider this issue and service structure*

Extended GP opening hours - noting that West CCG had implemented extended service as a pilot scheme to test uptake, HWB considered the demand for the services, the role of third sector for provision of some services, resources and capacity. HWB felt it would be useful to receive the results from West CCG and national pilots

RESOLVED –

a) *To note the report and associated work being carried out in Leeds to deliver high quality primary care services and improve general practice, dental, pharmacy and optometry services.*

b) That the comments made on the challenges and opportunities facing primary care in Leeds, in particular relating to access, quality and sustainability of services, be noted.

c) That a further report be provided to HWB members in due course on the results and/or success of the 7 day General Practice working undertaken by Leeds West CCG and nationally; to include information on the access and uptake of services and reference to any impact of the move of some provision from acute to General Practice provision.

d) That a further performance report on the CCGs be presented in due course following the implementation of the new ways of working.

2.3 Given the ongoing development of the health system, the following information – relevant to local primary care (in particular GP services) – is also appended to this report.

- Next Steps Towards Primary Care Co-commissioning – NHS England (November 2014).
- Framework for Responding to CQC Inspections of GP practices – NHS England (October 2014)

2.4 Representatives from NHS England (West Yorkshire Area Team) and Leeds' Clinical Commissioning Groups have been invited to attend the meeting and contribute to the Scrutiny Board's discussion..

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and attached appendices.
b) Consider the information provided and identify any specific issues or matters, associated with the commissioning and/or delivery of Primary Care Services in Leeds, that require further scrutiny.

4. Background papers[1]

4.1 None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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Leeds Health & Wellbeing Board

Report author: Alison Knowles
Tel: 0113 2474306

Report of: **Director NHS England West Yorkshire**

Report to: **Leeds Health and Wellbeing Board**

Date: **22 October 2014**

Subject: **Commissioning Primary Care Services in Leeds 2014-16**

Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

NHS England's West Yorkshire Team are responsible for commissioning primary care services in Leeds, and following an initial update to the Board in June as part of the NHS planning cycle, the attached paper sets out the commissioning approach and plans for primary care services in Leeds over the two years from 2014-2016, covering major commissioning areas: General Practice, Dental Services, Community Pharmacy and Community Optometry.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the report and associated work being carried out in Leeds to deliver high quality primary care services and improve general practice, dental, pharmacy and optometry services.
- Comment on the challenges and opportunities facing primary care in Leeds, in particular relating to access, quality and sustainability of services.

1 Health and Wellbeing Board Governance

1.1 Consultation and Engagement

1.1.1 The work of the NHS England in commissioning primary care is underpinned by regular consultation and engagement with CCG areas, GP practices, patient reference groups and the public, particularly through the GP survey.

1.2 Equality and Diversity / Cohesion and Integration

1.2.1 Strategic planning entails a significant amount of work to ensure services are planned and delivered with equality and diversity as key considerations. The work of NHS England is underpinned by regular considerations of the implications of plans for the cohesion of a diverse city such as Leeds.

1.3 Resources and value for money

1.3.1 There are no direct resources implications resulting from this report.

1.4 Legal Implications, Access to Information and Call In

1.4.1 There are no legal implications or access to information implications relating to this report. It is not subject to call in.

1.5 Risk Management

1.5.1 There are no risk management indications relating directly to this report.

2 Recommendations

The Health and Wellbeing Board is asked to:

- Note the report and associated work being carried out in Leeds to deliver high quality primary care services and improve general practice, dental, pharmacy and optometry services.
- Comment on the challenges and opportunities facing primary care in Leeds, in particular relating to access, quality and sustainability of services.

HEALTH AND WELLBEING BOARD

22ND OCTOBER 2014

SUPPLEMENTARY DOCUMENTS –

AGENDA ITEM 9 COMMISSIONING PRIMARY CARE SERVICES IN LEEDS 2014-16

A revised appendix to the report is attached. Please note the amendments in respect of the table included within para 3.2 “Improving Patient Experience and Access” (page 4 of the appendix)

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Leeds Health & Well-being Board

Commissioning Primary Care Services in Leeds – 2014-2016

October 2014

Introduction

This paper sets out the commissioning approach and plans for primary care services in Leeds over the two years from 2014-2016. There are four sections based on the four contractor groups:

A. General practice
B. Dental services
C. Community pharmacy
D. Community optometry

A. General Practice

1. Approach

This paper has been produced collaboratively by the four NHS organisations with commissioning responsibilities for General Practice in Leeds: NHS England, NHS Leeds North CCG, NHS Leeds South and East CCG, and NHS Leeds West CCG. It sets out the national Strategic Ambition for general practice, the local challenges and the commissioning response for the next two years.

2. NHS England Strategic Ambition for General Practice

In summer 2013, NHS England launched a Call to Action: *Improving general practice.* The purpose of this consultation was to support action to transform services in local communities and to stimulate debate as to how we can best support the development of primary care to improve outcomes and tackle inequalities.

Out of the Call to Action, NHS England has set out an ambition for primary care:

We want to ensure that everyone in England gets access to the same high quality services.

a. **Proactive, coordinated care**: anticipating rather than reacting to need and being accountable for overseeing your care, particularly if you have a long term condition.

b. **Holistic, person-centred care**: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.

c. **Fast, responsive access to care:** giving you confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations.

d. **Health-promoting care**: keeping you healthy and ensuring timely diagnosis of illness, engaging differently with communities to improve health outcomes and reduce inequalities.

e. **Consistently high quality care**: reducing unwarranted variations in effectiveness, patient experience and safety.

In order to support delivery of our ambitions, we believe that primary and community providers will need to operate **at greater scale and in greater collaboration** with one another, and with patients, carers and local communities.

Importantly, this does not necessarily have to involve a change in organisational form, but the organisations and individuals within those organisations across primary and community care will need to organise themselves together in larger groupings, in formal ways, supported by investment and management capacity.

Our approach is that there should be **no national blueprint** for how this is done but that change should be locally led and over the next two years, NHS England will deliver a series of commissioning workstreams that enable change:

	Description	**Deliverables**
Service Models	A description of the key service components required to deliver against our five ambitions, along with the implications for providers (primary care at scale).	Practical resources to support local strategy development, including: • Service component descriptions, by ambition • An explanation of the strategic choices providers will face • Practical examples and case studies in all areas. (This will also draw on learning from the Prime Minister's Challenge Fund)
Standards for out of hospital care	National standards for any out of hospital care providers that reflect our five ambitions and can be applied to the range of potential providers of the future.	A small number of measurable national standards for out of hospital care, to be incorporated into the contracts for all primary care providers. (It is anticipated that the majority of standards and associated goals for these services would be set locally.)
Co-commissioning	The nationally agreed arrangements for enabling CCGs to drive transformation across primary and community care, and supporting tools.	The options and governance arrangements for co-commissioning of GP practice. Contract forms to support greater formal collaboration across primary, community and secondary care providers. The options and governance arrangements for pooled budgets in 2015/16.
National Contracts	Ensuring that the vision for primary care at scale is appropriately reflected in the national contracts for GPs, dentists, pharmacy and optometrists.	A single negotiating remit for all national primary contracts for 2016/17, which reflects the vision and ambitions for primary care.
Workforce	Ensuring that the future primary care workforce is designed and developed in a way that supports primary care at scale and the new models of care.	Immediate work on returners, retention, international recruitment and GP remediation to increase the number of available GPs. A review into the future primary care workforce, including options for new roles and different skill mix.

3. Local Challenges & Commissioning Plans

Alongside the national work, NHS England in West Yorkshire and the three CCGs in Leeds have continued to work on improving the standards of general practice and developing integrated models of care. There are five principle challenges facing general practice in Leeds. These are the need to:

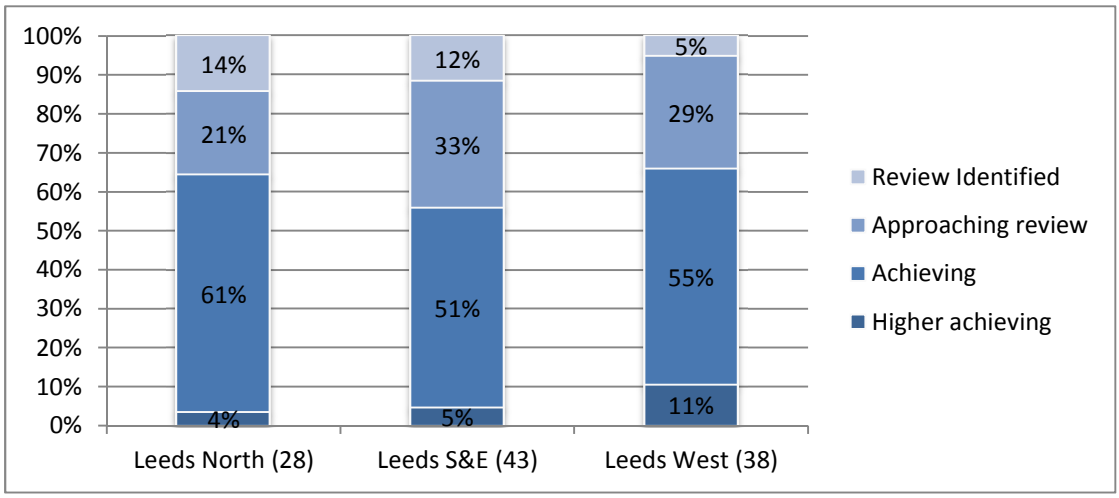
1. sustain and improve the quality of service provision for patients
2. improve patient experience, particularly in relation to access to services
3. develop and drive integrated care out of hospital
4. develop a sustainable workforce for now and the future
5. ensure value for money

3.1 Quality Improvement

(*Supports delivery of Leeds Health & Well-being Strategy – Outcome 3 – People will enjoy the best possible quality of life*)

In summer 2013, NHS England developed and published a Quality Assurance Framework for General Practice. This was the first time that service and outcome data on every general practice in England was brought together and published in a way that allowed commissioners, providers and the public to review and compare the performance of every practice. The Framework assesses practices against more than 30 indicators and establishes whether they are a statistical outlier against their expected performance.

For practices in the Leeds CCGs, the current (August 2014) position is:



For practices in the North and West, this compares favourably to the rest of England where, on average, 39% practices are approaching review or have a need for a review identified. For the South, the assurance framework does identify that 45% of practices are approaching review or have a need for a review identified.

Against this background, NHS England and the CCGs have put in place a number of initiatives to improve the quality of services for patients:

Organisation	Commissioning Approach for 2014-16
All	• Agreed MoU on quality improvement setting out roles and responsibilities. • Improvement plans developed with individual practices of concern.
Leeds North	• Practice level profiles developed for all practices. Profiles encompass key themes from Assurance Framework, JSNA practice profiles and other intelligence. Profiles used to support quality improvement plans for practices with "review identified" and to information action at practice, locality and CCG level. • Specific quality interventions in place across localities include diabetes care in Chapeltown, improving CVD prescribing, city-wide antibiotic / anti-microbial initiative.
Leeds South & East	• Quarterly quality visits to practices. • Specific interventions in place such as action to improve bowel screening uptake and patient safety reporting.
Leeds West	• 10 Locality development sessions per year with quality focus • Quarterly visits to practices. • Practice MOT distributed quarterly to benchmark practices across a number of local indicators and activity data. • Specific interventions in place linked to JSNA, to improve respiratory care, CVD, cancer and alcohol misuse.

3.2 Improving Patient Experience and Access

(Supports delivery of the Leeds Health & Well-being Strategy – outcome 2: people will live full and independent lives, outcome 3: people will enjoy the best quality of life, and outcome 4: people will be involved in decisions made about them)

The latest GP survey results (July 2014) show that patients in Leeds:

	Satisfaction with the quality of consultation (seven questions)			Satisfaction with overall care (two questions)			Satisfaction with access (three questions)		
	2013 - June %	2014 - July %		2013 - June %	2014 - July %		2013 - June %	2014 - July %	
NHS LEEDS NORTH	90.13	90.54	↑	86.25	85.90	↓	84.43	81.10	↓
NHS LEEDS SOUTH & EAST	89.07	89.17	↑	81.40	80.55	↓	80.20	77.57	↓
NHS LEEDS WEST	90.33	90.33	↑	84.65	83.65	↓	83.07	79.90	↓
WEST YORKS	89.63	89.74	↑	83.50	82.35	↓	82.03	77.80	↓
ENGLAND	89.76	89.96	↑	84.00	85.00	↑	83.57	82.70	↓
NORTH OF ENGLAND	90.71	90.59	↓	84.85	83.25	↓	83.83	79.10	↓

In common with patients across West Yorkshire and England, satisfaction with the quality of the actual clinical consultation remains high and is improving but the overall experience is deteriorating due, primarily, to dissatisfaction with access to services (getting through on the telephone, convenience of appointment and availability of appointments).

Against this background, NHS England and the CCGs have put in place a number of initiatives to improve patient experience and access:

Organisation	Commissioning Approach for 2014-16
All	• NHS England enhanced service for patient engagement • NHS England enhanced service for extended access • NHS England funding for system resilience in primary care. Leeds initiatives led by the CCGs include extended hours over bank holidays, additional clinics for children to avoid ED attendances, direct booking from ED to GP, and improved transport to hospital for potential GP admissions to facilitate early assessment and same day discharge. • Prime Minister's Challenge Fund – piloting new approaches to access for patients. First wave commenced July 2014. Second wave to be announced autumn 2014. • Introduction of Friends & Family Test in general practice at end 2014.
Leeds North	• Roll-out of Year of Care: to better inform and engage patients with long term conditions in their care. • Locality based approach to sharing bets practice in relation to primary care access and training with non-clinical staff to improve patient experience. • Commissioning practices to trial new approaches including pre-diabetes support group, practice champions and well-being co-ordinator posts to improve access and experience. • CCG co-ordinated Patient Reference Group bringing together representatives from across the CCG to inform commissioning.
Leeds South & East	• Roll-out of Year of Care: to better inform and engage patients with long term conditions in their care • Implementation of "yellow card" scheme to allow GPs to record soft intelligence on patient experience of services. • Practice development programme utilising service improvement and LEAN methodology to improve capacity and ways of working.
Leeds West	• Development of a Local extended access scheme (from 2014) to test out improving access across 5-days and 7-days, open to all 38 practices. Outcomes focussing on quality of consultation as well as access to appointments. • Roll-out of Year of Care: to better inform and engage patients with long term conditions in their care. • Introduction of Care Co-ordinators working between practices and community teams to pro-actively manage patients. • Roll-out of Productive General Practice programme to improve productivity and engagement with patients. • Patient comment boxes distributed to all practices to collect patient feedback throughout the year.

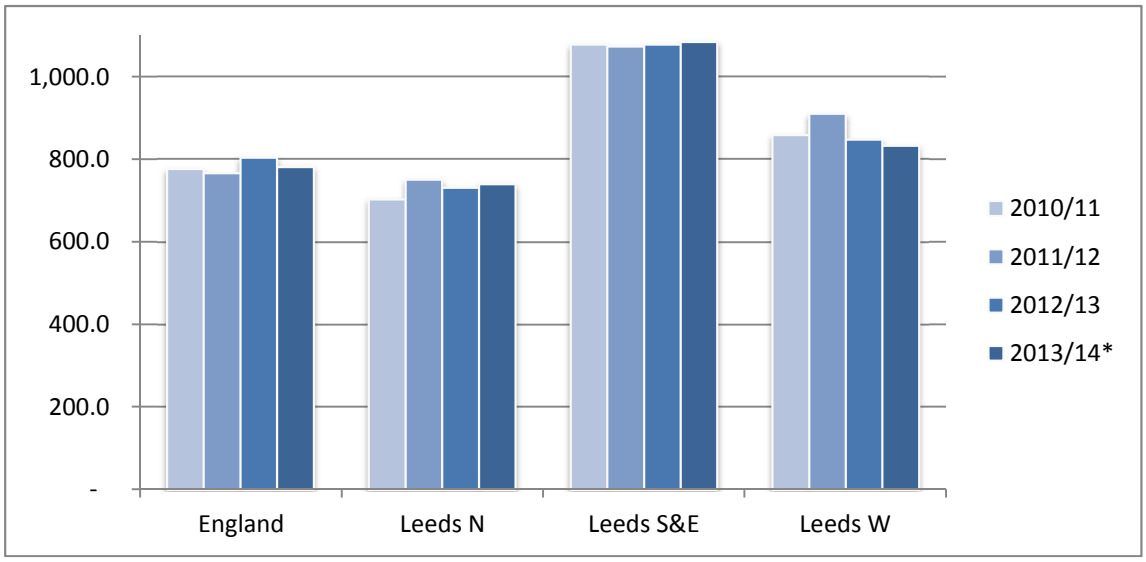
3.3 Develop and drive integrated care out of hospital

(Supports delivery of the Leeds Health & Well-being Strategy – outcome 2: people will live full and independent lives)

Benchmarking data on the three Leeds CCGs indicates that utilisation of secondary care in the north and west of the city is lower than the England average, but higher in the south and east of the city:

Per 1000 population (2013/14)	Leeds North	Leeds West	Leeds South and East	England
G&A emergency admissions	7.65	7.7	9.6	8.52
OP attendances	25.26	24.51	27.59	25.66

For conditions amenable to care outside of hospital, in 2013/14 (*provisional data), there were ca 2500 admissions to hospital where ambulatory care might have been a possible alternative:



Against this background, NHS England and the CCGs have put in place a number of initiatives to improve integrated care out of hospital (note: these initiatives focus solely on work in general practice. There is a much wider commissioning plan for integrated care involving acute, community and voluntary sector providers):

Organisation	Commissioning Approach for 2014-16
All	• NHS England enhanced service to deliver proactive care for the most vulnerable patients in each practice • NHS England enhanced services for dementia care, and alcohol related risk reduction. • Development of standards for out of hospital care to provide commissioner assurance and benchmarking of provision
Leeds North	• Clinical pharmacist working with practices and care homes to undertake medicine reviews for older people. Plan to roll out to patients with a learning disability and vulnerable patients at home. • Working with Otley and Wetherby localities to commission additional capacity to improve support for older people and those with complex

	needs. • Extension to pro-active care scheme and commissioning of additional system resilience initiatives over winter. • Locality-specific schemes relating to alcohol, diabetes and third-sector.
Leeds South & East	• Enhanced support to care home residents and providers • Extension to pro-active care scheme linked to plans for winter • Medication review scheme for most complex patients • COPD scheme to improve prevention, diagnosis, management, admissions avoidance and end of life care
Leeds West	• Year of Care scheme to improve patient engagement in planning and delivery of their care • Development of care co-ordinators to support pro-active care • Clinical pharmacists in care homes to review medications, minimise harm and reduce waste • Extending access to general practice to ensure patients have earlier access to primary care services. • Review of enhanced (medical) care to care homes.

3.4 Develop a Sustainable Workforce

(Supports delivery of the Leeds Health & Well-being Strategy – outcome 3: people will enjoy the best possible quality of life, and outcome 5: people will live in healthy and sustainable communities)

CCG Name	GP Providers	Registered population	GPs per 100,000 population
AIREDALE, WHARFEDALE AND CRAVEN	91	156,100	58
BRADFORD DISTRICTS	202	331,364	61
CALDERDALE	101	211,979	47
LEEDS NORTH	107	202,948	53
BRADFORD CITY	59	117,384	50
GREATER HUDDERSFIELD	130	239,437	54
LEEDS WEST	183	356,860	51
LEEDS SOUTH AND EAST	146	261,359	56
NORTH KIRKLEES	90	186,075	48
WAKEFIELD	201	355,373	56
AREA TOTAL	**1307**	**2,418,879**	**54**
REGIONAL TOTAL	**7,258**	**15,718,338**	**46**
NATIONAL TOTAL	**24,083**	**55,704,177**	**43**

Benchmarking data shows that the number of GPs per 100,000 population in Leeds is well above the figures for the north of England and England overall.

However, we know that more and more GPs are choosing to work part-time and that there are a significant number of GPs approaching retirement. In 2014/15, insufficient GP trainees were recruited to Yorkshire & Humber due to lack of interest from newly-qualified doctors.

In addition, there are pressures in practice nursing arising from an ageing workforce profile and difficulties with recruitment, and a need to consider the workforce requirements for new “at scale” / integrated care models.

Against this background, NHS England and the CCGs have put in place a number of initiatives to understand and improve the workforce position in general practice:

Organisation	Commissioning Approach for 2014-16
All	• Work with Health Education England to complete GP Workforce survey for 2014. • West Yorkshire Quality Improvement Network focus on workforce • Clinical fellowship posts to work alongside clinical leaders • TARGET programme of clinical training in practice • Development of city-wide Practice Nurse Conference and local practice nurse forums.
Leeds North	• Nurse leadership programme commenced in 2014 • Practice manager action learning sets, practice manager forum and training needs analysis supported by CCG. • GP Portfolio Leads development programme.
Leeds South & East	• Action Learning Sets for practice managers • Vocational training scheme for newly-qualified nurses (or nurses moving from secondary care) • Mentorship scheme for practice nurses • E-learning package for clinical skills
Leeds West	• Practice manager development programme • Undergraduate and post-graduate nursing scheme started in 2014 • Leadership course for nurse members – a bespoke leadership opportunity led by a performance coach. • Development of HCA apprenticeships. • Skills audit undertaken to inform future training provision.

3.5 Ensure value for money

There are two city-wide initiatives which will help drive value for money in the commissioning and contracting of GP services:

(i) Equitable funding review

General practice is predominantly funded through one of two national contracts: GMS and PMS. In common with practices across West Yorkshire, PMS practices in Leeds receive more funding than GMS practices. In some cases, this is due to the delivery of additional services but in other cases there is less clarity about what the additional funding delivers.

NHS England has commenced a funding review of PMS practices with the aim of ensuring that by 2018 there is an equitable approach to their core funding when compared to GMS practices.

	Funding per head 2014/15 (national value for GMS and mean value per CCG for PMS)	Range of funding per head in PMS practices
Core GMS Funding	£73.56	
Leeds North (12 PMS practices)	£73.69	£72.56 - £90.70

Leeds South & East (21 PMS practices)	£76.84	£68.16 - £114.67
Leeds West (24 PMS practices	£75.40	£70.32 - £101.04

This may result in core funding to individual practices being increased or decreased (depending on whether they are above or below the national level of core funding for GMS practices). In the circumstance where income is decreased then the practice will receive three years' of transitional relief.

Any funding released from this funding review will be reinvested in general practice in the CCG of origin.

(ii) Co-commissioning

In June 2014, NHS England announced that interested CCGs could choose to participate in the co-commissioning of general practice. The aim is to more closely align the commissioning of the national contract (NHS England's responsibility) with the CCGs' existing responsibility for quality of care and their local plans for integrated out of hospital care.

The three CCGs in Leeds have expressed an interest in co-commissioning from April 2015 and are exploring the opportunity of working together in one city-wide approach with NHS England.

The guidance from NHS England will be published in November 2014 with a view to having joint commissioning arrangements in place from April 2015. The legal framework to support formal joint commissioning arrangements between CCGs and with NHS England was published on 1 October 2014.

The ambition is that there will be opportunities to devolve and pool budgets for primary care to drive integration of general medical services with wider community care.

Alison Knowles – Commissioning Director, NHS England (West Yorkshire)

Gina Davey – Head of Primary Care – Leeds North CCG

Debbie McCartney – Senior Locality Manager – Leeds South & East CCG

Kirsty Turner – Head of Primary Care Transformation – Leeds West CCG.

Section B - Commissioning NHS Dental Services

1. Commissioning Responsibilities

Since the Health & Social Care Act 2013, there has been a tri-partite arrangement for oral health and dental services: Public Health England are responsible for oral health needs assessment, local

councils are responsible for oral health improvement for their residents and NHS England is responsible for commissioning NHS dental services (primary care, community and hospital).

2. **Adult Oral Health in Leeds**

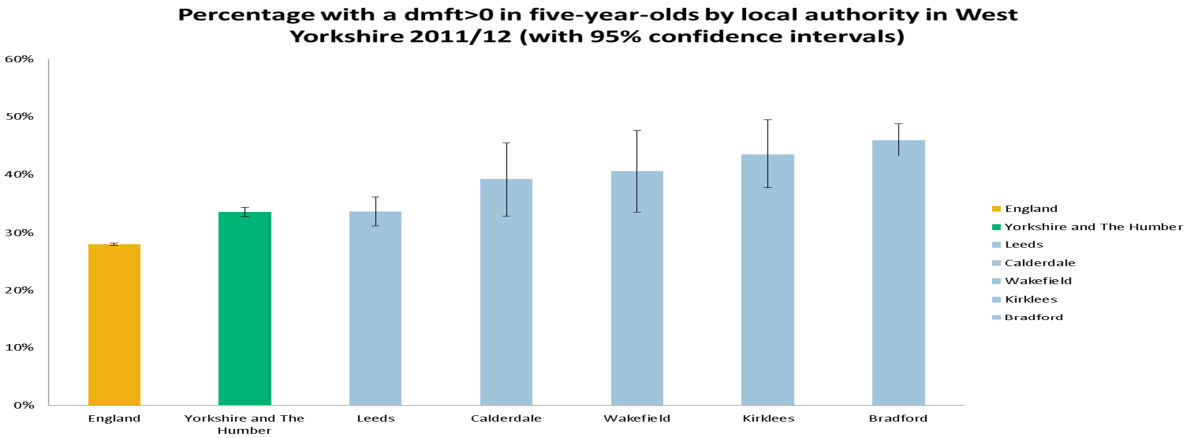
The most recent data available on adults is from the National Adult Dental Survey 2009 which provides analysis at a Yorkshire and Humber level and a postal questionnaire of Yorkshire and Humber adults in 2008 which provides Leeds level data.

The national data (2009) shows that the oral health of adults has been improving and the adult postal questionnaire (2008) shows that adults in Leeds report oral health on a par with people across Yorkshire and Humber:

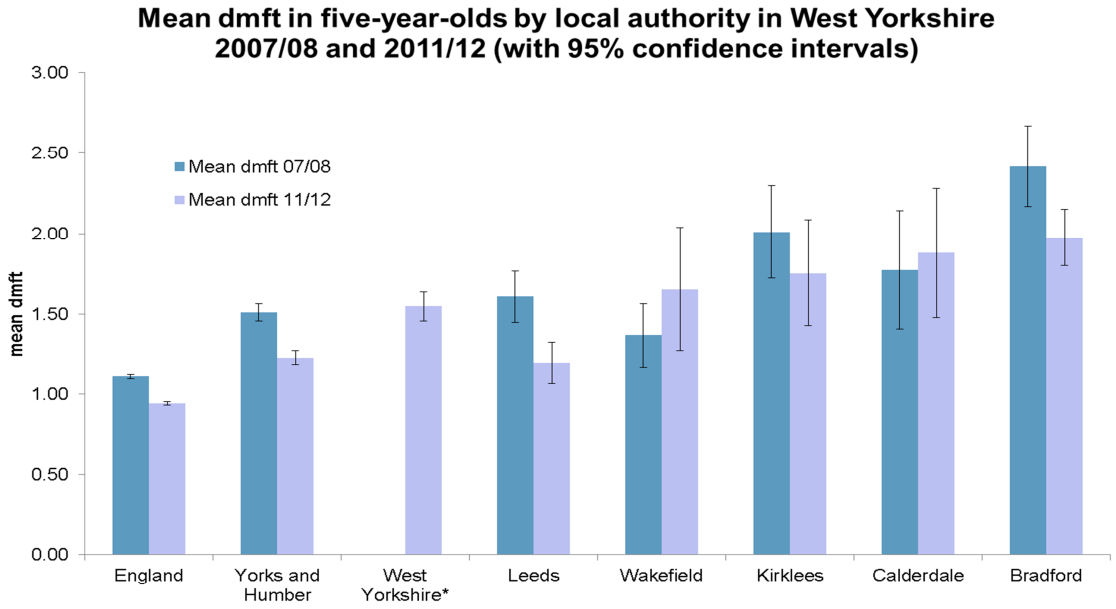
	Leeds	Yorks & Humber
If you went to the dentist tomorrow would you need treatment?	25.6%	25.4%
How would you rate your oral health? (% poor)	24.2%	25.3%

3. Children's Oral Health in Leeds

34% of 5-year old children in Leeds have a dmft score >0 (number of teeth decayed, missing or filled) which is the lowest in Yorkshire and Humber but still higher than the proportion in England overall which is 28%:



In the four years between 2007/2008 and 2011/12, the mean dmft score for 5 year old children in Leeds improved significantly. It is significantly better than the score for children living in other local authorities in West Yorkshire but still above the England score:



Source: PHE National Dental Epidemiology Programme for England.
Chart produced by PHE Knowledge and Intelligence Team Northern and Yorkshire

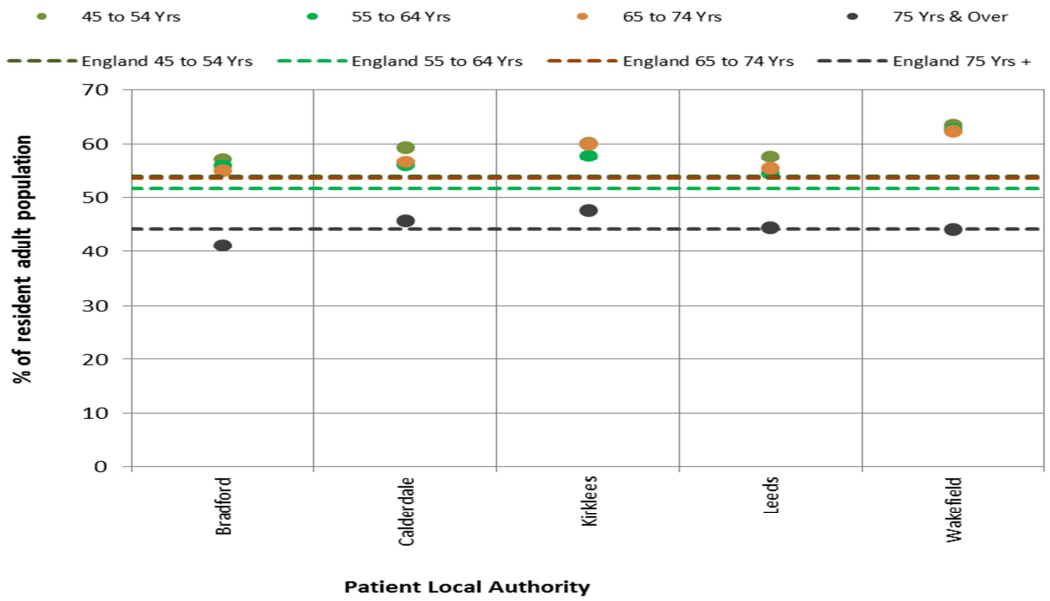
4. Service Structure in Leeds

The NHS spends £45.9 million on dental services in Leeds. The majority of patients attending LTHT are from the Leeds area but the more specialised services area also accessed by patients from across West and North Yorkshire.

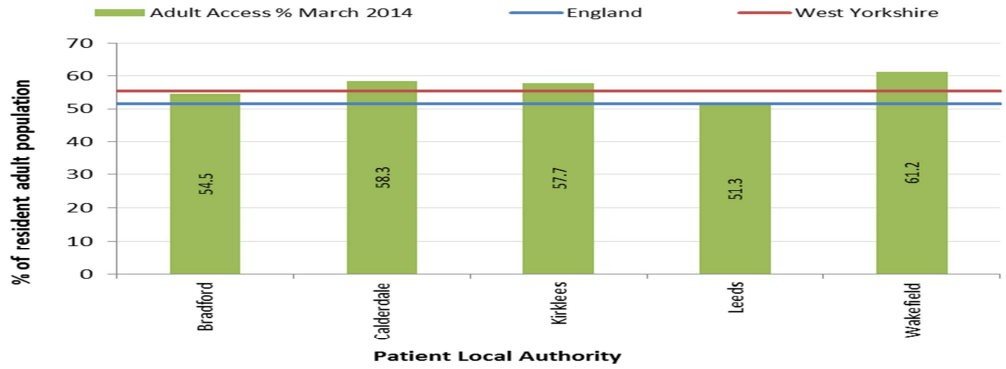
Sector	Provider	Scope	Value
Hospital	LTHT	Secondary care dental, oral surgery and maxillo-facial surgery	£8.2million
Community	LCH	Dental care for children and adults with special needs, and sedation service (including general anaesthetic)	£2.6million
Primary care	101 practices	1.27million UDAs to provide assessment and treatment.	£34.3million
Urgent care service	LCH	Urgent care, 365 days / year	£0.8million
Total Spend			£45.9million

5. Access to Primary Care Dental Services

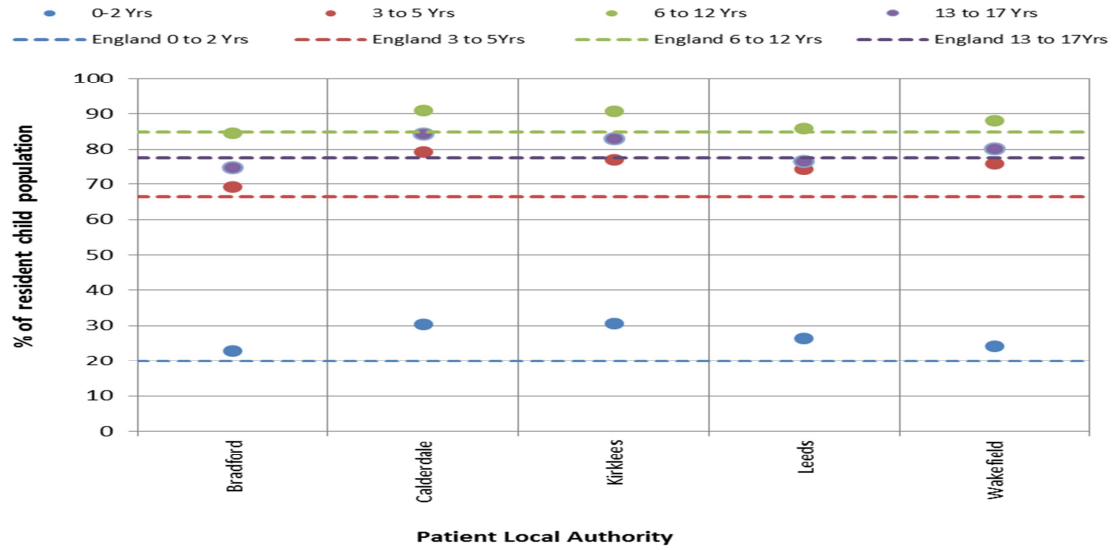
For adults, the access rates in Leeds are at or above the average for England in all age bands:



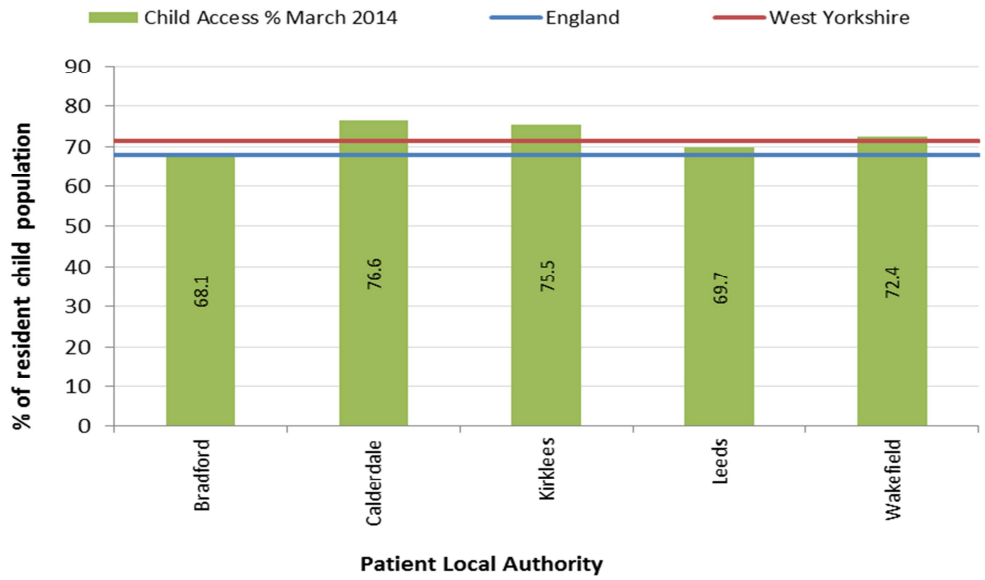
And 51.3% of adults have accessed a dentist within the last two years. This is the lowest access rate in West Yorkshire:



For children, access rates by age are good with particularly high rates in the under 5 age groups:



And 69.7% of children have seen a NHS dentist in the last two years, in line with the rate across England:



For urgent care, very few patients in Leeds attend A&E with dental needs but about 1 in 7 calls to 111 relate to dental health. This is consistent across Yorkshire & Humber.

11% of the commissioned activity in primary care is used to deliver urgent access for local patients but if a primary care dentist is not available to the patient then they are able to access the dedicated urgent care dental service provided through LCD and LCH. LCD provide a triage service supporting 111 and are able to book direct into slots at the LCH dental access centres.

6. **Quality of Primary Care**

NHS England introduced a Quality Assurance Framework for primary dental services in summer 2013. This is the first time that the quality of primary care dental services has been assessed consistently on a quarterly basis.

The quarterly results are reviewed by the Dental Commissioning Team working with clinical dental advisors. Concerns are either addressed through a quality visit to an individual practice or through contractual improvement notices, if warranted.

There are no significant concerns with dental practices in the Leeds area. The high level results from the Assurance Framework are:

Quality indicators	Leeds N	Leeds S & E	Leeds W	Leeds	W Yorks	England	
Radiograph Rate per 100FP17s	19	15.5	17.7	17.3	19.4	20.1	A low rate could indicate non-compliance with FGDP (UK) Good Practice Guidelines – "Selection Criteria for Dental Radiography".

Endodontic Treatment per 100FP17s	1.8	1	1.2	1.3	1.3	1.5	Low levels of endodontic treatment could indicate a number of factors but possibly a greater preference to extract rather than root fill or a high level of root treatments being provided under private contract.
Fluoride Varnish Rate per 100FP17s	34.2	41.7	38.1	38.3	42.9	30.6	A low level of fluoride varnish applications would suggest that treatment is not being offered according to "Delivering Better Oral Health"
Children Re-attending within 3 Months	8	7.4	7.7	7.7	8.5	7.9	In general, a patient who has completed a course of treatment that renders him or her "dentally fit" should not need to see a dentist again within the next three months. A high rate would indicate that further treatment has been provided outside the recall interval but could include urgent treatment etc.
Adults Re-attending within 3 Months	17.4	15.3	17.3	16.6	16	15.7	

7. Patient Satisfaction

There are no current measures of patient satisfaction in primary care dental services. NHS England is introducing the Friends & Family Test to primary care dentistry from April 2015.

Dental patient views on access are measured twice-yearly via the national GP Satisfaction Survey conducted by IPSOS Mori. Response rates to the dental questions in the survey are poor but for this area, the last survey showed satisfaction with access:

Tried to get appointment	**Number who reported trying**	**% successful**
In last 3 months	5216	92.9%
In last 6 months	8487	93.7%
In last 12 months	10802	92.7%
In last 2 years	12082	90.5%

These overall figures do mask differences in different populations and there is evidence that some groups of patients are disadvantaged by current access arrangements.

<u>% of patients successful in getting appointment</u>:

White	91.9%
Other ethnicity	83.8%

Working	91.0%
Retired	94.7%
Other	86.3%

Having seen the dentist before (ie existing patient)	95.4%
Having not seen the dentist before (ie new patient)	62.0%

The national access survey results are based on patients who report having tried to see a dentist recently. The survey also establishes the reasons why patients report not trying to see an NHS dentist are complex and include preferring to access private care and not requiring treatment which together account for ca 30% of patients:

Reason	**% of patients who did not try to get an appointment (n = 5284)**
Did not need to see a dentist	19.8%
No natural teeth	10.9%
Don't like going to the dentist	5.9%
On waiting list	1.6%
See a private dentist	34.3%
Didn't think they could get a NHS dentist	14.0%
Too expensive	3.5%
Other	10.1%

8. **Two Year Plan for Dental Services in West Yorkshire**

NHS England (West Yorkshire) has established a clinical network to steer the planning and commissioning of dental services across the area. The Local Dental Network is chaired by a primary care practitioner from Leeds and has representation from hospital services, community services, Public Health England and the Local Dental Committees. Healthwatch have opted to participate in individual pieces of work rather than have a place on the over-arching network.

In April 2014, the LDN working with NHS England established two-year plan for dental services in West Yorkshire. This sets out six priorities:

1. Moving to increasingly planned care with a reduction in the need for urgent care and a focus on continuity of care;
2. Reducing inequity in access;
3. Improving patient and public access to information about dental services and oral health;
4. Building capacity in primary and community-based services to ensure care is delivered at an appropriate level for every patient;
5. Commissioning care using the national pathways and based on consistent outcomes, quality standards and price irrespective of the place of delivery;
6. Working with Health Education England to ensure the support and development of a workforce which is able to deliver the new model of care.

The financial position within the NHS means that there will not be additional investment in dental services in the two year period. As such we need to ensure that we drive value for money in all sectors of the service.

In the first year, progress has been made on:

(i) Completing an oral health needs assessment for Yorkshire & Humber. This will be published in October 2015.

(ii) Establishing a clinical review of the model for urgent dental care services to reduce reliance on stand-alone provision and set the foundations for the new primary care dental contract which will re-establish a registered list for dental patients in primary care. The review will report in early 2015;

(iii) Reinvesting the funding released from annual primary care contract reviews (July 2014) into the areas of highest need as identified by Public Health England. This funding will be reinvested from October 2014;

(iv) Working with existing providers to review the service specification for community dental services for 2015/16 to establish a core and consistent service across the five providers and to release resources for improved access for frail elderly and bariatric patients;

(v) Introducing a new approach to coding and counting secondary care dental activity to standardise the approach across providers and release funding for investment in primary care.

(vi) Commissioning a dental advice line for West Yorkshire to improve public information about NHS dental services.

(vii) Planning for a central booking service for all secondary care activity. As a first step in 2014/15, all NHS dentists in West Yorkshire have been linked to NHSNet to facilitate electronic transfer of patient and diagnostic data.

Section C - Community Pharmacy Services

As at September 2014, there are 191 pharmacies across the Leeds area, with a good spread across the district and at least 1 pharmacy in every postcode region.

There are also 6 GP practices which are authorised to dispense prescription items directly to patients in rural areas: this covers places such as Bramham, Scholes and Collingham to ensure that patients living in rural areas also have access to services.

Across West Yorkshire during 2013/14 there was a total spend on pharmaceutical services commissioned by NHS England of £80million of which £27 million is spent in the Leeds area alone. This funds core services such as dispensing of prescriptions and disposal of patient waste/returned medications, as well as additional activities such as Medicines Use Reviews to enhance the use of medications.

In addition, the local authority commissions public health services from pharmacies and the CCGs commission some enhanced pharmacy services (such as minor ailment service) across Leeds.

NHS England (West Yorkshire) has established a Local Pharmacy Network to provide clinical input into the planning and commissioning of pharmacy services. The Network is chaired by a local

community pharmacist from the Leeds area and has representatives from across primary, community and secondary care in West Yorkshire. The LPN has established the following priorities:

1. Urgent & emergency care – promotion of Pharmacy First scheme to support general practice out of hours. Learning from Prime Minister's Challenge Fund pilot in Wakefield to establish opportunity for direct booking into pharmacy as an alternative to GP appointment.
2. Integrated care – rolling out Summary Care Record to community pharmacies to promote pro-active care of patients with long term conditions. West Yorkshire is one of three national pilot areas for this.
3. Patient Safety – building on medicine optimisation programme to increase effectiveness of prescribing and reduce medicine wastage.
4. Workforce – identifying opportunities for pharmacists to work in wider primary care settings – given the excess numbers of students that are currently being trained.

Section D - Community Optometry Services

As at September 2014, there are 91 shop based contracts across the Leeds area, with a further 67 contracts to allow sight tests in eligible patient's homes.

Across West Yorkshire during 2013/14, the total spend on core NHS optometry services (excluding community and secondary care which are commissioned by the CCGs) was £24.8million of which £8.2million was spend in the Leeds area.

The NHS-funded service is governed by nationally set eligibility criteria and covers sight tests and vouchers issued against glasses for children, those over 60 and also a range of people who may be on low incomes or receive specific benefits.

NHS England does not have the responsibility to commission enhanced optometry services and this function now sits with the local Clinical Commissioning Groups. A Local Eye Health Network has been established by NHS England to bring together Eye Health specialists and commissioners from across West Yorkshire. This met for the first time in early September 2014.

Alison Knowles
Commissioning Director
NHS England (West Yorkshire)
October 2014

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Next steps towards primary care co-commissioning

November 2014

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Next steps towards primary care co-commissioning

First published: November 2014

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Foreword by Amanda Doyle and Ian Dodge

"General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain … Steps we will take include … [giving] GP-led clinical commissioning GPs more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services".

The NHS Five Year Forward View, October 2014

The introduction of co-commissioning is an essential step towards expanding and strengthening primary medical care.

Co-commissioning is recognition that clinical commissioning groups (CCGs):

- are harnessing clinical insight and energy to drive changes in their local health systems that have not been achievable before now;

but

- are hindered from taking an holistic and integrated approach to improving healthcare for their local populations, due to their lack of say over the commissioning of both primary care and some specialised services; and

- are unable to unlock the full potential of their statutory duty to help improve the quality of general practice for patients.

That's why NHS England is giving CCGs the opportunity to assume greater power and influence over the commissioning of primary medical care from April 2015.

Although we are confident that co-commissioning - or delegation to CCGs - is in the best interests of patients, the *offer* from NHS England is just that: it is for each and every CCG to consider carefully, and make up its own mind as to how it will respond.

We know that the imposition of a single national solution just won't work, and will fail to take into account different local contexts.

CCGs are GP-led organisations. CCGs understand primary care, and are passionate about improving its quality, across all practices in their own geographical areas.

At the same time, individual GPs will also be conflicted in specific decisions about primary care commissioning. So, in order to harness the benefits of co-commissioning, yet guard fully against the risks, we have developed robust new and transparent arrangements for managing perceived and actual conflicts of interest. NHS England is formally consulting on these before issuing as statutory guidance for the first time.

In progressing this agenda, we have sought to provide NHS England and CCG leadership that is genuinely joint and open - and which has also involved lay members and councils.

In our discussions, we have promoted vigorous debate and challenge. We intend our approach to serve as a model for wider collaboration across NHS England and CCGs, right across the breadth of our shared agenda.

Right across the country, we are confident that CCGs and NHS England regions and areas will approach co-commissioning in a spirit of openness, partnership and practical problem solving.

We are optimistic that the agreements we have reached and proposals we set out in this document pave the way for better services for patients, and better value for the taxpayer. The proof is, of course, only in the doing - and the public evaluation of the doing.

This piece of paper signals the next stage in co-commissioning. By no means is it the end of the story. We will continue to work together closely to pick up and resolve teething troubles and to assess progress.

Ian Dodge
National Director:
Commissioning Strategy,
NHS England

Dr Amanda Doyle
Chief Clinical Officer,
NHS Blackpool CCG;
Co-chair, NHS Clinical Commissioners

Contents

1 Executive summary

Next steps towards primary care co-commissioning gives clinical commissioning groups (CCGs) the opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each co-commissioning model and the steps towards implementing arrangements. The document has been developed by the joint CCG and NHS England Primary Care Commissioning Programme Oversight Group in partnership with NHS Clinical Commissioners.

Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

There are three primary care co-commissioning **models** CCGs could take forward:

The **scope** of primary care co-commissioning in 2015/16 is general practice services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints management. However, co-commissioning excludes all functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation). Furthermore, the terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

Under joint and delegated arrangements, CCGs will have the opportunity to design a **local incentive scheme** as an alternative to the Quality and Outcomes Framework (QOF) or Directed Enhanced Services (DES). This is without prejudice to the right of GMS practices to their entitlements, which are negotiated and set nationally. In order to ensure national consistency and delivery of the democratically-set goals for the NHS outlined in the Mandate set for us by the government, NHS England will continue to set national standing rules, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF, and IT intra-operability.

In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing **contracts for primary care provision** or award new ones, depending on local circumstances. CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest. In delegated

arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act.

With regards to **governance** arrangements, we have developed draft governance frameworks and terms of reference for joint and delegated arrangements on behalf of CCGs, as appended in annex D, E and F. CCGs are encouraged to utilise these resources when establishing their governance arrangements.

A significant challenge of primary care co-commissioning is finding a way to ensure that CCGs can access the necessary **resources** as they take on new responsibilities. Pragmatic and flexible local arrangements for 2015/16 will need to be agreed by CCGs and area teams.

Conflicts of interest need to be carefully managed within co-commissioning. Whilst there is already conflicts of interest guidance in place for CCGs, this will be strengthened in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. A national framework for conflicts of interest in primary care co-commissioning will be published as statutory guidance in December 2014.

The **approvals process** for co-commissioning arrangements will be straightforward. The aim is to support as many CCGs as possible to implement co-commissioning arrangements by 1 April 2015. Unless a CCG has serious governance issues or is in a state akin to “special measures”, NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs who wish to implement joint or delegated arrangements will be required to complete a short proforma (annex A and B) and request a constitution amendment. The approvals process will be led by regional moderation panels with the new NHS England commissioning committee providing final sign off for delegated arrangements.

We also intend to make it as simple as possible for CCGs to **change their co-commissioning model**, should they so wish. Should this need arise, CCGs should discuss their plans with the relevant area team in the first instance as part of the CCG assurance process.

On-going assurance of co-commissioning arrangements will form part of the wider CCG assurance process. NHS England intends to work with CCGs to co-develop a revised approach to the current CCG assurance framework. NHS England will also ensure it continually **evaluates** the implementation of co-commissioning arrangements to share best practice and lessons learned with CCGs and area teams.

We hope this document is useful in helping to inform CCG decision making around primary care co-commissioning models and in providing clarity on the next steps towards the implementation of new arrangements. If you require any further information, please email: england.co-commissioning@nhs.net.

2 Background and context

In May 2014, NHS England invited CCGs to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities. There has been a strong response from CCGs wishing to assume co-commissioning responsibilities. We want to harness this energy and address the frustrations CCGs have expressed in the current primary care commissioning arrangements, to more effectively shape high quality local services.

There are three possible models of primary care commissioning that CCGs could pursue:

The purpose of this document is to give CCGs an opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each model, including associated functions; governance arrangements; resources; and any potential risks, with advice on how to mitigate these. The document then sets out the steps towards implementing co-commissioning arrangements, including the timeline and approvals process.

This document is accompanied by a suite of practical resources and tools which are appended to support local implementation of co-commissioning arrangements. In addition, a national framework for the handling of conflicts of interest management for primary care co-commissioning is under development in partnership with NHS Clinical Commissioners. Whilst there is already conflicts of interest guidance in place for CCGs, we are strengthening this in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. The conflicts of interest framework will be published as statutory guidance in December 2014.

This document has been jointly developed with CCGs and NHS England through the Primary Care Co-commissioning Programme Oversight Group. The group is co-chaired by Dr Amanda Doyle (Chief Clinical Officer, NHS Blackpool CCG and Co-chair, NHS Clinical Commissioners) and Ian Dodge (National Director: Commissioning Strategy, NHS England) with membership set out in annex G. It has also been developed in partnership with NHS Clinical Commissioners.

3 Vision and aims of co-commissioning

This section sets out the long term vision for co-commissioning and the potential benefits it could bring for local populations.

Co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. The *Forward View* emphasises the need to increase the provision of out-of-hospital care and to break down barriers in how care is delivered. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will drive the development of new integrated out-of hospital models of care, such as multispecialty community providers and primary and acute care systems.

Co-commissioning will give CCGs the option of having more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services. By aligning primary and secondary care commissioning, it also offers the opportunity to develop more affordable services through efficiencies gained.

Co-commissioning could potentially lead to a range of benefits for the public and patients, including:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- High quality out-of-hospitals care;
- Improved health outcomes, equity of access, reduced inequalities; and
- A better patient experience through more joined up services.

Co-commissioning could also lead to greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services. Furthermore, it will enable the development of a more collaborative approach to designing local solutions for workforce, premises and information management and technology challenges.

Primary care co-commissioning is the beginning of a longer journey towards place based commissioning – where different commissioners come together to jointly agree commissioning strategies and plans, using pooled funds, for services for a local population.

From 1 April 2015 we will be extending personal commissioning through The Integrated Personal Commissioning (IPC) programme. The IPC programme aims to bring health and social care together, identifying the totality of expenditure at the level of the individual, giving people more control over how this is used and enabling money to be spent in a more tailored way.

Furthermore, from 2015/16 CCGs will have the opportunity to co-commission some specialised services through a joint committee. We have also been encouraging CCGs and local authorities to strengthen their partnership approach so they can jointly and effectively work to align commissioning intentions for NHS, social care and public health services.

4 Scope of co-commissioning models

This section aims to support CCGs to make an informed decision on which co-commissioning model they would like to take forward. For each co-commissioning model, it set outs :

- the primary care commissioning functions it includes;
- governance arrangements; and
- opportunities, potential benefits and risks.

4.1 Overview of co-commissioning functions

The first step on the co-commissioning journey is for CCGs to decide which form of co-commissioning they would like to assume. There are three forms of co-commissioning CCGs could adopt:

In this section we aim to provide clarity and transparency around what each co-commissioning model would entail to support CCGs in their decision making.

4.1.1 Scope of primary care co-commissioning

Primary care commissioning covers a wide spectrum of activity. We have engaged with a large number of CCGs to agree the functions each co-commissioning model will encompass. We have agreed that in 2015/16, primary care co-commissioning arrangements will only include general practice services. CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no formal decision making role.

However, we recognise the ambition in some CCGs to take on a greater level of responsibility in the commissioning of dental, eye health and community pharmacy services and we will be looking into this for 2016/17, with full and proper engagement of the relevant professional groups.

4.1.2 **Local flexibilities for incentive schemes and contracts**

The purpose of primary care co-commissioning is to enable clinically led, optimal local solutions in response to local Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies. This will be done by delegating functions and decision making to the local level.

Under delegated arrangements, CCGs would have the ability to offer GP practices the opportunity to participate in a locally designed contract, sensitive to the diverse needs of their particular communities, above or different from the national requirements e.g., as an alternative to QOF or directed enhanced services (DES). Similarly under joint arrangements, NHS England and CCGs could explore the option of implementing a locally designed incentive scheme. This is without prejudice to the rights of practices to their GMS entitlements which are negotiated and agreed nationally. Any migration from a national standard contract could only be affected through voluntary action.

In designing their own approach, it would be useful for CCGs that wish to design a new local incentive scheme to review the evaluation of the Somerset Practice Quality Scheme, as we learn more about this pilot initiative.

There will be no formal approvals process for a CCG which wishes to develop a local QOF scheme or DES. However, any proposed new incentive scheme should be subject to consultation with the Local Medical Committee (LMC), and be able to demonstrate improved outcomes, reduced inequalities and value for money. On-going assurance of new schemes would form part of the CCG assurance process.

With the freedoms of co-commissioning arises the need for mitigation of the potential risks of inconsistency of approach in areas where national consistency is clearly desirable. There is already an ability to set out core national requirements in GMS, PMS and APMS contracts through regulations. In line with this, NHS England reserves the right to set national standing rules, as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets and IT intra-operability. The standing rules would become part of a binding agreement underpinning the delegation of functions and budgets from NHS England to CCGs.

4.1.3 **Commissioning and awarding contracts for primary care provision**

In joint arrangements, commissioning decisions would be taken by the CCG and NHS England area team. In delegated arrangements, CCGs would be responsible for taking these decisions.

In joint and delegated arrangements - as is the case for any services that they commission - CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest.

In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances.

In delegated arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act. In delegated and joint arrangements, where a CCG or a CCG and NHS England are found to have breached public procurement regulations and/or statutory guidance on conflicts of interest, Monitor may direct a CCG or a CCG and NHS England to act. NHS England may, ultimately, revoke a CCG's delegation.

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

4.1.4 **Parameters of primary care co-commissioning**

For all forms of primary care co-commissioning, there has been clear feedback from CCGs that it would not be appropriate for CCGs to take on certain specific pseudo-employer responsibilities around co-commissioning of primary medical care. We have therefore agreed that functions relating to individual GP performance management (medical performers' list for GPs, appraisal and revalidation) will be reserved to NHS England. NHS England will also be responsible for the administration of payments and list management. CCGs must assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services.

Furthermore, the terms of GMS contracts – and any nationally determined elements of PMS and APMS contracts – will continue to be set out in the respective regulations and directions and cannot be varied by CCGs or joint committees.

For the avoidance of doubt, CCGs will be required to adopt the findings of the national PMS and Minimum Practice Income Guarantee (MPIG) reviews, and any locally agreed schemes will need to reflect the changes agreed as part of the reviews.

4.1.5 **Summary of co-commissioning functions**

Primary care function	Greater involvement	Joint commissioning	Delegated Commissioning
General practice commissioning	Potential for involvement in discussions but no decision making role	Jointly with area teams	Yes
Pharmacy, eye health and dental commissioning	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role
Design and implementation of local incentives schemes	No	Subject to joint agreement with the area team	Yes
General practice budget management	No	Jointly with area teams	Yes
Complaints management	No	Jointly with area teams	Yes
Contractual GP practice performance management	Opportunity for involvement in performance management discussions	Jointly with area teams	Yes
Medical performers' list, appraisal, revalidation	No	No	No

Further information on each co-commissioning model and the functions it encompasses is set out in section 4.2 to 4.4.

4.2 Greater involvement in primary care co-commissioning: scope and functions

Greater involvement in primary care co-commissioning is simply an invitation to CCGs to collaborate more closely with their area teams to ensure that decisions taken about healthcare services are strategically aligned across the local health economy. This form of co-commissioning will assist CCGs to fulfil their duty to improve the quality of primary medical care[1].

4.2.1 Scope of greater involvement in primary care commissioning

CCGs who wish to have greater involvement in primary care decision making could participate in discussions about all areas of primary care including primary medical care, eye health, dental and community pharmacy services, provided that NHS England retains its statutory decision-making responsibilities and there is appropriate involvement of local professional networks.

4.2.2 Governance arrangements for greater involvement in primary care decision making

No new governance arrangements would be required for a CCG to have greater involvement in the commissioning of primary care services and this involvement could be agreed between the CCG and its area team at any time. The effectiveness of these arrangements is reliant upon the development of strong local relationships and effective approaches to collaborative working. It is in the CCG and area team's own interest to also engage local authorities, local Health and Wellbeing Boards and local communities in primary care decision making.

A CCG which adopts this model of co-commissioning is unlikely to encounter an increased number of conflicts of interest, as CCGs would not have formal accountability for decision making. However, they would need to remain mindful of conflicts of interests and follow prescribed guidance as set out in section 6.

In this model, CCGs have the opportunity - already available to them - to invest in primary care services. Annex H contains a series of frequently asked questions (FAQs) on investing in primary care for CCGs and area teams. Further details on the next steps to take forward this form of co-commissioning can be found in section 7.2.

[1] Section 14S NHS Act 2006 (as amended by the Health and Social Care Act 2012).

4.3 Joint commissioning arrangements: scope and functions

A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or "committees in common". Joint commissioning arrangements give CCGs and area teams an opportunity to more effectively plan and improve the provision of out-of hospital services for the benefit of patients and local populations. Within this model CCGs also have the option to pool funding for investment in primary care services as set out in section 4.3.3.

4.3.1 Joint commissioning functions

In 2015/16, joint commissioning arrangements will be limited to general practice services. The functions joint committees could cover are:

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

Joint commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS

England will also be responsible for the administration of payments and list management.

CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no decision making role.

4.3.2 **Joint commissioning governance arrangements**

CCGs could either form a joint committee or "committees in common" with their area team in order to jointly commission primary medical services.[2] With regards to joint committees, due to the passing of a Legislative Reform Order (LRO) by parliament, CCGs can now form a joint committee with one or more CCGs and NHS England. Further information on the LRO can be found here. NHS England's scheme of delegation is being reviewed and will be revised as appropriate to enable the formation of joint committees between NHS England and CCGs i.e., where NHS England invites one or more CCGs to form a joint committee.

A model terms of reference for joint commissioning arrangements, including scheme of delegation, are appended at annex D. This model applies to the establishment of a joint committee between the CCG (or CCGs) and NHS England. If CCGs and area teams intend to form a joint committee, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures. The joint committee structure allows a more efficient and effective way of working together than a committees-in-common approach and so this is the recommended governance structure for joint commissioning arrangements.

In joint commissioning arrangements, individual CCGs and NHS England always remain accountable for meeting their own statutory duties, for instance in relation to quality, financial resources, equality, health inequalities and public participation[3]. This means that in this arrangement, NHS England retains accountability for the discharge of its statutory duties in relation to primary care commissioning. CCGs and NHS England must ensure that any governance arrangement they put in place does not compromise their respective ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making. Arrangements should also comply with the conflicts of interest guidance – please refer to section 6 for further information.

The effectiveness of joint arrangements is reliant upon the development of strong local relationships and effective approaches to collaborative working. NHS England and CCGs need to ensure that any governance arrangements put in place enable them to collaborate effectively.

[2] A joint committee is a single committee to which multiple bodies (e.g. NHS England and one or more CCGs) delegate decision-making on particular matters. The joint committee then considers the issues in question and makes a single decision. In contrast, under a committees-in-common approach, each committee must still make its own decision on the issues in question.

[3] In the CCG's case these duties are set out in sections 14R, 14R, 14Z1, 14Z11, 14Z15, 223H, 223I, 223J and 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012; the Equality Act 2010.

Membership of joint committees

It is for area teams and CCGs to agree the full membership of their joint committees. In the interests of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the joint committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. It will be important to retain clinical leadership of commissioning in a joint committee arrangement to ensure the unique benefits of clinical commissioning are retained.

4.3.3 Pooled funds for joint commissioning

CCGs and area teams may wish to consider implementing a pooled fund arrangement under joint commissioning arrangements as per section 13V of Chapter A1 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). Establishing a pooled fund will require close working between CCG and area team finance colleagues to ensure that the arrangement establishes clear financial controls and risk management systems and has clear accountability arrangements in place.

The funding of core primary medical services is an NHS England statutory function. Although NHS England can create a pooled fund which a CCG can contribute to, the CCG's contribution must relate to its own functions and so could not relate to core primary medical services. However, CCGs are able to invest in a way that is calculated to facilitate or is conducive or incidental to the provision of primary medical care and provided that no other body has a statutory duty to provide that funding. For example,

Where an area team currently commissions services using an APMS contract they could consider pooling funds with a CCG to secure a wider range of services, for example, enhanced care for vulnerable older people.

Further details on the next steps to take forward joint commissioning can be found in section 7.3.

4.4 Delegated commissioning arrangements: scope and functions

Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning. Therefore, NHS England will require robust assurance that its statutory functions are being discharged effectively. Naturally, CCGs continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation[4].

4.4.1 Delegated commissioning functions

There was considerable variation in the range of primary care commissioning functions that CCGs proposed to assume in their initial expressions of interest. Following discussions with CCGs, we have agreed that a standardised model of delegation would make most sense for practical reasons. CCGs have expressed a strong interest in assuming the following primary care functions which will be included in delegated arrangements:

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

[4] Section 14Z2 of the NHS Act (2006), as amended by the Health and Social Care Act (2012).

Delegated commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England will also be responsible for the administration of payments and list management.

CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no decision making role.

4.4.2 **Delegated commissioning governance arrangements**

NHS England has developed a model governance framework for delegated commissioning arrangements in order to avoid the need for CCGs to develop their own model. The recommendation is that CCGs establish a primary care commissioning committee to oversee the exercise of the delegated functions. A model terms of reference for delegated commissioning arrangements including scheme of delegation are appended at annex F. If CCGs intend to assume delegated responsibilities, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures.

A draft delegation is also appended at annex E. This is the formal document which records the delegation of authority by NHS England to CCGs. NHS England will issue a formal delegation agreement once the approvals process is completed.

In delegated commissioning arrangements, CCGs will remain accountable for meeting their own pre-existing statutory functions, for instance in relation to quality, financial resources and public participation[5]. CCGs must ensure that any governance arrangement they put in place does not compromise their ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making.

Membership of CCG primary care commissioning committees

It is for CCGs to agree the full membership of their primary care commissioning committee. CCGs will be required to ensure that it is chaired by a lay member and have a lay and executive majority. Furthermore, in the interest of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the delegated committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

[5] Sections 14R, 223H, 223I, 223J and 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012.

CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. Furthermore, it will be important to retain clinical involvement in a delegated committee arrangement to ensure the unique benefits of clinical commissioning are retained.

In this model new steps will be needed to manage potential conflicts of interest and these are set out in section 6.

Further details on the next steps to take forward delegated commissioning can be found in section 7.4.

5 Support and resources for co-commissioning

This section sets out how CCGs can access support and resources to deliver primary care co-commissioning.

A significant challenge involved in implementing primary care co-commissioning is finding a way to ensure that all CCGs can access the necessary resources as they take on new co-commissioning responsibilities. Both CCGs and NHS England recognise the difficulties of managing this fairly and in a way that both supports those CCGs which want to take on co-commissioning responsibilities and allows area teams to continue to safely and effectively deliver their remaining responsibilities.

Primary care commissioning is currently delivered by teams covering a large geography normally spanning several CCGs, and also covering all parts of primary care not just limited to general practice. There is no possibility of additional administrative resources being deployed on these services at this time due to running cost constraints.

Pragmatic and flexible local solutions will need to be agreed by CCGs and area teams to put in place arrangements that will work locally for 2015/16. These local agreements will need to ensure that:

- CCGs that take on delegated commissioning responsibilities have access to a fair share of the area team's primary care commissioning staff resources to deliver their responsibilities; and
- Area teams retain a fair share of existing resources to deliver all their ongoing primary care commissioning responsibilities.

There will be no nationally prescribed model: this will be a matter for local dialogue and determination. However, NHS England is committed to supporting local discussions in any way deemed helpful, and the current Primary Care Co-Commissioning Programme Oversight Group will continue to operate during the implementation period to help address practical issues.

5.1 Potential approaches for staffing

Where CCGs intend to take on joint or delegated responsibility for primary care commissioning, they should have a conversation with the area team regarding accessing support through the existing primary care team.

Given the limited size of existing primary care teams, potentially only part-time capacity would be available for individual CCGs taking on delegated commissioning responsibility, so it may be that collaborative arrangements between CCGs would be desirable to achieve greater critical mass. Staffing models for these arrangements will vary across the country and will require careful discussion to ensure that the practical, legal and staff engagement issues are clearly understood.

However, it is for CCGs to agree whether and how they would wish to work together. Where like-minded CCGs in an area team patch wish to collaborate, they need not necessarily be contiguous. In instances where they are not contiguous, the area team and CCGs would need to consider geographical practicalities for the staff concerned. These arrangements will need to take into account the size of the CCG, the number of primary care contracts held and the need for the area team to continue to deliver primary care commissioning functions not being delegated to CCGs and for areas where CCGs do not opt to take on delegated responsibilities.

Alternatively, some CCGs may wish to integrate primary care commissioning support with wider commissioning support from their Commissioning Support Unit (CSU). Again, in this scenario, arrangements should be agreed and implemented locally with particular attention to the practicalities.

It will be critical that local conversations are handled with maturity and due regard for members of staff involved to ensure transparent and mutually workable solutions.

5.2 Financial arrangements for co-commissioning

5.2.1 Financial information sharing

NHS England will ensure transparency in sharing financial information on primary care with CCGs. All CCGs will have the opportunity to discuss the current financial position for all local primary care services with their area team. CCGs will be provided with an analysis of their baseline expenditure for 2014/15 broken down between GP services and other primary care services by the end of November 2014. Final decisions regarding allocations for 2015/16 will be made by the NHS England Board in December 2014. An example of the level of detail area teams will be able to share can be found in the financial plan template – direct commissioning section of the NHS England website.

5.2.2 Financial allocations and running costs

We recognise that it will be challenging for some CCGs to implement co-commissioning arrangements, especially delegated arrangements, without an increase in running costs. Whilst it is not within our gift to increase running costs in 2015/16, NHS England will keep this situation under review. CCGs should discuss

with area teams options for sharing administrative resource to support the commissioning of primary care services.

In delegated arrangements, CCGs will receive funding for known future cost pressures within current allocations e.g. net growth in list sizes. In such circumstances, there may be a linked efficiency requirement which will need to be delivered in order for budgets to balance. Furthermore, if supported by clear strategies, CCGs would also have greater flexibility to "top up" their primary care allocation with funds from their main CCG allocation. For example:

A CCG currently commissions district nursing services from its community provider. The CCG could consider pooling the funding for this service with its primary care funding and arrange for district nursing services to be commissioned as part of primary care linked to GP practice nursing.

Full details on how area team allocations for primary care for 2014/15 and 2015/16 were calculated are published in the Technical Guide to the formulae for 2014-15 and 2015-16 revenue allocations to Clinical Commissioning Groups and Area Teams. Annex F of this technical guide also sets out the detailed pace of change for each area team primary care allocation for 2014/15 and 2015/16.

Work is also currently underway to develop a target formula and place based allocations. Further information on the target formula will be available in early 2015 and the 'place-based' target in late 2015. It is anticipated that in 2015/16 the actual allocations for primary care will be made at CCG level rather than area team level.

5.2.3 **Variations in primary care funding**

It is recognised that there are historic variations in primary care funding across England and localities and we are taking steps to move towards a fair distribution of resources for primary care, based on the needs of diverse populations. The GMS Minimum Practice Income Guarantee (MPIG) will be phased out by April 2020, and a review of local PMS agreements is underway as set out in the Framework for Personal Medical Services (PMS) Contracts Review. Area teams should ensure that any decisions relating to future use of PMS funding are agreed with CCGs.

We envisage that CCG and primary care allocations will continue to move towards a fair distribution of resources and reflect inequalities, as in the current CCG formula. As part of any delegation of primary care commissioning responsibilities, area teams will provide details of any differential funding levels across localities.

6 Conflicts of interest

This section provides advice on conflicts of interest management for CCGs that implement co-commissioning arrangements.

Conflicts of interest, actual and perceived, need to be carefully managed within co-commissioning. Conflicts of interest are a matter of public interest, and it is also in the interest of the profession that this issue is robustly and transparently handled. CCGs are already managing conflicts of interests as part of their day-to-day work and there is formal guidance on Managing conflicts of interests and a Code of conduct in place for CCGs and General Practitioners in commissioning roles.

However, without a strengthened approach, co-commissioning could significantly increase the frequency and range of potential conflicts of interest, especially for delegated arrangements. Therefore, NHS England, in partnership with NHS Clinical Commissioners, has developed a significantly enhanced framework for conflicts of interest management with clear minimum expectations for CCGs which assume co-commissioning responsibilities.

6.1 Current conflicts of interest guidance

There is a legal requirement for CCGs to have arrangements in place for managing conflicts of interest. Section 14O of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) sets out minimum requirements including:

NHS England must:

- Publish guidance to CCGs on the discharge of their duties.

CCGs must:

- Maintain appropriate registers of interests;
- Publish or make arrangements for the public to access those registers;
- Make arrangements requiring the prompt declaration of interests by the persons specified (members and employees) and ensure that these interests are entered into the relevant register;
- Make arrangements for managing conflicts of interest and potential conflicts of interest (e.g. developing appropriate policies and procedures); and

- Have regard to guidance published by NHS England in relation to conflicts of interest.

NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013

- A relevant body (including a CCG) must not award a contract for NHS health care services where conflicts, or potential conflicts of interest affect, or appear to affect, the integrity of the award.

6.2 Forthcoming guidance on managing conflicts of interest in primary care co-commissioning arrangements

A national framework for conflicts of interest management in primary care co-commissioning is being developed in partnership with NHS Clinical Commissioners and with formal engagement of Monitor and HealthWatch England. The guidance will:

- build on existing guidance;
- have regard to any statutory guidance issued by Monitor; and
- continue to facilitate clinically-led decision-making as far as possible within the important constraint of the effective management of conflicts of interests.

The guidance will include a strengthened approach to:

- **the make-up of the decision-making committee**: the committee must have a lay and executive majority and have a lay chair;
- **national training for CCG lay members** to support and strengthen their role;
- **external involvement of local stakeholders**: the local HealthWatch and a local authority member of the local Health and Wellbeing Board will have the right to serve as observers on the decision-making committee;

- **register of interest**: the public register of conflicts of interest will include information on the nature of the conflict and details of the conflicted parties. The register would form an obligatory part of the annual accounts and be signed off by external auditors; and

- **register of decisions**: CCGs will be required to maintain and publish, on a regular basis, a register of procurement decisions.

The guidance will be published in December 2014 as statutory guidance in accordance with section 14Z8 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). The guidance will be specifically aimed at CCGs exercising delegated authority but all CCGs will be required to have regard to the principles set out in the guidance.

The CCG's audit committee chair and CCG Accountable Officer will be required to provide direct formal attestation that the CCG has complied with conflict of interest guidance.

7 Approvals and implementation process 2014/15

This section sets out the approvals and implementation process for co-commissioning arrangements including the:

- process for reviewing your preferred co-commissioning approach;
- approvals process for co-commissioning arrangements; and
- implementation timeline for 2014/15.

7.1.1 Principles of the approvals process

Based on feedback from CCGs and area teams, and in recognition that CCGs undertook a robust authorisation process in their establishment as statutory bodies, the approvals process for co-commissioning arrangements will be as straightforward as possible. The process will be governed by the following principles:

- It will be conducted openly and transparently and contain no surprises;
- It will minimise the administrative demands placed on CCGs and area teams; and
- On-going assurance of co-commissioning arrangements will form part of the CCG assurance process.

Unless a CCG has serious governance issues or is in a state akin to “special measures,” NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs must also be able to demonstrate appropriate levels of sound financial control and meet all statutory and business planning requirements to progress delegated arrangements.

7.1.2 Opportunity to review your preferred co-commissioning arrangement

CCGs have requested a fresh opportunity to decide upon their preferred approach to primary care commissioning. We are therefore inviting CCGs to review their intentions and indicate their preferred co-commissioning arrangement in **January 2015**. As membership organisations, CCGs should fully engage with their members when considering co-commissioning options. It would also benefit CCGs and local stakeholders such as patients, local authorities, Health and Wellbeing Boards and HealthWatch to have an open and inclusive conversation about options and possible arrangements.

CCGs and area teams are asked to complete a short proforma should they wish to assume joint or delegated arrangements, as set out in the table below.

Co-commissioning model	Proforma	Submission date
Greater involvement in primary care commissioning decision making	There is no proforma to complete. Please liaise with your area team to take forward these arrangements, as set out in section 7.2.	Not applicable.
Joint commissioning	CCGs and area teams are asked to complete a proforma for joint arrangements (annex A). This proforma focuses upon the proposed governance arrangements for joint committees.	**30 January 2015**
Delegated commissioning	CCGs and area teams are asked to complete a proforma for delegated arrangements (annex B). This proforma focuses upon the CCG's approach to conflicts of interest management.	**12 noon on 9 January 2015**

Proformas for joint and delegated arrangements should be emailed to england.co-commissioning@nhs.net along with the requested supporting documentation which includes constitution amendment requests.

All delegated proformas must be submitted by **12 noon** on **9 January 2015** for arrangements to be implemented on **1 April 2015**. This is to allow sufficient time for financial transfers to be made. It would be preferential if arrangements were put in place on 1 April 2015 in the interests of agreeing staffing arrangements with area teams, although it may be possible to enable CCGs to implement delegated arrangements in-year in 2015/16.

Whilst these are formal deadlines, we know that in many areas CCGs and area teams are already engaging about co-commissioning, including financial arrangements and resources. We consider this to be good practice and would encourage all CCGs and area teams to adopt this approach.

7.1.3 **Procedure to agree a change to a CCG constitution**

Proposals for joint and delegated commissioning arrangements will require an amendment to a CCG's constitution. A suggested form of words for joint commissioning constitutional amendments, which can be tailored to individual circumstances, is included in annex C. Other minor amendments may also be

required in relation to delegated commissioning arrangements and these will be considered on an individual CCG basis.

The procedure for making an amendment is set out in the following guidance: Procedures for clinical commissioning group constitution change, merger and dissolution. As membership organisations, CCGs should consult with their members on any constitutional changes. CCGs also have a duty to consult with relevant stakeholders, such as local authorities, on constitutional changes.

The deadline for constitution amendment requests has been extended from 1 November 2014 to **12 noon** on **9 January 2015**. There is a further extension till 30 January 2015 for constitution amendments that relate solely to joint commissioning arrangements.

Co-commissioning form	Submission date for CCG constitutional changes
Joint commissioning	30 January 2015
Delegated commissioning	9 January 2015
All other constitution amendment requests	9 January 2015

All requests for constitution amendments should be emailed to england.co-commissioning@nhs.net **and the relevant regional team**. NHS England will acknowledge all applications for constitutional variations within two weeks of receipt and will notify the CCG in writing of the outcome of its decision within 8 weeks.

7.1.4 Governance arrangements for joint and delegated commissioning models

This document is accompanied by a suite of practical tools to support CCGs to implement co-commissioning arrangements locally including:

- Joint commissioning model governance structure, including model terms of reference for joint commissioning arrangements and scheme of delegation (Annex D)
- Draft delegation by NHS England (Annex E)
- Delegated commissioning model-draft terms of reference (Annex F)

NHS England has developed the governance frameworks on behalf of CCGs. CCGs are encouraged to use the template documents when developing co-commissioning arrangements. They can be amended to reflect local arrangements and to ensure consistency with the CCG's particular governance structure. They contain a number of points where the detail will need to be discussed and agreed as co-commissioning proposals are developed.

7.1.5 **Overview of the approvals process**

The approvals process for primary care co-commissioning is intended to be straightforward:

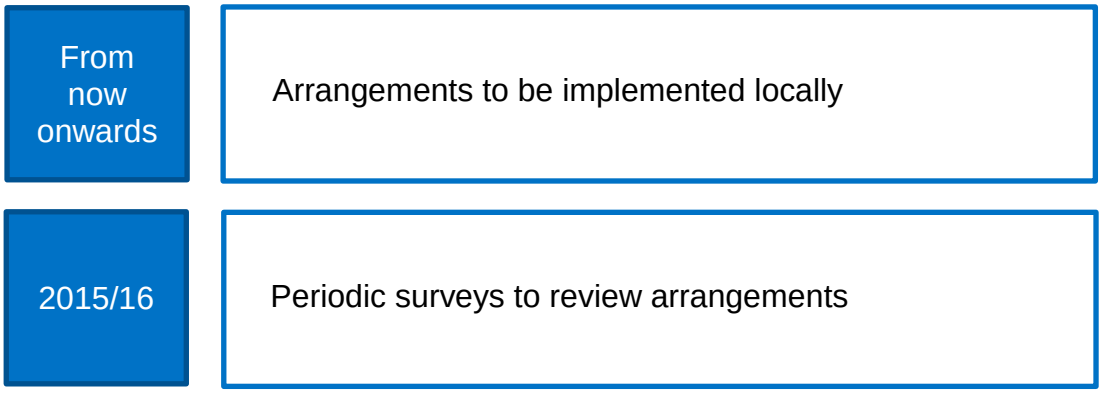
Co-commissioning model	Approvals process
Greater involvement in primary care commissioning decision making	No formal approvals process. Arrangements should be taken forward locally.
Joint commissioning	Proposals should be submitted to england.co-commissioning@nhs.net by 30 January 2015. Proposals will be agreed by regional teams, if they are assured that arrangements comply with the governance framework, for instance through the creation of a joint committee or "committee in common".
Delegated commissioning	Proposals should be submitted to england.co-commissioning@nhs.net by **12 noon** on **9 January 2015** for initial review by regional moderation panels. Final sign off will be undertaken by the proposed new Commissioning Committee of NHS England's Board.

Further information on the approvals process is set out in sections 7.2 to 7.4. On-going assurance of arrangements will form part of the CCG assurance process.

7.2 Greater involvement in primary care co-commissioning: approvals process and timeline

There is no formal approvals process for any CCG which wishes to have greater involvement in primary care decision making. Many CCGs are already working closely with their area teams to influence and shape primary care decision making and NHS England will continue to work with CCGs to establish effective arrangements. Periodic surveys will be conducted to provide an opportunity for CCGs and area teams to feedback on local arrangements. More information on the surveys will be provided in due course.

7.2.1 Summary of the approvals process and timeline



7.3 Joint commissioning proposals: approvals process and timeline

7.3.1 Joint commissioning proforma

CCGs that wish to assume joint commissioning responsibilities should work with their area teams to complete a short proforma (annex A) to confirm the agreed governance arrangements. Proformas should be submitted to england.co-commissioning@nhs.net by **30 January 2015** along with requested supporting information, including the proposed governance structure and constitution amendment request. A draft governance structure for joint commissioning arrangements is appended at annex D and can be amended to reflect local arrangements.

7.3.2 Approvals process

Regional moderation panels will convene in early February 2015 to review all submitted proposals, focusing upon the proposed governance arrangements and ensuring consistency of area team approach. Where a joint commissioning arrangement involves a pooled fund, the arrangement would need to comply with financial instructions (please refer to section 4.3.3). This is also an opportunity to take stock of the practical arrangements put in place locally by CCGs and area teams and to highlight and share best practice in this area.

Once regional teams are satisfied that the proposed arrangements comply with the legal framework and constitution amendments have been approved, arrangements can be implemented by **1 April 2015**. Area teams will inform CCGs once proposals have been approved and CCGs and NHS England will be required to sign a legally binding agreement to confirm how NHS England and CCGs will operate under the joint arrangement. Where proposals are not recommended for approval, regional teams will work with CCGs and area teams to support the development of joint arrangements.

All new arrangements for information handling as a result of joint commissioning arrangements must meet relevant information governance standards. CCGs are encouraged to review their Information Governance Toolkit assessment to ensure compliance with Department of Health Information Governance policies and standards.

7.3.3 **Summary of the approvals process and timeline**

November 2014 to January 2015	• CCGs and area teams should work together to further develop joint commissioning proposals.
30 January 2015	• Submission of proposal for joint arrangements (annex A). • Submission of constitutional amendment (annex C).
February to March 2015	• Regional moderation panel reviews proposals and makes recommendations for approval. • CCGs informed of the outcome of their constiutional amendment request. • If required, regional teams support the further development of proposals.
From 1 April 2015 onwards	• Arrangements implemented in full locally.

7.4 Delegated commissioning arrangements: approvals process and timeline

7.4.1 Delegated commissioning proforma

CCGs that wish to assume delegated commissioning responsibilities are asked to submit a short proforma (annex B) which focuses on the CCGs approach to conflicts of interest management. Proformas should be submitted to the national support centre team (england.co-commissioning@nhs.net) by **12 noon** on **9 January 2015** along with the requested supporting information, including the proposed delegated governance structure and constitution amendment request.

7.4.2 Approvals process

Regional moderation panels will convene in **mid-January 2015** to review all delegated proposals, specifically the CCG's proposed approach to conflicts of interest management. This is also an opportunity to take stock of the practical arrangements put in place locally by CCGs and area teams and to highlight and share best practice in this area.

A national moderation panel, in place to ensure consistency of approach across the country, will make final recommendations to the relevant new NHS England committee (likely to be the proposed new Commissioning Committee) on which proposals are ready to be taken forward from 1 April 2015. The committee will provide final sign off for delegated proposals in **February 2015**. Once proposals are approved, CCGs will need to set out their plans as per the 2015/16 NHS planning guidance which will be published in December 2014. Proposals will then be implemented on **1 April 2015**.

Where proposals are not recommended for approval, an appropriate plan will be developed between the CCG and area team, supported by regional teams, to either further develop proposals or to establish joint arrangements for 2015/16, if this is agreed to be the preferred approach. It would be preferential if arrangements were put in place on 1 April 2015 in the interests of agreeing staffing arrangements with area teams. However, there may be some flexibility to enable CCGs, who submit delegated arrangement proposals for 2016/17 to implement delegated arrangements in year in 2015/16.

Once delegated arrangements have been established, their effectiveness will be monitored as part of the CCG assurance process.

7.4.3 **Implementation arrangements**

Once delegated commissioning proposals have been signed off by the proposed new Commissioning Committee, CCGs will be required to sign a legally binding agreement to confirm the detail of how NHS England will delegate its general practice functions to CCGs.

NHS England's finance directorate will arrange for funds to be transferred on **1 April 2015** to enable CCGs to take forward arrangements thereafter**.** Funds will be transferred via an inter authority transfer in 2015/16. When discharging their duties, CCGs must comply with the Statement of Financial Entitlement (SFE) directions which set out the payments to be made under general medical services contracts. Business rules, which CCGs currently adhere to, will also apply to primary care commissioning. The 2014/15 business rules can be found in annex B of the financial plan template – direct commissioning section of the NHS England website.

All new arrangements for information handling as a result of delegated commissioning arrangements must meet relevant information governance standards. CCGs are encouraged to review their Information Governance Toolkit assessment in compliance with Department of Health Information Governance policies and standards. Information sharing will form part of the formal delegation agreement once arrangements have been approved.

7.4.4 **Summary of the approvals process and timeline**

November 2014 to January 2015	• CCGs and NHS England work together to further develop delegated commissioning proposals.
9 January 2015 (12 noon)	• Submission of proposal for delegated arrangements (annex B). • Submission of constitutional amendment (annex C).
February 2015	• Regional moderation panel review proposals and make recommendations for approval. • NHS England Commissioning Committee approves proposals
March 2015	• Subject to approval, NHS England's finance directorate arrange the transfer of delegated budgets. • CCGs informed of the outcome of their consitutional amendment request.
From 1 April 2015 onwards	• Arrangements implemented in full locally.

8 Changing a co-commissioning arrangement from 2015/16 onwards

This section sets out the process for changing a co-commissioning arrangement from 2015/16. This includes the approvals process and timeline.

CCGs are at different stages of their developmental journey and are facing a variety of local challenges. Therefore it is likely that the appetite to take on further responsibilities for primary care co-commissioning will vary across the country. We want CCGs to be able to move at their own pace, whilst also indicating that we see co-commissioning as a needful development towards mitigating current health inequalities and securing better integrated, more easily accessed, high quality care for patients. We expect that many CCGs may wish to enter into joint commissioning arrangements for 2015/16 to see how the agenda develops, before deciding to take on delegated responsibilities for 2016/17.

We intend to make it as straightforward as possible for CCGs to assume greater commissioning responsibilities from 2015/16 onwards, should they wish to. For example:

- CCGs which have no co-commissioning arrangements in place or opted for greater involvement, could apply for joint or delegated arrangements; or
- CCGs in joint arrangements could apply for delegated arrangements.

CCGs should discuss any plans to change their co-commissioning model with their area team in the first instance and new proposals should be discussed and planned as part of the CCG assurance process.

Future co-commissioning model	Approvals process *from 1 April 2015/16 onwards* to assume a new co-commissioning arrangement
Joint commissioning	CCGs should discuss their proposals with their area team and regional team. Any requests should be reviewed and agreed within the quarterly CCG assurance review meetings. The approvals process will follow the process set out in section 7.3 and the timeline will be confirmed by the area team.
Delegated commissioning	CCGs should discuss their proposals with their area team and regional team. NHS England and NHS Clinical Commissioners will in due course be developing the timetable for applications for 2016/17.

In the circumstance that a CCG wishes to terminate their co-commissioning arrangement, this would need to be by mutual agreement with NHS England. In these circumstances, it is expected that the CCG would move either from delegated arrangements to joint arrangements or joint arrangements to greater involvement.

9 Ongoing assurance

This section sets out on-going assurance arrangements for co-commissioning.

9.1 Overarching approach

NHS England is committed to working with CCGs to co-develop a revised approach to the current CCG assurance framework for 2015/16. The new assurance framework will be published in 2015. The on-going assurance of primary care co-commissioning arrangements will be managed as part of this wider CCG assurance process.

9.2 Principles

NHS England requires on-going assurance that its duties are being discharged effectively. The assurance process will be adapted according to the commissioning function that the CCG is undertaking. NHS England will look at ways of reducing the burden of assurance on the service whilst implementing a robust process that is mindful of the legislative framework.

There are three key principles governing the assurance process:

- It will be simplified to reduce unnecessary bureaucratic processes for both CCGs and NHS England;
- It will be based on a supportive conversation and the process will reflect the flexibility of NHS England to intervene differently in different circumstances; and
- There will be clear interventions for failing CCGs.

In particular, for co-commissioning the new assurance process will:

- test that core governance arrangements are working successfully, with specific attention to the effective local management of conflicts of interest;
- be specific about the achievement of local outcomes, with a particular focus on service delivery across the local health economy; and it will
- be co-designed and developed in strong partnership with CCGs and other key stakeholders prior to publication.

10 Development support and evaluation

This section sets out the support available to CCGs to implement co-commissioning and the on-going evaluation of co-commissioning arrangements.

10.1 Implementation roadshows and legal support

A series of roadshows will take place across the country to support CCGs and area teams to move towards implementing primary care co-commissioning arrangements. The purpose of these events is to:

- Set out the vision for the future as we move towards place-based commissioning, taking into account the vision described in the Five Year Forward View;
- Provide an opportunity for CCGs and area teams to raise any questions they may have about primary care co-commissioning and the impact of the changes;
- Provide technical advice to support the implementation of co-commissioning, specifically on the timeline and approvals process, the legalities of joint and delegated arrangements and conflicts of interest management; financial arrangements and HR and resources, and
- Offer a further opportunity for area teams and CCGs to work together on their joint proposals if they so wish.

The workshops will take place between 19 November and 2 December 2014. Further information and registration details can be found here. Due to high demand, CCGs are asked to only send one representative to the events. The events are not open to private businesses.

Further legal advice will also be available for CCGs that intend to implement joint and delegated arrangements. Your regional team will provide further information on how this can be accessed.

10.2 Learning and continuous development

It will be important that we review and share learning from the implementation of co-commissioning arrangements in real time in order to support CCGs' continuous development and improvement. We will evaluate the following:

- what is and is not working;
- any unforeseen perverse incentives and system blockages; and
- examples of good practice.

This will help us to improve the policy for future years. In addition, we are exploring options on how best to do the following:

- provide technical support where required;
- enable the dissemination of 'lessons learned' and supporting a network of practitioners to problem solve and share learning and experiences; and
- provide a web-based interactive platform for exchange and ideas.

Further information will be shared in due course.

11 Next steps

We hope this document is useful in helping to inform CCG decision making around primary care co-commissioning models and in providing clarity on the next steps towards the implementation of co-commissioning arrangements. If you require any further information, please email: england.co-commissioning@nhs.net.

We will be keeping the arrangements set out in this document under review in the light of the experience of their operation during 2015/16.

Furthermore, as primary care co-commissioning is the start of a longer journey towards place based commissioning, we recognise there is much work to be done to achieve this goal. NHS England is therefore committing to the following in 2015/16:

- We will look at options for the co-commissioning of dental, eye health, community pharmacy and public health services (such as immunisation and vaccinations), as we know some CCGs are keen to assume commissioning responsibilities in these areas. This will be done with full and proper engagement of the relevant professional groups.
- We will continue to work on arrangements for involving CCGs in the commissioning of specialised services.
- We will continue to monitor running cost allowances and resources to ensure that co-commissioning arrangements are sustainable.
- We will look into GP premises development, as part of the implementation of the NHS Five Year Forward View.

12 Glossary

APMS	Alternative Provider Medical Services
CCGs	Clinical Commissioning Groups
CSU	Commissioning Support Unit
DES	Directed Enhanced Services
FAQs	Frequently Asked Questions
GMS	General Medical Services
GPs	General Practitioners
IPC	Integrated Personal Commissioning Programme
JSNAs	Joint Strategic Needs Assessments
LES	Local Enhanced Services
LMC	Local Medical Committee
LRO	Legislative Reform Order
MPIG	Minimum Practice Income Guarantee
PMS	Personal Medical Services
QIPP	Quality Innovation Productivity and Prevention
QOF	Quality Outcomes Framework
SFE	Statement of Financial Entitlement

13 References

Department of Health, Information Governance Toolkit

Department of Health, 16 July 2008, End of Life Care Strategy

Department of Health, 29 September 2014, Statement of Financial Entitlement

HM Government, 2012, Health and Social Care Act 2012

NHS, 23 October 2014, NHS Five Year Forward View

NHS England, October 2012, Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services

NHS England, 28 March 2013, Managing conflicts of interests: Guidance for clinical commissioning groups

NHS England, 7 May 2013, CCG Assurance Framework 2013/14

NHS England, 24 May 2013, Procedures for clinical commissioning group constitution change, merger and dissolution

NHS England, September 2013, Transforming Participation in Health and Care guidance

NHS England, 25 March 2014, Technical Guide to the formulae for 2014-15 and 2015-16 revenue allocations to Clinical Commissioning Groups and Area Teams

NHS England, September 2014, Framework for Personal Medical Services (PMS) Contracts Review

NHS England, 4 September 2014, Integrated Personal Commissioning (IPC) programme

NHS England, 29 September 2014, Update on the Legislative Reform Order (letter)

NHS England, Financial plan template – direct commissioning 2014/15 to 2018/19

14 Annexes

This document is accompanied by a suite of practical tools to support CCGs to implement co-commissioning arrangements locally including:

Annex A: Submission proforma for joint commissioning arrangements

Annex B: Submission proforma for delegated commissioning arrangements

Annex C: Model wording for amendments to CCGs' constitutions

Annex D: Model terms of reference for joint commissioning arrangements, including scheme of delegation

Annex E: Draft delegation by NHS England

Annex F: Delegated commissioning model - draft terms of reference

Annex G: Members of the Primary Care Co-commissioning Programme Oversight Group

Annex H: CCG investment in primary care frequently asked questions (FAQs)

Framework for responding to CQC inspections of GP practices

Framework for responding to CQC inspections of GP practices

Version number: 1

First published: 20 October 2014

Prepared by: Commissioning Operations, NHS England

Classification: Official

Contents

Executive summary

General practice, at its best, is often described as the jewel in the crown of the English NHS. We know that the vast majority of GPs do their utmost to provide the best possible care, in the face of rising demand from the public. But we also know from early visits carried out by the Care Quality Commission (CQC) that there are a very small number of practices who may be struggling to meet the standards that both patients and taxpayers alike have the right to expect.

From October 2014, the CQC will begin to roll out their new inspection regime to inspect and rate every GP practice in England by April 2016. Practices will be inspected across five key questions, considering the extent to which they are safe, effective, responsive, caring and well-led. They will be rated in one of four categories; outstanding; good; requires improvement; or inadequate.

This framework is designed to support area teams to work with the minority of practices that are rated inadequate so that there is a consistent approach to avoiding risk to patients and ensure continued patient confidence in the local NHS and primary care services.

As independent contractors, it is ultimately the practice's responsibility to address any problems identified at inspection and to ensure improvement. However, it is important that area teams - and Clinical Commissioning Groups (CCGs) when co-commissioning - ensure there are clear and transparent improvement plans in place and support appropriate interventions if services to patients are at risk.

This guidance describes how area teams:

- collaborate with CQC through ongoing monitoring and surveillance of contracts, prior to and during practice inspection to share intelligence.
- support practices rated inadequate in one of the key domains or population groups by putting in place an improvement plan and signposting to external support to ensure sustained measurable improvement.
- oversee progress against the plan and take further contractual action if there is no demonstrable improvement.

The principles described throughout this framework have been co-developed with area teams, CCGs, GP practices, CQC and experts in general practice improvement. They are based on experience of supporting practices and professionals to improve quality, safety and resilience.

The framework will be updated in due course as CQC's inspection and special measures regime is tested further and becomes embedded within the system.

Chapter 1: Ongoing monitoring and surveillance

1. Effective monitoring and surveillance of primary medical care services requires effective collaboration between CQC, NHS England and CCGs. Mature local relationships are required to ensure that information on general practice is shared and discussed in an appropriate and timely manner and that any risk is identified and managed and escalated where necessary.

2. The Quality Surveillance Groups (QSG) have become an essential forum for sharing concerns relating to primary care contractors. Critical to the success of the QSG is the commitment of senior leadership from each organisation and the opportunity to share concerns at an early stage to build a picture of the difficulties facing challenged practices. All QSGs are encouraged to ensure there is an appropriate sharing of information on risk and service delivery in primary care between the relevant agencies.

3. This chapter aims to give greater clarity on how CQC inspection teams, NHS England regional and area teams and CCGs combine their knowledge and resources. The impact of a failure to work together would significantly increase workload and reduce the effectiveness of all parties and the impact of poor coordination between area team and CQC could result in the continuation of an unsatisfactory service for longer than is necessary.

4. The introduction of a special measures regime makes it even more important that roles and responsibilities are clarified and that a consistent way of working together is established to oversee and support not just the practice, but the local clinical community, if risk to patient care is to be managed.

5. The logistics of what and how information is exchanged, when and how meetings take place, must be determined at a local level and these arrangements will be dependent upon factors such as geography, number of CCGs per area team and CCG constitutions for example. Different models of working have evolved with examples of weekly or monthly review meetings taking place between CQC inspection managers and area teams, some having all CCGs from an area represented and others meeting on a more individual basis with CCGs to discuss member practices. Regular meetings should take place where CQC and area team staff have specific discussions regarding a number of practices causing concern. It is important to agree a set of principles for joint working with CQC leads and implement a consistent system locally.

6. Principles for joint working should clearly set out:
   - Clarity of roles and responsibilities across CQC, NHS England and CCGs.
   - The personal leadership of the Area Director in setting up these arrangements and explicit involvement of Medical and Nursing Directors as well Primary Care Commissioning Leads.
   - An established on-going relationship between NHS England, CQC and CCGs outside of the inspection process to ensure there is an on-going route of communication and information sharing.

- How surveillance and ongoing monitoring is used to maintain shared risk assessments, at both practice and locality level (in recognition of the potential domino effect if an inadequate practice fails to improve).
- A consistent approach to pre-inspection planning – particularly important to manage the post inspection work load on area teams and CCGs.
- CQC inspections that are joined up with CCG and NHS England activities.
- Greater transparency of meaningful information sharing (both hard and soft) about registered providers.

7. Table 1 sets out the proposed roles and responsibilities of CQC, NHS England and CCGs working collaboratively before, during and after inspections. The key elements include:
   - Agreed information data set, available prior to discussions and normally discussed prior to any inspection.
   - A schedule of inspections made available in good time.
   - Targeted inspections by agreement.
   - Pre and post inspection information sharing meetings between CQC, area teams and CCGs.
   - Mechanism for immediate escalation to all parties.

Co-commissioning

8. CCGs have a statutory responsibility to support the improvement of primary care and their contribution to a Primary Care QSG is an essential element to this role. On 1 May 2014, NHS England announced plans to allow CCGs to develop new models of co-commissioning primary care. One of the stated aims of co-commissioning was:

   "raising standards of quality (clinical effectiveness, patient experience and patient safety) within general practice services, reducing unwarranted variations in quality, and where appropriate, providing targeted improvement support for practices."

9. The potential scope for co-commissioning of primary care encompasses a wide spectrum of activity, including the assessment of needs, decision making on strategic priorities with Health and Wellbeing Boards, designing and negotiating local contracts (e.g. PMS), managing financial resources, and monitoring contractual performance.

10. Three categories of interest in co-commissioning have been described.
    - Greater involvement in primary care commissioning alongside NHS England area teams.
    - Joint commissioning arrangements through the creation of a joint committee or "committees in common" across NHS England and the CCG(s).
    - Delegated commissioning arrangements.

11. Whilst NHS England is able to give full delegated powers to CCGs to commission primary medical care services, NHS England is unable to delegate responsibility for the commissioning of primary care. It will be essential therefore that NHS England retains an element of oversight of primary medical care services.

12. Area teams and CCGs will need to agree within the principles for joint working the nature and extent of the CCG role through co-commissioning arrangements and ensure this is clearly articulated to CQC and to member practices.

Information and data sources

13. A range of information should be utilised throughout the processes of robust contract management and service improvement. NHS England, CCGs and the CQC should routinely aim to share all available information, in particular during pre-inspection meetings.

14. Some sources (primary care web tool) are accessible to GP practice staff, CCGs, NHS England area and regional teams and other approved stakeholder organisations including CQC. However, other information (complaints, contractual compliance, individual performance concerns and workforce information) will be held locally.

15. The following list may be helpful for pre-inspection preparations:
    - General Practice High Level Indicators (GPHLI) and General Practice Outcomes Standards (GPOS) within the primary care web tool:
        - Agreed subset of key indicators from both datasets. e.g.
            - Patient experience domain indicators.
            - Friends and family test (when available).
            - Patient safety domain indicators.
            - Patient annual turnover.
        - Practice profile.
        - Practice electronic declaration.
    - QOF data.
    - Complaints / SUI / SEA / whistleblower / performance concerns.
    - Contractual compliance.
    - CQC data packs and intelligent monitoring.
    - CCG information regarding quality / clinical effectiveness including possibly information for prescribing audit data, referral data.
    - Professional investigations.
    - Workforce information.
    - Premises information:
        - Any known issues / ongoing or proposed developments.
        - Minimum standards audit (Principles of Best Practice part 8) to be released.
        - Infection prevention control audit (Principles of Best Practice part 9) to be released.
        - Any premises 6 facet survey held by the area team

Table 1: Roles and responsibilities of area teams, CCGs and CQC before, during and after inspections

Who	Before	During	After
Area team *Each area team has a small senior team who lead on primary care issues. It will include the Medical Director (MD), Director of Nursing (DoN) and the Primary Care Commissioning Lead, as a minimum. It is important that this team has established lines of communication with the CQC Inspection Manager (IM) to share real time concerns. They should look to hold weekly meetingswith CCGs and CQC to discuss any concerns or issues arising and agree any action required.*	• Provides any relevant contextual information to CQC (e.g. enhanced services, demographics, history). • Provides information about the practices being inspected (eg contractual issues, complaints, improvement plans). • Advises CQC whether there are any other practices that should be inspected (this should usually be picked up in the ongoing work together but this could include where some recent concerns have been raised).	• Identifies a named responsible officer at director level to be accessible should any immediate risks be identified. • Informs the relevant CCG lead of any concerns identified by the CQC. • Manages any immediate contract issues. • Appropriate professional lead in the area team manages any immediate professional issues.	• Senior representative to be available if risks or concerns are identified. • CQC will have a specific meeting with the area team and CCG after visiting practices in a particular CCG area. • Any professional issues will be managed by the appropriate professional lead in the area team. • Good and outstanding practice identified will be shared with CCG and others. The area team will clarify the mechanism for doing this at local level. • Thresholds for escalation for discussion at local and regional QSGs to be agreed.
CCGs *CCGs have a duty in relation to the quality of primary medical services provided, as described in statute Section 14S NHS Act 2006. They assist and support NHS England in discharging its duty relating to securing continuous improvement in the quality of primary medical*		• Identifies a named responsible officer at director level to be accessible should any immediate risks be identified.	• CCG quality improvement and support may form part of any action plan to resolve concerns or risks identified by the inspection visit.

services. CCGs monitor performance of services commissioned directly from primary care providers against agreed service standards. CCGs should share information with CQC to help prioritise where inspections may be needed.			
CQC *The Inspection Manager (IM) at the CQC builds and leads ongoing relationships with key relevant stakeholders, including area teams and CCGs. They share information and concerns, escalating risks in real-time, attends the local QSG as a member and facilitates informal information sharing, e.g. CQC attendance at local 'huddles or monthly attendance at area team quality/risk meetings. The IM coordinates CQC resources across the local area to enable inspections to be prioritised and will share the risk register with area teams.*	• IM coordinates and chairs pre-inspection information sharing meeting with area team and CCG. • If there are significant issues the Head of Inspection supports the inspection manager at the meeting. • Clarifies and improves understanding of new approach and process with area team and CCG. • Leads discussion on providers being inspected agree any variation to the list (this is not an opportunity to add additional inspections but depending on issues/actions inspections may be paused). • IM briefs inspectors and Head of Inspection on the outcome of discussions at meeting.	• Inspector feeds back to practice at the end of the inspection, including if there are any immediate concerns. • In the case of any major of immediate concerns the inspector will discuss this with their inspection manager and the Head of Inspection. Any major or immediate concerns will also need to be fed back to NHS England. IM will contact the area team on the same working day.	• IM presents overview of findings/themes across practices at post-inspection meeting to area team and CCG, including good and outstanding practice. • IM will highlight where there are concerns about individual practices prior to this meeting, for example if a practice is rated inadequate. • A CQC Management review meeting will be held to decide next steps if there is a need to consider any enforcement activity.

CQC inspections and ratings

16. CQC will inspect practices and ask whether they are safe, effective, caring, responsive and well-led. The inspections focus on six key population groups (older people, people with long term conditions, working age people; families, children and young people, people living in vulnerable circumstances and people with poor mental health.

17. Following CQC inspections, each GP practice will receive ratings at four levels:
    Level 1: Rate every population group for each key question.
    Level 2: An aggregated rating for each population group.
    Level 3: An aggregated rating for each key question.
    Level 4: An aggregated overall rating for the practice as a whole.

18. The following illustration shows how the four levels work together:

Level 1: Every key question for every population group

	Safe	Effective	Caring	Responsive	Well-led
Older people	Good	Outstanding	Good	Outstanding	Good
People with long term conditions	Good	Inadequate	Good	Inadequate	Good
Families, children and young people	Good	Good	Requires improvement	Good	Requires improvement
Working age people (including those recently retired and students)	Good	Good	Outstanding	Good	Outstanding
People living in vulnerable circumstances	Good	Outstanding	Good	Requires improvement	Good
People with poor mental health (including people with dementia)	Good	Good	Requires improvement	Good	Requires improvement

Overall
*
*
*
*
*
*

Level 2: Aggregated rating for every population group

Level 3: Aggregated rating for every key question

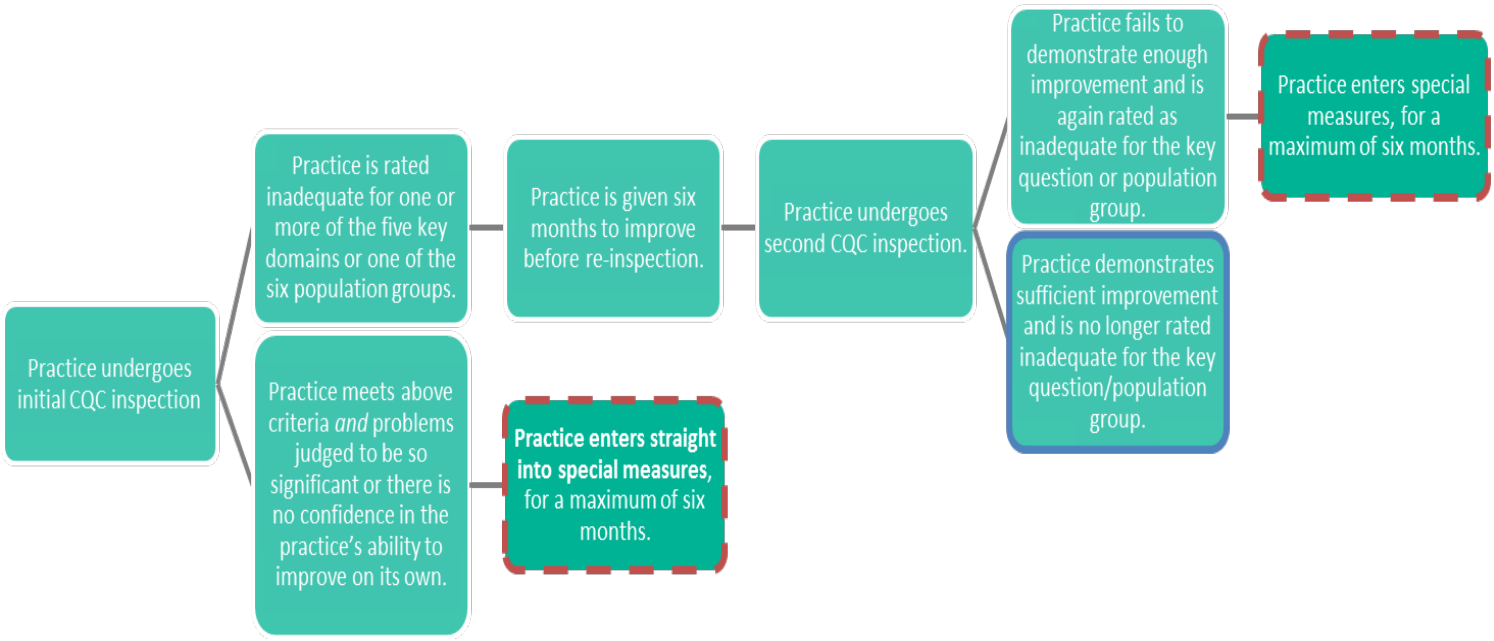
Overall	*	*	*	*	*

Overall location
*

Level 4: Overall rating for the practice

Inadequate rated practices and special measures

19. The diagram below illustrates the relationship between a practice found to be inadequate and the special measures regime.



20. Where a practice is rated inadequate for one or more of the five key questions (safe, effective, caring, responsive or well-led) or one of the six population groups, CQC will give the practice six months to improve and require the practice to set out the actions that it will take to address the findings.

21. The next chapter describes how area teams should work with practices rated inadequate for one or more of the five key questions or one of the six population groups to develop an improvement plan that can be used by the practice to respond to CQC on the actions being taken, but which also goes further in setting out how they will address the underlying root issues, aim for continual improvement and identifies relevant sources of support to draw upon. A template is enclosed at annex 2. Clearly, there may be instances where a practice receives a level one inadequate rating and the resolution is straightforward. Whilst it is just as important for the area team to work with the practice to ensure the issues are rectified ahead of any re-inspection, a lighter touch improvement plan may be developed by the area team which is more proportionate to the issues identified.

22. The practice will be re-inspected six months later and if there has been no demonstrable improvement and is again rated inadequate for the key question or population group then the practice will be placed into special measures by the CQC.

23. In some cases a practice will be rated as inadequate for one of the five key questions or one of the six population groups and the problems are either judged to be so significant that patients are at risk, or there is no confidence in the practice's ability to improve on its own that the GP practice will be placed straight

into special measures. This will usually include when a practice is judged to be 'inadequate' for the well-led domain as well as one of the other five domains or population groups.

24. In either instance (following an initial inspection or a re-inspection), once a practice is placed into special measures, this will be for a maximum period of 6 months. Being placed into special measures should be seen by the contractor and NHS England as an indication that this is the last chance for the practice to improve, and if improvements are not made, CQC will move to cancel the registration of that provider.

25. In all of these circumstances NHS England must ensure that they take the necessary, appropriate and timely contractual action, to ensure ongoing patient safety and access to services.

Support for practices placed in special measures

26. From October 2014 to October 2015, NHS England will be working with the Royal College of General Practitioners to pilot a peer support programme which will provide expert support, mentoring and coaching for practices placed in special measures. The costs will be split between NHS England and practices on a matched funding basis, each contributing half. More information about the pilot is available at annex 1 and details will be shared with area teams in due course.

Chapter 2: Improvement

27. It is the responsibility of the contract holder of the practice to improve services to patients and ensure the appropriate action is taken following any CQC inspection. Area teams and CCGs, however, can play a vital role in ensuring a positive climate of improvement in a health community, guiding and appropriately supporting a practice in the direction of improvement

28. Area teams are advised to invest in building effective working relationships with local stakeholders including Local Medical Committees (LMCs) before inspections. Other bodies can contribute a great deal in terms of helping to identify problems, providing facilitation and expertise for discussions about solutions, and providing direct assistance in implementing change.

29. Notwithstanding the potential future of co-commissioning, CCGs already have a responsibility to improve the quality and safety of primary care provision for local people and are a key partner for area teams in responding to performance concerns identified by CQC. In many cases, the CCG will already have specific knowledge of the issues concerned, as well of improvement approaches adopted by other practices. In addition to its statutory role in improving primary care, it has a leadership role among local practices by virtue of its being a membership body. Peer support between practices and networks for practice staff are well established sources of support for practices to use on improvement journeys.

30. Many CCGs have already established programmes, resources and processes to promote and support continuous quality improvement in practices. Peer support between member practices is an obvious example. This is very welcome and NHS England strongly encourages all CCGs to engage actively in supporting improvement.

31. Table 2 summarises many of the roles and abilities of different local stakeholders. It is not intended to be exhaustive or to replace contractual or other obligations already in place.

Table 2 : Responsibilities and expectations of key stakeholders

	Responsibilities	Expectations
CQC	• Clearly identify in the inspection report and post-inspection discussions what needs to be improved/reasons for inadequate ratings. • Use enforcement powers to: o Protect people who use regulated services from harm and the risk of harm. o Hold providers and individuals to account for failures in how services are provided.	
The practice	• The practice itself is responsible for the care it provides and for improving in response to CQC instructions. Others may be able to provide advice and practical support, but that does not lessen the responsibility on the practice. • Undertake a root cause analysis to establish any underlying issues that need to be addressed within the improvement plan or that may require referral to other organisations such as NCAS or the GMC. • Create a plan for improvement, agreeing key milestones and measures with the area team and submit this to CQC. • Commit sufficient time to creating and implementing a plan for improvement. • Provide the area team and CQC with regular updates on progress in enacting change.	• Collaborate openly with the area team in creating and implementing a plan for improvement. • Work with others (eg CCG, LMC) to identify collaborative solutions to local needs. • Incorporate learning from others, including from neighbouring practices.

Area team	• Support the practice to draw up an improvement plan. • Undertake monitoring against the improvement plan. • Consider any relevant contractual action.	• Help the practice to identify sources of support for improvement. • Provide direct advice and support from the medical and nursing teams. • Where a practice in special measures secures support through the national Royal College of General Practitioners offer, work closely with the support team to ensure they have all relevant information about the practice and locality, including other local support resources.
Clinical Commissioning Group	• Support the process of improvement planning, and identification of solutions and sources of support for the practice.	• Support the practice in identifying root causes of issues. • Identify ways in which new opportunities could be created as part of plans for the locality or the development of federations and mergers. • Gather and share learning which benefits all practices locally. • Consider the benefit of peer support.

Creating an improvement plan

32. Where a practice is rated inadequate for one or more of the five key questions (safe, effective, caring, responsive or well-led) or one of the six population groups, CQC will give the practice six months to improve and require the practice to set out the actions that it will take to address the findings.

33. Area teams should work with these practices to develop an 'improvement plan' which can be used by the practice to respond to CQC on the actions being taken, but which also goes further in setting out how they will address the underlying root issues, aim for continual improvement and identifies relevant sources of support to draw upon.

34. A proposed template for the improvement plan can be found **at annex 2** and a step by step guide aimed at practices to support its development is enclosed at **annex 3.**

35. The template is offered as a specimen to help area teams work with practices to record their improvement plan and track progress. It includes the recommended information to be sent to CQC, to satisfy the requirement to notify them of proposed actions.

36. Clearly, there may be instances where a practice receives a level one inadequate rating and the resolution is straightforward. Whilst it is just as important for the area team to work with the practice to ensure the issues are rectified ahead of any re-inspection, a lighter touch improvement plan may be developed by the area team which is more proportionate to the issues identified.

37. There is a strong expectation that the improvement plan will be co-developed between the area team, the CCG and practice. Where the practice is not forthcoming in sharing the information, area teams should consider whether it would be appropriate to take contractual action to require the information.

38. The process of reflection, discussion and planning which results in such a document is more significant in improvement than the document itself. The best plan will be one that is developed collaboratively and one that addresses underlying issues not only superficial symptoms, aims to achieve continual improvement, draws on relevant sources of support and forms the basis of a rigorous delivery of change.

39. **Annex 4 contains a range of case studies** of practice improvement that have worked in some areas. Area teams may find these helpful, however, it is important to note that we are not endorsing nor recommending any one type of approach locally. Ultimately, it is the practices responsibility to improve and address any concerns highlighted in the inspection and has to be at the discretion of the area team how much support is possible.

40. **Annex 5 contains a list of potential sources of support** for practices to help inform decisions about securing support to improve. Entry on the list does not constitute a recommendation or commitment to provide funding. If there are

additional suggested entries, please forward these to Dr Robert Varnam, Head of General Practice Development at NHS England (robert.varnam@nhs.net).

41. Practices may benefit from the support of a wide variety of people and organisations. In many cases, they will want to seek others' input to help compile a coherent package of support, while, in others, a more piecemeal approach will be appropriate.

42. CCGs have a significant role to play in stimulating the development of support offers to help practices innovate and improve. These may combine in-house and external resources, depending on local circumstances. Some CCGs have already contributed to the creation of locally based expert teams and systems for sharing experience between practices. Others are beginning to work with national organisations to support practices directly or build local capabilities. It is likely that every CCG will need access to both local and wider expertise to help all practices improve quality and transform services for the future, and development of the right capacity and capabilities this will need to be an area for detailed planning and investment over coming years.

Monitoring of Implementation

43. Improvement plans should include clear details of how and when progress will be assessed by the area team (ideally in partnership with the CCG). Important principles for monitoring are as follows:
    - Include an early assessment of the extent to which the practice as an effective organisation, and all relevant members of the practice team are engaging in the process of improvement and accept their responsibility. The area team should consider performance issues of GPs that may be associated with the problems found during the inspection.
    - Look for signs of any new issues emerging, or other evidence that plans may need to be amended. This is not uncommon during an improvement process, and often indicates that additional root cause analysis may be required.
    - Agree at the outset whether, when and how the area team or others will review the preparedness of the practice prior to re-inspection by the CQC.
    - Aim to minimise the burden of monitoring, to ensure the practice is able to concentrate on its improvement work.

Informing patients

44. It is important that patients are kept continually informed when issues are identified with the quality or the conformity of their services, for example when a practice is rated inadequate or is placed into special measures. Patients should be kept up to date what the rating means and, in particular, what action the practice is taking to improve.

45. Area teams should support practices to inform patients through all reasonable means, including information in the waiting room, on the practice website and NHS Choices, as well as in direct meetings with patients such as the patient participation group.

46. Area teams should also take appropriate action to ensure that the largest possible number of patients are aware of the outcomes. This could include notices via Healthwatch, area team and CCG websites, and other communications channels.

47. CQC already publish their reports and ratings to patients, and during autumn 2014, the Department of Health is consulting on whether to require providers to display their CQC ratings, including on their website and within their premises.

48. It is good practice to ensure a senior responsible person in the area team (or CCG through co-commissioning arrangements) ensures effective measures are put in place to make patients aware of the action being taken by the practice, the area team and the CCG. Patients are generally very supportive of their practice, and rightly expect to be informed about important developments. They are also often a significant source of support in improvement efforts.

Chapter 3: Performance oversight and contractual action

50. NHS England has a statutory obligation, pursuant to Section 13E of the NHS Act 2006, to exercise all its functions with a view to securing continuous improvement in the quality of services provided to individuals for, or in connection with, healthcare which would include taking contractual action, where necessary to do so, to ensure the safety of patients and compliance with contracted services.

51. This chapter sets out the framework for taking a contractual response to concerns raised by the Care Quality Commission (CQC) following a practice inspection visit and/or an 'inadequate' rating given to a GP practice.

52. In the most part it is likely that matters will be resolved through the development and implementation of improvement plans. There will be occasions, however, when area teams will need to take contractual action to resolve matters either alongside the CQC regulatory arrangements or completely independently from them.

53. This chapter aims to support area teams in consistently taking the proportionate and appropriate contractual action in response to CQC concerns and ratings, signposting to existing guidance and policies in the event of intractable problems and to ensure patient safety, continuity of services and choice are considered at all times throughout the processes.

54. Timely, effective and appropriate information sharing between CQC and area teams will be essential to minimise duplication of effort and allow NHS England to take forward its management of a contractor. However, it is relatively likely that NHS England will need to undertake some further investigation using its contractual powers where the CQC has identified concerns about a provider. In drafting the terms of reference for such an investigation, area teams should have regard to information supplied by the CQC.
55. Nothing will restrict area teams in their right to act independently of the CQC inspection and rating, in enforcing contractual compliance in line with the single operating model policies, legislation and regulations.

CQC enforcement action

56. This section summarises the approach that CQC takes in deciding when to use its enforcement powers. These are described in full in the CQC Enforcement policy which is published on the CQC website (http://www.cqc.org.uk/content/how-we-enforce).

57. Where CQC identifies concerns a decision will be made about what action is appropriate to take. The action taken is proportionate to the impact or risk of impact that the concern has on the people who use the service and how serious it is. Where the concern is linked to a breach in CQC registration regulations, CQC has a wide range of enforcement powers given to take action. The CQC enforcement policy describes these powers in detail and the general approach to using them.

- Enforcement action can be taken under either:
- Civil enforcement: to protect people from harm.
- Criminal law: to hold a registered provider or manager to account in court in relation to a significant failing.

58. CQC also “recommends improvements” where they have identified changes that could or should be made but where a regulation has not been breached.

59. In addition to using the enforcement powers, CQC will also work with other organisations, including other regulators and commissioners, to help ensure action is taken on concerns that have been identified. This includes placing a practice which is found to be providing inadequate care into special measures.

CQC’s urgent powers to suspend or cancel registration

60. CQC can also use their powers of conditions, suspension and cancellation through urgent procedures, which have immediate effect (providers are able to appeal after CQCs decisions to use urgent procedures).

61. CQC decides, when it is appropriate, to impose conditions or suspend registration using urgent procedures. To cancel a registration using urgent procedures CQC must apply to a justice of the peace for a court order.

62. The CQC action taken under urgent procedures takes immediate effect though the registered person affected by these actions does have the right of a fast track appeal to an independent tribunal.

63. The CQC will alert the area team to their views within one working day of a concern being identified following inspection and will notify the area team of its intention to suspend or cancel a provider’s registration under urgent action and any other relevant information in respect of that suspension as soon as that decision has been made.

64. Where a provider’s registration is to be suspended they are suspended from providing the relevant regulated activity from all locations. If the provider is suspended from providing all regulated activities the effect of this is that the provider will be temporarily blocked from being able to deliver services under the GMS/PMS or APMS contract until such time as that suspension is lifted, the outcome of any fast track appeal hearing is known and/or the CQC cancels the registration.

65. In these circumstances the contractor must immediately engage with the area team to consider the options for ensuring the continuity of service delivery which may include consideration of sub-contracting or parachuting arrangements.

Subcontracting

67. Subcontractors that provide treatment or care services that include the provision of a regulated activity will usually need to register with CQC in their own right, although this will always depend on the nature of the subcontracting arrangement.

68. CQC's Scope of Registration provides further detail on who needs to register (http://www.cqc.org.uk/sites/default/files/documents/20130717_100001_v5_0_scope_of_registration_guidance.pdf).

69. Generally, a sub-contractor with a contract to supply part of a wider and more comprehensive service will have to be registered for any regulated activity they perform if they retain any responsibility for the delivery of the service (such as the operational policies and protocols, day-to-day operational or staff management, clinical governance or quality assurance).

70. In situations where an existing registered provider takes over the running of the services from another practice the sub contracted provider must register the practice as a new locality under their own registration.

71. The locations that a provider is registered to operate from are listed in one condition of registration and sub-contracted providers can apply to vary this condition.

72. Sub-contracted providers must have their application approved before they can start to implement the changes (ie to provide care from a new location).

73. If providers are adding a new location, or changing the location to another, they will need to provide the CQC with information about this and the CQC may need to make a visit as part of the assessment of the application.

74. The sub-contracted provider will remain responsible for the services at the new/added locality while it remains part of their registration.

Urgent cancellation of registration

75. The CQC will consider using urgent procedures to cancel a registration as a last resort where the problem cannot be resolved in any other way and where a person(s) is at serious risk to their life, health or wellbeing.

76. When using its powers to cancel a registration using urgent procedures, the CQC must apply to a justice of the peace for a court order.

77. The CQC will notify the area team of the intention to make an application to cancel a provider's registration and any other relevant information in respect of that application.

78. Action under urgent procedures takes immediate effect. Registered persons have the right of a fast track appeal to an independent tribunal.

79. It is important to note that the CQC does not have the power to close the doors of a practice, only to take action in respect of the registrations associated with that practice.

80. Cancellation of a provider's registration means that they are no longer able to provide the relevant regulated activities which as the effect of removing the ability of the contractor to deliver services under their GMS/PMS or APMS contract resulting in the necessity to close the practice doors. This would constitute a significant breach of the contract and in such circumstances an area team should take, or is very likely to have taken, the appropriate contractual action as set out in the following information.

NHS England – contractual actions

81. This section sets out the actions that area team primary medical care contract teams should follow on receiving notification from the CQC that they have concerns in respect of a practice that is likely to be reported as "inadequate", entering special measures or moving towards CQC suspension or cancellation of registration .

82. Where the CQC have concerns about a practice, following the first inspection, they will notify the area team, within one working day of the visit providing a brief description of the concerns and any evidence available at that time.

83. In due course the CQC will provide a full report and rating, identifying any further action required by the practice in regard to their CQC registration. Area team contracting teams should not wait for this full report before assessing the risks and taking any necessary contractual action.

84. Timely, effective and appropriate information sharing between the CQC and NHS England will be essential to minimise duplication of effort and allow area teams to take forward management of a contractor. However, it is relatively likely that the area team will need to undertake some further investigation using its contractual powers where the CQC has identified concerns about a provider. In drafting the terms of reference for such an investigation, area teams should have regard to information supplied by CQC.

85. On receipt of the concern notification from the CQC, the area team should complete a risk assessment to establish whether it is necessary to undertake a contractual management visit to the practice for further investigation and/or the most appropriate contractual action, if any, to take. See flow chart at Annex 7.

86. Upon completion of the initial risk assessment and any subsequent visit and investigation, the area team may take one of the following actions:

Action 1: No contractual action

87. CQC ratings are provided against a set of criteria that do not always directly relate to contracted matters capable of a breach and therefore a concern and/or

inadequate rating may not always result in the issue of a contractual remedial/breach notice.

88. Following the risk assessment and any necessary contractual practice visit and investigation, the area team may consider that no further contractual action is either necessary or appropriate and will inform all interested parties in writing accordingly.

89. Practices that are notified that no contractual action is to be taken must have regard to the remaining requirements of the CQC registration and must use all best endeavours to improve their compliance with the standards over the period specified by CQC. Template letter provided at Annex 8.

Action 2: Remedial/Breach notices

90. Where, following the risk assessment and any necessary contractual practice visit and further investigation, an area team consider that the concern/inadequate rating also constitutes a contractual failure which is capable of remedy, the area team should issue the contractor with a remedial notice under the terms of the contract/agreement.

91. This notice should be issued in accordance with the policy for *Managing contract breaches, sanctions and termination for primary medical services contracts* and must relate to the contracted terms that have been breached, rather than the CQC concern/inadequate rating.

92. The notice must set out the actions that the contractor must take in order to remedy the breach and this may include the development of an improvement plan to be monitored by the area team over an agreed period of time, for the contractor to demonstrate their compliance with the contracted obligations.

93. Where the breach is not capable of remedy, and/or where the contractor has failed to satisfy the terms of any previous remedial notice, the area team may issue a breach notice in accordance with the policy for *Managing contract breaches, sanctions and termination for primary medical services contracts*.

94. Practices that are both notified of an inadequate CQC rating, or are breaching the CQC registration requirements and are issued with a contractual remedial/breach notice, must be made aware that they are required to satisfy both the CQC registration and area team regulatory requirements within the individually specified time scales. For example, CQC may allow the practice a six month period for improvement where the area team remedial/breach notice may require more rapid action to be taken to ensure contractual compliance and patient safety matters are resolved more quickly, usually within 28 days.

95. Where possible, CQC and area teams should coordinate their responses to contractual and CQC regulatory requirements in order to align timescales for achieving both sets of required actions.

96. Failure to comply with a contractual notice may result in the termination of the contract regardless of how long may be left in respect of any agreed CQC improvement period. Area teams must make this clear to contractors when issuing a notice that is in parallel to CQC actions being taken. Template letters provided at Annex 9(a) and (b).

Action 3: Sanctions/Terminations

97. Where the practice has been placed into special measures, or following a failure to comply with earlier contractual notices area teams must urgently assess the risk to patients and the NHS of allowing the contract to continue.

98. Following the risk assessment, a contractual practice visit and further full investigation, where the area team consider that the contractors breach is substantial enough to represent a significant risk to patient safety it may issue a notice of termination to the contractor in accordance with the policy for, *Managing contract breaches, sanctions and termination for primary medical services contracts*.

99. The area team will not have established a right to terminate purely on the outcome of a CQC inspection, concern notification or rating. It is therefore essential that the correct procedures are followed, the full supporting evidence gathered and considered and the appropriate legal advice sought prior to issuing a notice of termination.

100. Where the right to terminate has been established, the area team may instead choose to apply a contractual sanction in accordance with the contract regulations and single operating model policy.

Investigation

101. A right for NHS England and its area teams to take contractual action cannot be established by CQC ratings alone. In the vast majority of cases, where the CQC reports adverse findings or concerns are raised, it will be necessary for area teams to carry out their own investigation before they are able to consider taking formal contractual action.

102. This section provides the general principles for assessing the necessary level of further investigation whilst ensuring the most suitable use of resource is deployed in each case.

103. The level of investigation required will vary from case to case but should fall into one of the following three categories:
    1. Minor level.
    2. Moderate level.
    3. Major level.

104. In addition, consideration needs to be given whether any concerns identified during an investigation, raises concerns regarding professional performance of individual GPs (or other clinicians).

105. NHS England has a responsibility under the National Health Service (Performers list) regulations (2013) to ensure that practitioners on the national performers list are 'fit for purpose' - potential performance concerns will need to be addressed through the NHS England framework for managing performance concerns.

Minor level – Assurance

106. A minor level investigation would be required to assure the area team of the contract compliance and quality of service provision. Depending on the seriousness and nature of the findings against the contractor, a first step in some circumstance may be to seek information from the contractor and/or assurances as to the provision of services.

107. The area team may write to a contractor setting out the issues identified and remind them of their contractual obligations and any formal action which the area team may be able to take in the event that contractual breaches are identified.

108. The letter should request either information or written assurance from the contractor in relation to their compliance with the contract, continuity and quality of service provision. An example of a risk that might be satisfied through minor investigation is where the concern is that the contractor may not hold adequate liability insurance.

109. It may be that no further contractual action will be required once assurances are obtained.

110. If the contractor is not able to provide the information or assurance required, the area team should reassess the level of risk and may then feel it appropriate to escalate the matter and complete more thorough investigations.

Moderate level – practice visit

111. If the failings are more serious or widespread and it is felt that a practice visit will be necessary, or satisfactory assurances cannot be obtained under a minor level investigation, the area team should arrange an investigative visit to the practice at the earliest opportunity.

112. This should comprise of a meeting with the contractor and their team, including CCG representation and aim to address the specific concerns raised. The visiting team should collate any information or evidence necessary to satisfy the area team that the concerns are capable of remedy and that appropriate action is being taken by the contractor to satisfy the terms of the contract.

113. Under the terms of the contract, area teams must provide sufficient notice to the practice of the visit and may wish to make a formal request for further information in accordance with the regulations.

114. If the contractor is not able to provide the evidence or refuses to engage with the visit, the area team should reassess the level of risk and may then feel it appropriate to escalate the matter for more immediate action either in terms of contractual notices or through a major investigation.

Major level – detailed investigation

115. Where the failings are of a serious and widespread nature, the area team will need to schedule full practice audit, including (but not limited to) a premises inspection, clinical governance audit, information security review, patient records review, and interviews with individual staff members. An audit should target the areas of concern identified as well as core areas of general medical practice and must result in a detailed audit report identifying areas of concerns, the contractual terms that are being breached and any action (with timescales) that must be taken by the contractor.

116. A multidisciplinary approach will be required. The outcome of the audit will inform the area team's next steps in terms of contractual management and may include referral of an individual performer which should be managed in accordance with the Framework for managing performer concerns: NHS (performers lists) (England) Regulations 2013.

117. The terms of reference for the audit will be central to achieving the required outcomes of the audit and should be directly linked to the practice's contractual obligations.

118. Obtaining and accurately recording all evidence, including but not limited to witness statements, such as practice staff and patients, is essential to support any necessary contractual action that an area team may need to take.

119. This guidance does not intend to set out the detailed instructions in respect of completing a full practice visit and audit but does direct that where statements are being taken, the area team must obtain consent from witnesses for the information contained in their statements to be used by it in exercising its right to act under the regulations and to the information's disclosure for use in any GMC proceedings, to the doctors legal representative and the parties' experts and advisors and, depending on the facts of the case, the police and/or NHS protect.

GMS/PMS/APMS - alternative arrangements for service provision

120. Where a contract holder/CQC registered provider is aware that they are likely to either have their registration suspended or cancelled they must immediately engage with the area team to consider the options available for ensuring continuity of services.

121. One possible option would be for the contractor to sub-contract services, in accordance with the regulations. The contractor must in all cases, have taken reasonable steps to satisfy itself that it is reasonable in all the circumstances

and that the sub-contractor is qualified and competent to provide the service, including being fully registered with the CQC and that registration includes the contractors practice as a locality.

122. No sub-contracted service can be delivered at that locality until such time as the full variation to a sub-contractors registration with the CQC takes effect, to include the practice premises.

123. There should be no gap in service provision between the time when an existing provider's registration is suspended or cancelled and the sub-contracting service provision commences. It is also important that patients are kept informed and involved in the decision making if alternative arrangements are being put in place. NHS England has a duty to engage with the public under section 13 of the Act in relation to changes to services.

124. The contractor must have notified the area team in writing of its intention to sub-contract as soon as reasonably practicable before the date on which the proposed sub-contract is intended to come into force and in accordance with the terms of their contract.

125. The area team may request further information relating to the proposed sub-contract and the contractor shall not proceed with the sub-contract or, if it has already taken effect, shall take steps to terminate it, where, within 28 days of the contractors notice, the area team has served a notice of objection to the sub-contract on the grounds that:
    (a) the sub-contract would:
        (i) put at serious risk the safety of the Contractor's patients.
        (ii) put the Commissioning Board (NHS England) at risk of material financial loss.
    (b) the sub-contractor would be unable to meet the Contractor's obligations under the Contract.

126. Where the area team does not object to the sub-contracting arrangement, this will be deemed as a contract variation and the sub-contractor will be held accountable for the delivery of the regulated activity carried out at the practice premises in accordance with their CQC registration. The contract holder remains accountable and liable for the overall delivery of the primary medical care contract and for the actions of their sub-contractor. Any sub-contracting arrangement has no bearing on the area team's right to act and to take appropriate contractual action against the contract holder.

127. The area team may instead propose to contract with a parachute provider for the suspension period to ensure the safe and efficient delivery of essential services to the registered population.

128. Each case of suspension should be individually considered with regard to all possible options for ensuring the delivery of services to the registered population including the availability of alternative provider services, any proposal to sub-contract by the contractor and all other local matters relevant to the case.

Termination of Contract

129. In the event of termination of the contract area teams would undertake all expected steps with regard to procurement for new permanent contract arrangements, merger or dispersal of patient lists. This is not specifically covered by this guidance but due process and consultation must be followed. Any timing on termination must be taken so services to patients are maintained and timed to be consistent with any actions necessary by the CQC.

Resilience - capacity and capability

130. Whilst CQC estimate that the numbers of practices receiving an inadequate overall is likely to be fairly low at any one time, consideration will need to be given regionally about the potential impact on an area team's capacity to deliver timely and proportionate support across a number of GP providers who may be assessed as inadequate through CQC inspection in a locality.

131. Contract management, particularly putting in place urgent measures to secure primary care provision is extremely resource intensive. Area teams should explore with regional teams options to explore how resources can be mobilised across the system to support an area team where there is risk of multiple practices being identified with concern, or risk of systemic failures in primary care resilience being identified through the CQC inspection regime.

132. Area teams, working with regional teams, should undertake some rapid contingency planning to assure local system resilience. NHS England's central team will be working with regions to explore how to support area teams in taking consistent and well advised action.

Annex 1: Pilot support programme for practices placed in special measures

The Department of Health and NHS England have commissioned the Royal College of General Practitioners (RCGP) to provide a pilot programme offering expert peer advice and support for GP practices that enter special measures following inspection by the Care Quality Commission (CQC).

Purpose of the programme

The programme is intended to support practices needing to make significant changes to improve their services. It will provide a package of expert professional advice, support and peer mentoring from senior GPs, practice managers and nurse practitioners with specialist expertise in quality improvement coordinated by the RCGP. The programme will draw on insight and support from other local practices and professional leaders, including the LMC and CCG.

The RCGP support team will draw up a tailored plan for each practice in the programme. The duration and sequencing will be agreed at the outset, although reasonable efforts will be made to ensure the support adapts to changing circumstances in the practice. The focus is likely to include work to:

- help the practice understand the problems identified by the CQC
- support the practice to develop an improvement plan (or refine their existing plan) to address issues underlying the problems identified by the CQC
- provide direct advice and mentoring to GPs, practice managers and other staff as they work on improvements
- draw on insight and support from other local professional leaders, including the LMC, area team and CCG

The practice is at liberty to engage other support in addition to this programme.

This pilot programme ends in October 2015. The RCGP will therefore work with practices to plan a programme of mentoring and development that fits within this time frame and the timetable for improvements set by CQC.

Eligibility and cost

Any practice placed into special measures between 1 October 2014 and 30 June 2015, where NHS England does not enact contractual action, will be eligible to apply for this support.

NHS England will provide up to £5,000 of funding directly to the RCGP for each practice entering the programme, providing the practice matches that 1:1.

Agreement

When agreeing to participate in the programme, the practice will sign an agreement jointly with the area team and the RCGP. The key terms of this will be as follows:

- **Standards.** The RCGP undertakes to operate to the very highest professional standards in their work. It is understood that practices receiving support will

often be in a very difficult situation. The team will work supportively and non-judgementally. They will adopt a coaching, mentoring and advisory approach to help the practice gain insight into the problems identified by the CQC and from other local feedback, and develop solutions in partnership with the Practice. They will respect the confidentiality of the practice and the individuals within it, except where they have a duty to report back to the NHS England or raise concerns regarding matters such as serious professional misconduct or fraud.

- **Participation.** The practice team will undertake to participate fully in this programme of support. This will require GPs, the practice manager and other staff as needed to commit to regular meetings together with the support team. A high level of commitment is essential for success. Where all relevant senior staff do not engage consistently and appropriately, the RCGP team may terminate their involvement.

- **Evaluation.** The practice will be required to provide anonymised feedback about the support programme as part of the national evaluation of the pilot. The workload impact of this will be minimal.

- **Payment.** The practice will be required to arrange payment to the RCGP prior to support commencing. The NHS England area team will match fund the practice payment. If the practice or the RCGP terminates the support agreement prior to completion of the initially agreed package of support, determination will be made by the RCGP of whether a partial refund is appropriate, on the basis of the staff time spent thus far.

- **Liability.** The practice retains full responsibility for all aspects of their contractual and ethical obligations regarding the provision of services to their patients. Neither the RCGP nor NHS England assumes any responsibility for the quality of the practice's services nor any actions the practice takes to improve them.

- **Other support.** Where a practice engages in other support, it is expected they will liaise with the RCGP team to ensure the value of all support is maximised, and duplication avoided.

A mock template for the agreement is enclosed below.

RCGP Special Measures Support Programme

Agreement

Between

The Royal College of General Practitioners (RCGP)

and

[Enter name] (Area team)

and

[Enter name] (Practice)

This Agreement sets out the terms and understanding agreed between the RCGP, [enter name] area team and [enter name] practice for the support programme for the Practice to address the problems which led to it being placed in special measures.

Background

The Department of Health and NHS England have commissioned the Royal College of General Practitioners (RCGP) to provide a programme offering expert peer advice and support for GP practices that enter special measures following inspection by the Care Quality Commission (CQC).

The programme is intended to support practices that need to make significant changes to improve their services. It will provide a package of expert professional advice, support and peer mentoring from senior GPs, practice managers and nurse practitioners with specialist expertise in quality improvement, coordinated by the RCGP. The programme will draw on insight and support from other local practices and professional leaders, including the LMC and CCG.

The RCGP will support the Practice in drawing up, or refining their existing improvement plan, to be agreed with the NHS England area team, which is tailored to the specific needs identified by the CQC. The duration and sequencing will be agreed at the outset and will be designed to fit within the timetable for improvements set by CQC, although reasonable efforts will be made to ensure the support adapts to changing circumstances in the Practice. The focus is likely to include work to:

- help GPs understand the problems identified by CQC;
- support the Practice to develop an improvement plan to address issues underlying the problems identified by CQC and any additional issues identified by the RCGP (including those highlighted by local contacts) (the Improvement Plan);
- provide direct advice and mentoring to GPs, practice managers and other staff as they work on the improvements agreed in the Improvement Plan;
- draw on insight and support from other local practices and professional leaders, including the LMC and CCG.

The Practice is at liberty to engage other support in addition to this programme.

The RCGP will oversee an evaluation of the support programme, including external input, in October 2015.

Purpose

This Agreement sets out the roles and responsibilities of the Practice, area team and the RCGP in respect to the Special Measures support programme.

RCGP Responsibilities

1. The RCGP undertake to operate to the very highest professional standards in their work. It is understood that the Practice may be in a very difficult situation. The RCGP will work supportively and non-judgmentally. They will adopt a coaching, mentoring and advisory approach to help the Practice gain insight into the problems identified by CQC and from other local feedback, and will develop solutions in partnership with the Practice.

2. The RCGP will respect the confidentiality of the Practice and the individuals within it, except where they have a duty to report back to NHS England or raise concerns regarding matters such as serious professional misconduct or fraud.

3. The RCGP will make initial contact with the Practice within one week of receiving a request for support. The Practice will be invited to have an initial discussion with the RCGP before a formal request for support is made.

4. Upon return of a signed agreement, the RCGP will arrange a meeting with key persons within the Practice, to be attended by an RCGP adviser or small team of advisers. The RCGP will help the Practice develop an Improvement Plan that is tailored to the practice's needs and achievable within the limits of funding available, timescales and other logistical considerations.

5. Once an Improvement Plan is agreed by relevant parties, the RCGP will coordinate a local "Turnaround Team" that will include appropriate expert input, whose purpose will be to offer advice and peer support in order to help the Practice meet the objectives of the Improvement Plan.

6. The Turnaround Team will provide support for the practice, in accordance with the terms agreed in the Improvement Plan and subject to sufficient funding, for a period up to 6 months when it is envisaged that CQC will make their reassessment. The progress of the Turnaround Team will be monitored by the RCGP.

7. The RCGP will seek anonymised feedback from the Practice, its patients and other relevant stakeholders during and following its period of support to the Practice to inform the evaluation of the first phase of the programme.

8. The RCGP will not provide support to the Practice beyond the scope or period of support agreed in the Improvement Plan.

9. The RCGP will provide peer support, advice and mentorship to the Practice, but is not responsible for the Practice's success or failure in its CQC re-assessment.

10. It is acknowledged and agreed that the nature of the work being carried out under this Agreement is such that specific results cannot be guaranteed and that all work is done without any express or implied warranties, representations or undertakings. Save as set out in 1 above, RCGP makes no warranty, express or implied, and shall not be held responsible for any consequence arising out of any work performed under this Agreement. The liability of RCGP shall be limited to the aggregate amount of any payments received from the Practice in respect of this Agreement.

Practice responsibilities

1. The Practice will request support through the RCGP's administrative team, which will also manage any subsequent issues relating to the RCGP's agreed package of support.

2. The Practice team will participate fully in this programme of support and specifically in implementing and co-operating with the Improvement Plan. This will require GPs, the practice manager and other staff as needed to commit to meetings with the RCGP. A high level of commitment is essential for success. Where all relevant senior staff do not engage consistently and appropriately, the RCGP's administrative team will notify the Practice of the RCGP's concerns and if these are not resolved to RCGP's satisfaction, RCGP reserves the right to terminate their involvement.

3. The RCGP welcomes the engagement of additional support but where a practice engages in other support, they must liaise with the RCGP to ensure the value of all support is maximised and duplication avoided.

4. The Practice will share all information that is relevant to the development and implementation of an Improvement Plan with the RCGP.

5. The Practice will be required to provide anonymised feedback as part of the national evaluation of the programme. The Practice will also facilitate a suitable mechanism to enable the RCGP to gather feedback from patients during and following the RCGP's period of support to the practice to inform evaluation.

6. The Practice will agree a plan of payment with the RCGP for costs associated with the RCGP's work in supporting the development and implementation of an Improvement Plan prior to the commencement of an intervention. If the Practice or the RCGP terminates the agreement prior to completion of the initially agreed package of support, determination will be made by the RCGP of whether a partial refund is appropriate, on the basis of the staff time spent and direct and third party costs incurred thus far. The RCGP will not refund the Practice in any way based simply upon the Practice deeming the College's intervention to be ineffective, unless it is agreed that there has been an area of insufficient engagement in exceptional circumstances.

7. The practice retains full responsibility for all aspects of their contractual and ethical obligations regarding the provision of services to their patients. Neither the RCGP nor NHS England assumes any responsibility for the quality of the Practice's services nor any actions the Practice takes to improve them after the support provided.

8. The Practice will not spread negative publicity about the RCGP based on the service provided.

NHS area team responsibilities

1. The area team will share any relevant information with the RCGP that may inform its intervention.

2. The area team will agree an Improvement Plan with the Practice, CQC and the RCGP in a timely fashion.

3. The area team will support the programme by providing relevant expertise if requested by the RCGP.

Duration

This Agreement shall become effective upon signature by the authorised officials from the following organisations. .

Practice
Practice name
Practice representative
Position
Address
Telephone
Fax
E-mail

_____Date:
(Signature)

area team
area team name
area team representative
Position
Address
Telephone
Fax
E-mail

_____Date:
(Signature)

RCGP
RCGP representative
Position
Address
Telephone
Fax
E-mail

_____Date:
(Signature)

Annex 2: Example improvement plan template

This template is offered as a specimen, to help area teams work with practices to record their improvement plan and track progress. It includes the recommended information to be sent to CQC, to satisfy the requirement to notify them of proposed actions.

Report on actions you plan to take to meet CQC essential standards.

Please see the covering letter for the date by which you must send your report to the Care Quality Commission and where to send it. Failure to send a report may lead to enforcement action.

CQC registration details

Account number	<Provider ID>
Our reference	<Inspection ID>
Location name	<Organisation name>

It is recommended to update the document regularly, to allow you to track and report on progress over time. Remember to update the date in the box below each time.

Completed by: (please print names (s) in full)	
Position(s):	
Date:	

Please use a new page for each regulation where action is required. Where multiple underlying issues are identified for a single problem, you may wish to use a new page for each issue and related action plan (ie resulting in a number of pages for a single problem).

Regulated activity(ies)	Regulation
<Regulated activity(ies)>	<Regulation number and description> < Regulation heading
	How the regulation was not being met:
	<*Copy from the How the regulation was not being met section within the inspection report*>

Underlying issue(s) identified Record root causes here, or note if further work is planned to identify them.	
Action(s) planned Are these S.M.A.R.T.? (Specific, Measurable, Achievable, Relevant, Time bound)	
Lead person	
Resources required	
Sources of support	

Eventual goal How will you know when this problem and any underlying issues have been resolved?	
Planned completion	
Milestones For complex or lengthy actions, how will you know you are making progress towards the eventual goal?	
Progress to date Use this as a log of work completed so far and your assessment of its impact.	

Next steps to take For complex or lengthy plans, what will you do next?	

Annex 3: Step by step guide for creating an improvement plan

Step	Goal	Common pitfalls	You may want to….
Review your CQC report Does everything make sense? Are there any surprises?	Clarify the goals of your improvement plan.	Overlook some problems.	Liaise with your area team or the CQC to ensure there is a common understanding of the problems to be addressed.
Identify underlying issues For any problem cited, do you know why the practice is not doing well in that area?	Find root causes	Develop plans which address symptoms of issues, rather than underlying root causes. This often results in only superficial or short-term improvements. New problems are likely to continue appearing until root causes are dealt with.	Look for common themes among problems. For any one problem, ask “Why is it like this?”. Continue asking why until no new answers arise. It is often found that “five whys” are needed in order to get at pervasive underlying issues. [more at bit.ly/1uCdrUr] Use external help to facilitate discussions about underlying issues, especially where relationships are involved.
Draft improvement ideas As a team, list every idea for improving the problems identified.	Generate ideas and build the team’s shared commitment to improving.	Overlook potentially useful ideas from members of the team. Fail to secure team commitment to the goal of improving patient care and the improvement process. This will make implementation of change much harder.	Hold team meetings to discuss the problems and potential solutions. Run a brainstorming session for all staff to contribute suggestions. Refer to Annex 6 on improvement frameworks. Use external help to facilitate the process of identifying possible solutions.

Agree actions Ensure you are using every relevant idea for improvement.	Produce a list of actions which is comprehensive and practical, addresses root causes and makes best use of existing sources of support.	Overlook potentially useful ideas from other practices' experience. Fail to make best use of existing sources of support.	Ask senior peers to review your improvement ideas. Read examples of other practices' improvement ideas, eg provided by your LMC or CCG.
Identify resources and sources of support Who is going to help you gain a good understanding of your issues, develop a comprehensive plan and implement change?	Increase your chance of success.	Fail to make improvements in the right areas in the right timescale.	Liaise as soon as possible with the area team and CCG.
Put actions into a plan Agree on a sequence of actions (with SMART objectives), and milestones at which you will check on progress.	Develop a rigorous plan for implementing changes.	Fail to make improvements because of a lack of clear planning and robust management of the process. Underestimate the time commitment required. Fail to break complex or lengthy changes into smaller actions.	Use the SMART checklist to review each action proposed in the plan. Aim to specify a series of manageable tasks, rather than a single complex one. Ask peers to review your plan, including assumptions about timescales.
Submit & continuously update the plan Forward your plan to the CQC and the area team, to notify them of your intended actions. Update the plan document as actions are updated or other progress is made.	Ensure the CQC and your commissioners are kept up-to-date on your progress.	Fail to report intentions or progress within specified timescales.	Where a lot of work is required, it may be helpful to use calendar reminders as a prompt to complete actions or provide updates within specified timescales.

Standards for improvement plans

They should be action-oriented. Plans should contain practical actions with SMART objectives (rather than areas for discussion or exploration):

- **Specific** – does the plan identify the details of what the issue is, and what action needs to be taken? Does it explicitly say what they want to achieve and who is going to make these changes?

- **Measurable** – does it say how they are going to ensure that changes have been made? What measures are they going to put in place? Who will do this?

- **Achievable** – are the measures they are going to put in place achievable, attainable and sustainable? Has the provider described the resources needed to implement the changes? Are these in place?

- **Relevant** – is it clear that proposed actions will address the problems identified by CQC, as well as any underlying issues? Will the actions help to create lasting change as part of a process of ongoing improvement?

- **Time bound** – is there an appropriate date by which the changes will have been made? How will this date affect people who use services? How will the practice demonstrate that progress is being made, throughout the process of enacting change (many plans will take months to complete, but progress should be demonstrable early)?

- They should address underlying issues rather than superficial symptoms wherever possible.

- They should ensure that problems presenting the most immediate threat to patients should be addressed as a matter of urgency. If necessary, this will involve the application of interim solutions which reduce risk to patients while permanent improvements are made.

- The goal should be to deliver excellent care for patients, not merely to become adequate. Effective plans should have a clear focus on significantly improved care. They will therefore often need to describe a journey of improvement which is longer and has higher ambitions than that required to meet essential regulatory or contractual standards.

- They should take account of local strategic plans for primary care. For example, where there are moves to establish greater inter-practice collaboration or new approaches to integrating with other providers, improvement plans should align with the ambitions and plans for the locality. This will often create potential benefits for the index practice and the wider health economy. For example:
    - new solutions to premises problems might be identified as part of plans to establish new organisational forms for inter-practice collaboration (eg federations or mergers), or by exploring co-location with other agencies such as community services, pharmacies, social care providers or third sector.

staffing challenges might be addressed through pooling of staff among local practices in the course of federating.

- They should make the most of assets in the local economy. In most cases, plans should include input from a range of people and organisations – suggestions are included in '*Sources of support*'. Where external support is used, it will be important to draw up a clear memorandum of understanding, and to agree what resources (time, financial and other) will be necessary.

Annex 4: Case studies of improvement

These are stories of real approaches to supporting practice improvement. They illustrate the application of the above principles. Some details have been amended to preserve anonymity. It is important to stress that there is no mandatory requirement on area teams to provide specified support. No one approach will work in every locality; there are different demands facing different areas and as such commissioners must have flexibility to decide on potential solutions that respond to the needs of their health community.

Solutions-finding for GP recruitment

The problem: A practice was measuring falling patient satisfaction and receiving a growing number of complaints from patients unable to obtain an appointment. On discussion with the partners, the area team identified significant problems in recruiting and retaining clinicians.

Improvement plan: The area team medical directorate, supported by the LMC, supported the partners in reviewing their approach to recruitment and skill mix. The area team contacted local practices to identify urgent clinical cover. The LMC provided examples of successful recruitment approaches and partnership agreements. They supported the practice in considering how to apply for the retainer scheme.

Outcome: The immediate capacity problem was resolved. The practice reviewed their approach to recruitment and is now applying for a GP through the retainer scheme.

Rapid financial governance review

The problem: A practice expressed concerns to the area team about their financial governance following the unexpected departure of the practice manager.

Improvement plan: The finance and primary care teams of the area team helped the practice investigate their position and processes. The LMC identified another local practice manager to mentor the interim practice manager through the creation of new processes.

The Shropshire and Staffordshire 'SWAT team'

The area team, in collaboration with local CCGs and LMCs, has established a multi-professional team to provide practice appraisal and improvement support. The team is made up of GPs, very experienced practice nurse, practice manager, an administrator and their own analyst.

The time-limited support provided by the team is intended to help the practice identify and understand issues, find new opportunities to improve and begin the process of improvement. They see their role as building the practice's own capability for improvement, rather than doing the work for the practice team.

Practical inputs provided by the team vary according to need, but can include mentoring, advice and practical help with service redesign, and locum assistance – doctor or nurse. The team work entirely independently of the area team's primary care commissioning functions.

Local peer intervention

The problem: A practice identified multiple areas of non-compliance with CQC requirements, covering almost every domain. An improvement plan was agreed between the practice and area team. However, this resulted in very little improvement. Subsequently the CCG took the lead in driving the improvement planning, resulting in more detailed plans which drew on the support of a range of stakeholders in the local health community.

Improvement plan: The CCG acted as broker and coordinator of inputs from others, including CCG staff and local practice peers. Public Health informatics created a balanced scorecard to help understand quality in the practice, looking particularly at preventive care. The CCG and area team collaborated to broker new premises plans with the NHS Property Services, and to help the practice develop transition plans. The LMC provided pastoral support and mentorship to the partners during the improvement process. The area team advised on matters of appraisal and CPD.

Outcome: At re-inspection, the practice was compliant with all but one domain.

A CCG-led proactive support system

Following positive experiences of collaborative peer-led improvement approaches, Trafford CCG have established a proactive support system available to all member practices. Quarterly practice education events provide specific training on quality improvement. A member website contains a one stop CQC resource containing a self-assessment checklist developed by the CCG, case studies and best practice examples drawing on learning from other practices. The CCG's primary care team offers "mock" CQC visits to give additional insight and confidence for practices, and peer support between practices is facilitated for both clinical and managerial staff.
Action planning for specific practice improvements is now led by the CCG with support from other stakeholders who can contribute to solutions. The learning practices generate is then fed back to neighbours through the member website.

Multi-agency response to multiple problems

The problem: Concerns regarding safeguarding were raised by CQC. The practice also raised concern about their ability to recruit and retain, with high turnover of GPs and Practice Nurses. During the same period, the Practice Manager had unplanned long-term sick leave. The Area Team received increased complaints relating to access. The remaining partners were isolated from other local colleagues.

Improvement plan: The area team Safeguarding lead worked with the practice to review systems and processes and agree an action plan to address areas of concern: practical examples provided, along with advice on actions being taken. Engagement Team worked with the practice to ensure appropriate management of complaints. Communication Team helped the practice with communication to patients and managing press enquiries. Primary Care Team contacted local practice to request details of part-time GPs, Practice Nurses or Practice Managers who could support the practice. Finance Team provided financial breakdown for PMS to GMS and reviewed payments made. Primary Care Team then briefed the deputy Practice Manager about key payment issues coming up. The LMC provided a Practice Manager mentor, to support the deputy practice manager. We met with the practice and neighbouring practice separately, to discuss opportunities for working together to resolve staffing and physical capacity issues. The LMC facilitated a subsequent joint meeting of both practices. Medical Directorate colleagues provided support to one of the remaining partners, linking in to other professional support mechanisms.

Outcome: Recruitment has improved and is not now critical, but they are still below GP capacity. CQC reviewed and approved the actions taken on Safeguarding/Engagement. The practice administrative team has remained stable, with the deputy practice manager acting up. Financial stability has been retained and the practice has decided to return to GMS. Relationships with the neighbouring practice have improved, with on-going contact between the two.

Brokerage of shared premises discussion

The problem: Four practices within the same town were receiving rising rates of complaints relating to access, and falling patient experience measures. Partners were expressing concern about their workload and an inability to continue operating at that level. Existing premises had limited scope for expansion. Forthcoming housing developments would swell the local population.

Improvement plan: The area team supported the four practices to begin discussions about short and longer term premises solutions, based on a sharing of the space.

Outcome: The practices continue to actively explore options, including greater organisational collaboration to provide more resilient services from shared premises.

Multi-skilled consultancy team

The problem: Complaints had been made to the CCG and GMC regarding standards of care at a practice. The CCG commissioned an external consultancy to undertake a review and make recommendations for improvement. The consultancy involved staff with experience covering clinical quality, professional performance, practice management, contracting, project management, conflict resolution and negotiation.

Improvement plan: The consultancy team was able to uncover problems and root causes which had not come to light previously. Problems were uncovered with a range of factors including referral rates, the quality of referral communications, prescribing decisions and levels, use of a new clinical system and clinical record keeping. The team judged that underlying these were relationship breakdown between GPs, under-developed demand management systems and a lack of IT confidence. Their improvement plan combined team-building, the creation of a new partnership agreement based on an agreed vision, training in redesigning demand management and support to create new systems for referrals and'audit.

Annex 5: Potential sources of support

This list is intended to help inform decisions about securing support to improve. Entry on the list does not constitute a recommendation or commitment to provide funding. Please forward suggestions for additional entries to Dr Robert Varnam, Head of General Practice Development at NHS England (robert.varnam@nhs.net).

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

Local sources of support

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

Organisation	Expectations
Health Education England	Offer personal mentoring schemes to support quality improvement.
RCGP Faculty	Offer personal mentoring schemes to support quality improvement.
Health and Wellbeing Board	Potentially contribute to discussions about the future of local community based health services, where practice performance issues raise these. Contribute to discussions about new premises solutions.
Local authority	Provide advice and support to improve services they have commissioned from the practice, where relevant.
Patients and the public	Can contribute ideas and practical support, and are often very keen to champion their practice.

National & commercial sources of support (listed alphabetically)

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

Organisation/company	What they can help with	Further details
National Association of Patient Participation	Support for PPGs which could contribute to improvement plan and deliver perspective on performance	www.napp.org.uk
National Care Forum	Providing links to various organisations that can provide toolkits for working with patients (hard to reach/marginalised groups etc.)	www.nationalcareforum.org.uk
NCAS	Expert advice and support, clinical assessment and training for staff who give cause for concern.	www.ncas.nhs.uk
NHS Improving Quality	Productive General Practice. A guided practice development programme focusing on teamwork and service redesign using Lean principles.	www.nhsiq.nhs.uk
Personal Strengths Ltd	Team development, conflict resolution, leadership development	www.personalstrengthsuk.com
PCC	Access to interim practice management/business management. Facilitation for planning and direct support. Free best practice resources. Training workshops, events and e-learning.	www.pcc-cic.org.uk

Organisation/company	What they can help with	Further details
Practice Management Network	A national community run by practice managers for practice managers. The Network offers support and opportunities to share, develop and influence.	www.practicemanagement.org.uk
Primary Care Foundation	Support to measure and understand urgent workload.	www.primarycarefoundation.co.uk
Productive Primary Care	Redesigning GP access using the Stour Access model (‘Doctor First’ programme)	www.productiveprimarycare.co.uk

Annex 6: Frameworks for improvement planning

When drawing up plans for improvement, it is often helpful to refer to an established framework for organisational development and change planning. Two commonly used frameworks are listed below. Suggestions are made for how they can be used to develop a solutions-focused understanding and a comprehensive set of improvement plans.

The NHS Change Model

The **NHS Change Model** can help to move a practice team's focus from problems to solutions. It ensures a comprehensive range of improvement areas are considered, and that alignment among them is achieved.

- www.changemodel.nhs.uk

While the Change Model primarily indicates how to effect change, it also points to areas of organisational capacity and capability required for successful change and high performance. Just as success will often depend on alignment between all the components of change, building capabilities in them will often present opportunities to address several (or all) at once. This is attractive in general practice, where change leadership skills and systems are less well developed, and where a practical approach to personal and organisational development is generally preferred.

NHS Change Model Component	Description	Implications for diagnosis & understanding	Implications for planning improvements
Our shared purpose **Links:** • Change Model resources, shared purpose • Leading with purpose, video	Evidence confirms that the most powerful commitment comes from the “heart”, not just the “head”, and in the NHS, we know that what drives most people, most strongly, is their common vocational motivation. So, a good shared purpose will be about serving patients rather than simply surviving as an organisation. It will be truly shared by all the staff, and all decisions and activities will be clearly aligned behind it. It will be evident to patients and others outside the practice, both through the team culture and the quality of care.	A lack of focus is very common cause of poor organisational performance. This is often because a ‘higher’ purpose such as providing excellent care becomes supplanted by a ‘de facto’ purpose such as maintaining profitability. De facto purposes are not necessarily wrong, but they are best kept in check behind higher priorities. • Does the practice have a statement of purpose, vision or objectives? • Is excellent patient care the chief priority? • Have staff contributed to its production? • Do staff have the chance to review and revise it periodically? • Is it clear that all decisions and activity in the practice are aligned behind this purpose? • What proportion of	• Having a clear, shared purpose for change in essential if improvements are to occur rapidly and sustainably. It also acts to ensure coherence where multiple changes are being implemented, increasing the effectiveness of each and reducing duplication or gaps. • Engaging all staff in discussing the practice’s purpose, its vision for the future and the means of achieving that is a powerful means of building teamwork, creating a culture for quality and identifying high impact actions to improve. • It can be helpful to produce a ‘vision for the future’ in visual form, ideally involving all staff in the process. This vision can be used to generate the words that will form the shared

		decisions or activities detract from or conflict with the shared purpose?	purpose. • Keeping the shared purpose at the heart of the changes required, (a visual representation in the practice and / or frequent references to it in meetings) would be a recommended way for the practice to achieve its improvement goals.

Engagement to mobilise **Links:** • Change Model resources, engagement to mobilise	People are more likely to be committed to something if they are involved in both its development and delivery. Engagement also unearths views that need to be managed, whether they are supportive or not. This is about the way in which all those who make care good are engaged and empowered to play their part. This engagement determines the extent to which people are inspired to commit to the practice's purpose.	Much poor performance stems from limited engagement of patients and staff in strategic decisions or operational improvement. • What are the rates and trends of staff efficiency, sickness absence, recruiting and retention. • Is there evidence of a learning and improvement culture? What are the rates and trends of Patient satisfaction and complaints? • Is there evidence that the practice promotes self-care and changes in help seeking behaviour?	• Creating multiple opportunities for staff to shape their work and the improvement plan, for example through facilitated meetings. • Follow through on opportunities to make it easier to do the right thing via an improvement plan. • Help patients to feel a sense of ownership in the practice, making it easy and attractive to provide ideas for improvement and play their own part in achieving it. Methods could include a social media strategy, feedback boards, action planning at PPG meetings and patient champion roles. • Feedback rapidly and clearly with proposed action from complaints.

Leadership for change **Links:** • Change Model resources, leadership for change	Teams need to be led, not just managed. In times of change, the need for skilled and inspiring leadership is particularly prominent. An effective change leader will unleash others' commitment, and support them through transitions.	• Is it clear who leads the practice team? Is there a practice organogram or list of roles and responsibilities? • Do they lead in a way that inspires loyalty, unleashes commitment, releases potential and supports the team through change? • Is there evidence of distributed leadership? Are staff encouraged to take responsibility for solving problems?	• Leaders need to be clear about their role, and given the support to do it. • Specific training in leadership for change, particularly in generating commitment (rather than expecting compliance) is beneficial for many leaders. • Feedback, coaching and peer support are also helpful, particularly at times of stress.
Spread of innovation **Links:** • Change Model resources, spread of innovation	Innovations, big and small, are generally slow to spread in the NHS. Someone else often has a potential solution to a problem you face. Adoption of innovation requires knowledge of it, as well as evidence of and belief in its benefits and applicability. Staying up to date with best practice requires a deliberate commitment, supported by a systematic and persistent approach to implementation. Just as importantly, once an innovation is identified for adoption a plan for this needs to be agreed including a member of	• How does the practice identify, evaluate and implement new and improved ways of working, including best evidence clinical practice? • Is priority given to this? • Is there a systematic, efficient and reliable approach to it? • Are all relevant staff engaged in the assimilation of new knowledge and ways of	• Review current systems, practices and performance against best evidence guidance. • Assess and focus on the learning culture of the practice with regular educational activities and time to share ideas and experiences. • Focus particularly on areas where the practice is known to perform poorly, which have not been reviewed recently or for

	staff to act as its champion, staff training, measurement of progress and regular sharing of successes / troubleshooting.	working? • Are new changes sustained over time?	which there is no 'champion' within the practice. • The area team, CCG and LMC may be able to provide examples of high potential innovations. • Try involving the multidisciplinary team, +/- colleagues in other practices and from other providers. • Agree a systematic approach for implementing a care innovation, and try it out on a specimen topic.

Improvement methodology **Links:** • Change Model resources, improvement methodology	Although they have often developed organically over time in established GP surgeries, intuitive or ad hoc approaches to improving systems or processes are often inefficient or ineffective. They frequently achieve change through staff working harder. Improvement methodologies facilitate change through working smarter. They are a group of tools and methods underpinned by an assertion of the value of systematic, measurable approaches which strive for excellence and which allow all staff to contribute. Through small scale, rapid change they make it easier to test and refine change ideas, adapt innovations for local use and make continuous improvement possible. They also drive the development of a practice-wide learning culture.	Does the practice use a recognised improvement methodology (such as the Model for Improvement or Lean)? Are ideas for new or improved ways of working tested and refined at small scale before wholesale implementation? Are data and patient feedback used to ensure change results in improvement? Are staff expected and empowered to improve their own work?	• Planning an improvement in the practice can use one of many improvement methods, for example, identify opportunities to reduce waste using the 5S method or finding unnecessary work using value stream mapping. • Test out solutions using rapid Plan-Do-Study-Act cycles. • Try measuring the change daily using SPC charts rather than periodic averages to judge if it is working or not.

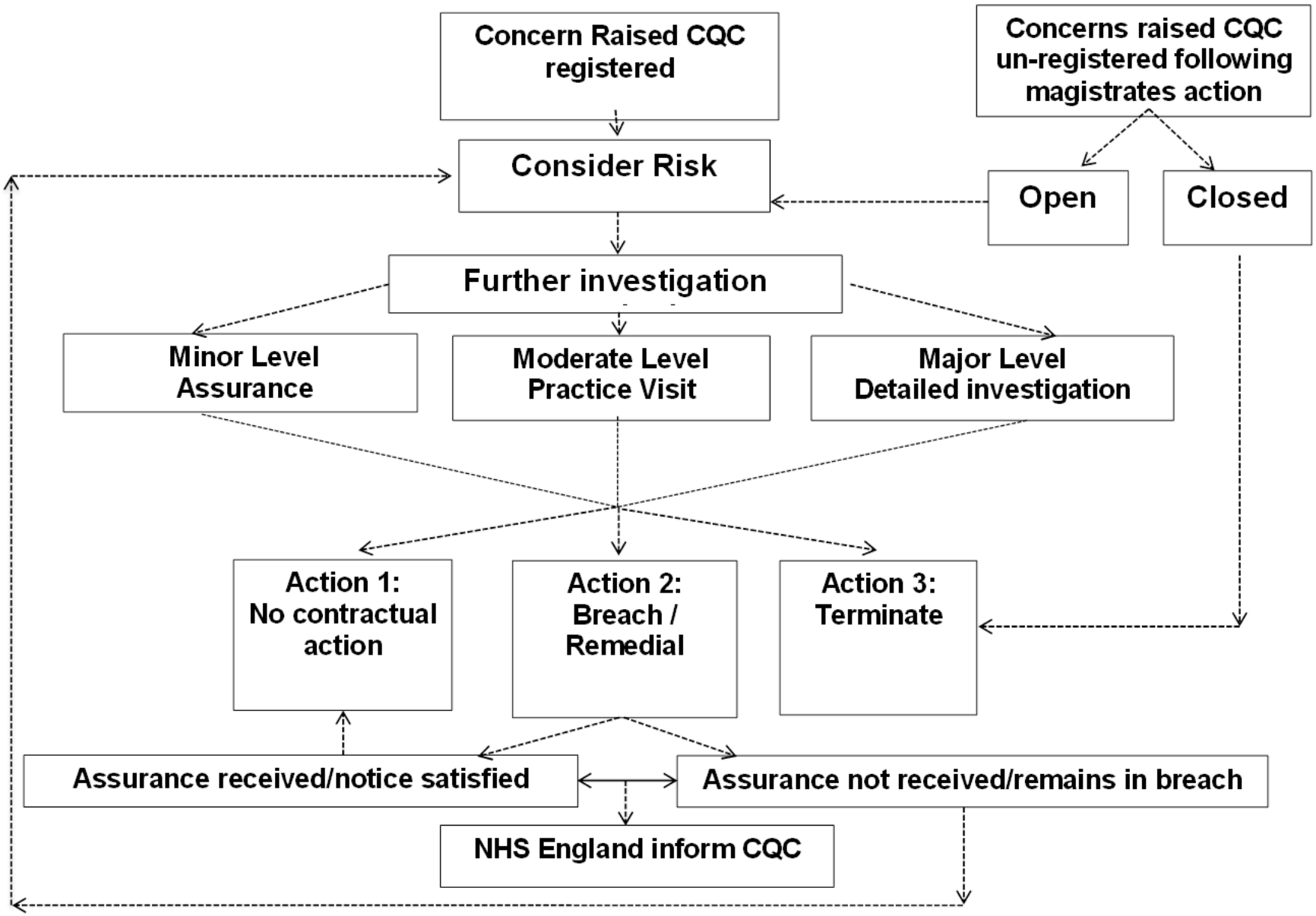
Rigorous delivery **Links:** • Change Model resources, rigorous delivery	A systematic approach is needed to ensuring that good ideas and intentions are translated into sustainable change. Many changes are not seen through to completion, often meaning that much or all of the initial effort is wasted. Setting clear goals and managing the work required to achieve them is an essential skill for a practice. There are several well established project management tools that are extensively used in the NHS. Just as important, system leaders need to identify those individuals with the right personality and skill set to persistently drive an improvement plan.	Do you have a rigorous approach to planning and implementing change? Does everyone know about it and regard themselves as accountable to it? Are SMART objectives always set? Are they translated to individual requirements in a way staff understand and can comply with? Is an effective approach taken to incentivising compliance? Are effective sanctions used when appropriate? Does this apply to doctors as well as other members of the team?	• Use a guide or eLearning package to introduce the key principles, tools and practices of project management to everyone in the team responsible for managing change. • Pick an improvement to be made and apply a rigorous project management approach to it. • Write plans down. Develop measurable objectives for every element of the project. • Collect the data you have specified. • Use lists, diaries and reminders to monitor progress and drive continued action. • As you move forward, celebrate success and help staff feel encouraged that progress is being made.

Transparent measurement **Links:** • Change Model resources, trans parent measurement	Credible, relevant, timely and accessible data is a very powerful tool in informing, initiating and sustaining change. However, many practices have a culture of using opinion and intuition more than data to inform decisions. Success relies more on hard work and good luck. Putting data (qualitative and quantitative) at the heart of the practice can engage staff, stimulate curiosity and grow commitment. It will result in better plans, more rapid change and improved accountability. Knowledge of continuous improvement as a concept and tools such as run charts can introduce a real-time element to a change and allow rapid cycles of change and a much more effective end result.	How much does data (in the form of measurement or patient stories) inform your decisions and change processes? Are priorities set on the basis of evidence or opinion? Are decisions about change led by agreed measures or force of personality? Is data gathered in a way that answers the team's questions? Does it allow successful or unsuccessful changes to be identified and improved quickly? Is it presented in a way which is engaging and understandable for everyone who needs to be influenced by it?	• Choose a planned change and engage the team in designing key measures for it. • Seek to include measures which cover activity, outcomes and unintended consequences. • Aim to choose a few simple measures rather than a lot of complicated ones; those that are already collected or that can be pulled from the IT system automatically are most likely to embed. • Test out with staff how relevant, timely and understandable they are. • Ask how well the data links to the daily work done by the people you want to be influenced by it. • In the early stages of the change, collect data as frequently as possible and publish it for all relevant people to see, in an interesting and accessible way. • Actively seek opinions about what the data are showing and what should

			be done next.

System drivers **Links:** • Change Model resources, system drivers	Good ideas, commitment and hard work are necessary for successful change but usually not sufficient for it to be successful and sustained. Deliberately aligning key aspects of the working environment behind the shared purpose for change is an important task for leaders. Key aspects include incentives and sanctions, workforce skills, availability of equipment and information. System drivers are also relevant looking outside the practice – are all incentive schemes being tackled in a systematic way to maximise funding for example?	Are all the key influences on your staff aligned behind your shared purpose for change? Do you have incentives and sanctions which support the change you desire? Do you have processes, premises, equipment and information systems which make it easier for people to work in the way you want? Do any of these things actively inhibit the change you want?	• Working with staff, identify any ways in which current systems, incentives, skills or infrastructure make it hard to deliver the shared purpose. • Seek to quantify them and rate the ease with which they can be improved. • Agree priority issues to address, based on this assessment. • Establish systems to routinely hear from staff about things which make it hard or unattractive to do the right thing. • Create a habit of responding. Find new non-monetary ways of incentivising desired behaviours, for example through public recognition, greater autonomy or opportunities for development.

Annex 7: Simple flow diagram – NHS England process for contractual action



Annex 8: Example letter to practice – no contractual action

This annex is provided as an example only and area teams should ensure that they have sought appropriate advice and support, in line with NHS England protocols, prior to issuing such a letter.

Dr (other)……..
Practice Address:

Date:

Dear Dr (Other)……,

Re: GMS/PMS/APMS contract dated……..

Following a recent Care Quality Commission inspection at your practice, NHS England were advised of [a] concern[s] identified in respect of compliance with your CQC registration.

The concerns raised were [include details from the CQC notification]:

[*Following request for evidence/assurance*] NHS England has reviewed your compliance with your contract in respect of the CQC concerns raised and have requested submission of (please include details) to provide us with assurance of your contractual compliance and the safety of your registered patients.

Following submission of the evidence requested, we are now assured of your compliance and [**]

[No further evidence or assurance sought] NHS England has reviewed the concerns identified by the CQC and considers that you are not currently in breach of your contracted terms [**].

[**]NHS England advises that we will be taking no further contractual action in this matter at present but would refer you to the requirements as set out in the full report of your CQC inspection and any outstanding action that is required of you in order to satisfy the terms of your continued CQC registration.

Yours……..

Annex 9(a): Example remedial notice:

This annex is provided as an example only and area teams should ensure that they have sought appropriate advice and support, in line with NHS England protocols, prior to issuing such a notice.

Remedial notice

Following our recent communications and discussion on the [insert date(s), we hereby serve notice that NHS England considers you are in breach of your (GMS/PMS/APMS)*delete as appropriate contract/agreement dated *[insert start date of contract]* on the following grounds:

[Insert bullet points setting out the breach details and referencing clause numbers from contract]
[Insert details of any evidence relied upon in reaching this decision]

In accordance with schedule 6 part 8, regulation 115 of the NHS (GMS contract) regulations 2004, (schedule 5, regulation 107 of the PMS Agreement Regulations 2004)*delete where appropriate NHS England requires you to remedy this breach by taking the following steps:

[Insert details of action required]

In order to remedy this breach this action must be completed to the satisfaction of NHS England on or before [*insert date*]

[The notice period shall be no less than 28 days from the date of this notice, unless NHS England *is satisfied that a shorter period is necessary to:*

- *protect the safety of the contractor's patients; or*
- *protect itself from material financial loss]*

Your progress in taking the required action will be reviewed at a further meeting on the *[insert date]* to be held at *[insert venue details]*

If you fail to comply with this notice, repeat this breach or otherwise breach the contract resulting in further breach notices being issued, NHS England may take steps to terminate your contract or consider the imposition of a contract sanction.

Should you wish to appeal against this decision, you must do so in writing to *[insert details of appeal contact address]* within a maximum of 28 days from the date of service of this notice and you do, of course, retain the right to seek support from your Local Medical Committee.

NHS England would advise that this notice does not relate to the requirements of your registration with the Care Quality Commission. You must satisfy both the terms of your contract held with NHS England **and** the terms of your CQC registration and fulfil all requirements to satisfy **both.**

Taking the remedial action required under this notice does not, and will not, in any way relinquish you of the obligation to satisfy any requirements made by the CQC in respect of your registration.

Annex 9(b): Example breach notice

This annex is provided as an example only and area teams should ensure that they have sought appropriate advice and support, in line with NHS England protocols, prior to issuing such a notice.

Breach notice

Following our recent communications and discussion on the *[insert date(s)],* we hereby serve notice that the NHS England considers you are in breach of your (GMS/PMS/APMS)*delete as appropriate contract dated *[insert start date of contract]* on the following grounds:

[Insert bullet points setting out the breach details and referencing clause numbers from contract]
[Insert details of any evidence relied upon in reaching this decision]

In accordance with schedule 6 part 8, regulation 115 of the NHS (GMS contract) regulations 2004, (schedule 5, regulation 107 of the PMS Agreement Regulations 2004)*delete where appropriate NHS England requires that you do not repeat this breach.

If you fail to comply with this notice in that you repeat this breach or otherwise breach the contract resulting in a remedial notice or a further breach notice being issued, NHS England may take steps to terminate your contract or consider the imposition of a contract sanction.

Should you wish to appeal against this decision, you must do so in writing to *[insert details of appeal contact address]* within a **maximum of 28 days** from the date of service of this notice and you do, of course, retain the right to seek support from your Local Medical Committee.

NHS England would advise that this notice does not relate to the requirements of your registration with the Care Quality Commission. You must satisfy both the terms of your contract held with NHS England **and** the terms of your CQC registration and fulfil all requirements to satisfy **both.**

Satisfying the terms of this notice does not, and will not, in any way relinquish you of the obligation to satisfy any requirements made by the CQC in respect of your registration.
Yours sincerely,

Annex 10: Relevant legislation, regulations and guidance

This is by no means an exhaustive list and is likely to be subject to future changes. Area teams should ensure they seek appropriate legal advice when considering the interpretation of any applicable legal requirements.

- The National Health Service Act 2006 as amended by the Health and Social Care Act 2012
- The National Health Service (Performers Lists) Regulations 2004
- The National Health Service (Performers Lists) Amendment Regulations 2005
- The National Health Service (Performers Lists) Amendment and Transitional Provisions Regulations 2008
- The National Health Service (Performers Lists) Direction 2010
- The National Health Service (General Medical Services Contracts) Regulations 2004
- The National Health Service (Personal Medical Services Agreements Regulations 2004
- The National Health Service (Primary Medical Services) (Miscellaneous Amendments) Regulations 2004
- The National Health Service (Primary Medical Services) (Miscellaneous Amendments) Regulations 2005
- The National Health Service (Primary Medical Services) (Miscellaneous Amendments) (No 2) Regulations 2005
- The National Health Service (Primary Medical Services and Pharmaceutical Services) (Miscellaneous Amendments) Regulations 2006
- The National Health Service (Primary Medical Services) (Miscellaneous Amendments) Regulations 2007
- Public Contracts Regulations 2006, as amended
- The Alternative Provider Medical Services Directions 2010, as amended

Guidance

- Procurement guide for commissioners of NHS-funded services, 30 July 2010.
- Principles and rules for cooperation and competition, 30 July 2010.
- Records Management: NHS code of practice, 5 April 2006 and

  NHS information governance – guidance on legal and professional obligations, 17 October 2007.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 25 November 2014

Subject: Work Schedule – November 2014

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to consider the progress and ongoing development of the Scrutiny Board's work schedule for the current municipal year.

2 Main issues

2.1 Further to the discussions held at the beginning of the current municipal year, work has progressed to include some of the areas identified by the Scrutiny Board into a structured work schedule for the remainder of the municipal year. An outline of the areas to be covered in forthcoming meetings area as follows:

<u>November 2014</u>

- Primary Care provision in Leeds (NHS England: West Yorkshire Area Team) – first session

<u>December 2014</u>

- Child and Adolescent Mental Health Services (CAMHS) – commissioning and provision in Leeds (second session)

<u>January 2015</u>

- Leeds Mental Health Framework & draft action plans
- Maternity Services Strategy for Leeds
- LYPFT – Care Quality Commission (CQC) Inspection outcome
- LTHT – Progress against CQC inspection outcomes/ recommendations

- Primary Care provision in Leeds (NHS England: West Yorkshire Area Team) – second session

February 2015

- Child and Adolescent Mental Health Services (CAMHS) – commissioning and provision in Leeds (third session)
- Review of Homecare – final report & recommendations for Executive Board
- LYPFT – Care Quality Commission (CQC) Inspection action plan
- LCH – Care Quality Commission (CQC) Inspection outcome

March 2015

- Primary Care provision in Leeds (NHS England: West Yorkshire Area Team) – third session
- LCH – Care Quality Commission (CQC) Inspection action plan

April 2015

- Child and Adolescent Mental Health Services (CAMHS) – commissioning and provision in Leeds (final report)
- LTHT – Progress against CQC inspection outcomes/ recommendations
- LYPFT – Progress against CQC inspection outcomes/ recommendations
- LCH – Care Quality Commission (CQC) Inspection outcome

Items identified but not yet scheduled

- Position statement on availability of healthy food options at health care establishments across the City and at Leeds City Council Sports establishments
- Director of Public Health Annual Report

2.2 The details outlined above should be considered as an indicative rather than definitive work programme. A number of areas (in particular work associated with CQC inspections) are dependent on the outcome of work from third parties and may therefore be subject to change. There also has to be sufficient flexibility in the Board's work programme in order to react to any specific matters that may arise during the course of the year.

Working Groups

2.3 The Scrutiny Board has established two working groups, one focusing on Adult Social Care matters, while the other working group considers proposed changes and development of local health services.

2.4 A verbal update from recent working group meetings held in early November 2014 will be provided at the meeting, as required. It is planned that both working groups will meet again in early 2015.

Minutes from Executive Board and the Health and Wellbeing Board

2.5 In order to keep the Scrutiny Board appraised of activity through the Council's Executive Board and Leeds' Health and Wellbeing Board, the latest available minutes are included for members' information and consideration. The minutes presented are:

- Health and Wellbeing Board meeting held on 22 October 2014.

2.6 As the Executive Board is not scheduled to meet until 19 November 2014 (i.e. after this report has been published), any draft minutes available will be presented at the meeting.

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and its appendices.
b) Agree the future work schedule for the Scrutiny Board.
c) Identify any specific matters to be incorporated into the work schedule for the remainder of the current municipal year.

4. Background papers[1]

4.1 None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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HEALTH AND WELLBEING BOARD

WEDNESDAY, 22ND OCTOBER, 2014

PRESENT: Councillor L Mulherin in the Chair

Councillors J Blake, N Buckley, S Golton, and A Ogilvie

Representatives of the Clinical Commissioning Groups
Dr Jason Broch – Leeds North CCG
Dr Andrew Harris – Leeds South and East CCG
Dr Gordon Sinclair – Leeds West CCG
Nigel Gray – Leeds North CCG
Matt Ward – Leeds South and East CCG

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health
Sandie Keene – Director of Adult Social Services
Nigel Richardson – Director of Children's Services

Representative of NHS (England)
Moira Dumma – NHS England

Third Sector Representative
Susie Brown – Zest – Health for Life

Representative of Local Health Watch Organisation
Linn Phipps – Healthwatch Leeds
Tania Matilainen – Healthwatch Leeds

Representatives of NHS Providers
Chris Butler – Leeds and York Partnership NHS Foundation Trust
Julian Hartley – Leeds Teaching Hospitals NHS Trust
Thea Stein – Leeds Community Healthcare NHS Trust

26 Chairs Opening remarks

The Chair welcomed all present to the meeting, particularly to the three new NHS representatives who had been nominated to the Health and Wellbeing Board (HWB). Brief introductions were made.

Councillor Mulherin also paid tribute to and thanked the Director of Adult Social Services, Sandie Keene, for her services to the city, as this would be the final Health and Wellbeing Board meeting in which she would be in attendance prior to her retirement.

RESOLVED – To note the appointment of the following:
Chris Butler - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

27 Late Items

One formal late item of business had been added to the agenda at the request of the Chair: - "Proposed Congenital Heart Disease Standards and Service Specifications". (Minute 38 refers).

Additionally, a revised copy of Appendix A to the report "Commissioning Primary Care Services in Leeds 2014-16" had been despatched to the Board prior to the meeting (minute 33 refers)

28 Declarations of Disclosable Pecuniary Interests

The following declarations of interest were made:
Linn Phipps (Healthwatch Leeds) – Late Item "Proposed Congenital Heart Disease Standards and Service Specification" - as a member of NHS England Clinical Priority Advisory Group which had provided comments on the specifications (minute 38 refers)

Gordon Sinclair (Leeds West CCG) and Jason Broch (Leeds North CCG) - agenda item 9 Commissioning Primary care Services in Leeds - as General Practice had a role within the commissioning of services (minute 33 refers)

29 Apologies for Absence

Apologies for absence were received from Phil Corrigan (Leeds West CCG)

30 Open Forum

No matters were raised by the public on this occasion

31 Minutes

RESOLVED - That the minutes of the previous meeting held on 16th July 2014 be agreed as a correct record

32 Health and Social Care in Leeds: a two year look ahead for the city

The Chief Officer, Health Partnerships, presented a report providing the Board with a two year 'look ahead' at the major issues, challenges and opportunities facing partners in the city.

The report provided an update on work undertaken since the June HWB meeting and contained contributions from each major healthcare organisation represented at the Board (NHS provider trusts, NHS CCGs, NHS England, Leeds City Council) in response to key indicators.

Representatives of each of the organisations presented a brief overview of the responses provided.

During discussions the following matters were considered

- The possibility of including the private sector in future reviews of Leeds health and social care provision
- The need to emphasise the importance of service user involvement in service design and to emphasise "wellness" in the future, rather than sickness

- The models of General Practice social prescribing and a review of the success of that process
- The role of third sector involvement in health and social care provision
- The need to widen the focus of the traditional services
- The implications for the respective work forces in terms of preparation for implementation and that this matter was included within the Transformation Board work stream
- The reach and benefits of the "Families First" scheme was noted for further consideration with partners

HWB also recognised the role and impact of health professionals in the world of child care, schooling and safeguarding. Members considered the proper place for children and young people's mental health provision; noting that a Scrutiny Inquiry was due to commence 28 October 2014 on this issue and that the CCG Integrated Commissioning Board had asks begun a review of child and youth mental health services . HWB suggested the Inquiry could consider evidence from teachers/school staff who were often first point of contact for a child. Councillor Eileen Taylor, Member of Scrutiny Board (Health and Wellbeing and Adult Social Care) was in attendance and agreed to refer this comment to the Chair of the Scrutiny Board.

RESOLVED –

a) That the contents of the report and attached plans and the comments of the Board on the plans submitted by the health and local authority partner organisations on the Health and Wellbeing Board, giving a two year 'look ahead' for their organisations, be noted.
b) That the comments made by the Board on how the plans and strategies for each organisation contribute to the Leeds Joint Health and Wellbeing Strategy be noted.

33 Commissioning Primary Care Services in Leeds 2014-16

Further to Minute 7 of the meeting held 18 June 2014, Moira Dumma, NHS England, West Yorkshire, presented a report on the NHS England commissioning approach and plans for primary care services in Leeds for 2014-2016, covering the major commissioning areas of General Practice, Dental Services, Community Pharmacy and Community Optometry.

A revised version of the appendix to the report had been circulated prior to the meeting.

The Chair reported that she had responded on behalf of HWB to NHS England's request for comments on co-commissioning by welcoming the move to more local decision making and seeking a role for the HWB

In considering the report, the following matters were highlighted:

- Co-commissioning – noted the development work being undertaken across the CCGs in readiness for implementation in April 2015. Updates would be provided as plans emerged
- Oral health - noted the progress made by Leeds and that the Oral Health Strategy would be presented to HWB early next year

- Links and monitoring - the need to ensure that issues raised in various partner meetings were fed into the co-commissioning plans and that monitoring of the new working arrangements would ensure progression
- Ambitions – commented that the plans did not reference co-commissioning as an ambition for Primary Care and that additional narrative on how patient feedback shaped service provision was required in order to meet the criteria of the JHWS
- Recognition of the need to discuss how change will be instigated and delivered, and the external factors which might affect delivery.
- Existing practice - recognised that some existing practices had grown out of immediate service need rather than an overview of provision being taken.

HWB discussed examples –

- HWB discussed the example of child mental health which was dependant on individual teachers and cluster organisations taking a role and required behavioural changes in adults to recognise children in difficulty. Noted the comment that Clusters should be involved in service planning for this issue
- deprivation and it's influence on provision, noting that individual former PCTs would have had regard to the deprivation indexes and shaped provision accordingly although it could be said that those indicators were now out of date. A workshop scheduled for the New Year would consider this issue and service structure

Extended GP opening hours - noting that West CCG had implemented extended service as a pilot scheme to test uptake, HWB considered the demand for the services, the role of third sector for provision of some services, resources and capacity. HWB felt it would be useful to receive the results from West CCG and national pilots

RESOLVED -

a) To note the report and associated work being carried out in Leeds to deliver high quality primary care services and improve general practice, dental, pharmacy and optometry services.
b) That the comments made on the challenges and opportunities facing primary care in Leeds, in particular relating to access, quality and sustainability of services, be noted
c) That a further report be provided to HWB members in due course on the results and/or success of the 7 day General Practice working undertaken by Leeds West CCG and nationally; to include information on the access and uptake of services and reference to any impact of the move of some provision from acute to General Practice provision
d) That a further performance report on the CCGs be presented in due course following the implementation of the new ways of working

34 Better Care Fund Update

Matt Ward (Leeds South and East CCG) presented the report of the Deputy Director of Commissioning (Adult Social Care) and the Chief Operating Officer (Leeds South East CCG) on the latest position of the Better Care Fund (BCF).

The report outlined the work to be undertaken prior to the official BCF 2015/16 live year.

The Chair expressed thanks to all partners and officers who worked on the submission

RESOLVED -

a) To note the progress on the BCF in Leeds to date; namely

I. That the most recent version of the BCF template was submitted on 19 September 2014.

II. That Leeds has established 2014/15 as a shadow year of the Better Care Fund through putting in place “pump-priming” arrangements ahead the first official BCF year in 2015/16.

III. That a number of schemes have been worked up to varying degrees of detail, as set out in the report.

b) To note that work will continue throughout 2014/15:

I. To fully articulate the cost benefit of the individual schemes of the BCF with a view to their inclusion in 2015/16

II. To put in place robust management and governance processes through the Transformation Board programmes and a Section 75

c) To note that other joint commissioning arrangements through the Integrated Commissioning Executive as part of the wider ambition for a high quality and sustainable health and care system for the city are being considered

d) To note the increased financial risk associated with the revised payment-by-performance element of the Fund which only relates to a reduction in all non-elective admissions and to note that whilst this provides greater assurance to the acute setting around payment for non-elective activity if the BCF does not deliver the expected reduction, it potentially adds additional risk and reduces the flexibility of the fund to develop community services if the reduction is not delivered.

35 Leeds Safeguarding Children Board Annual Report

The Board received the report of the Leeds Safeguarding Children Board (LSCB) which provided a brief summary of the key issues and challenges from the LSCB Annual Report Executive Summary

The Chair reported receipt of a letter from DCLG in respect of proposed inspection visit to Leeds by Louise Casey

Bryan Gocke presented the Annual Report on behalf of LSCB and extended apologies from Jane Held, Chair of LSCB

Mr Gocke outlined the improvements identified in the report against the five priorities and noted the services' increased awareness of the need to engage with young people to help shape future services. The use of the 'front door' approach which serves as referral/reporting point and as first point of access for young people to access other services was also highlighted

In particular the HWB discussed

- The 'Think Family' approach when working with a young person and the opportunities to highlight this approach through discussions and training with partners at a series of forthcoming events
- The importance of partnership working between HWB, LSCB and Leeds Adults Safeguarding Board
- The setting of bereavement services for young people and the most appropriate provider. Noting that the CCGs had recently discussed this issue, it was suggested that a CCG/HWB partnership review be organised
- Noted reassurance that Child Sexual Exploitation was recognised as a major issue, with a specialised sub group created by the LSCB specific to this matter with a co-ordinated partnership across the city
- Recognition that the need for confidentiality should not get in the way of safeguarding
- Noted that the Leeds Safeguarding Adults Board Annual report had been published, with a workshop planned for November 2014 following which a report would be presented to HWB

RESOLVED – That the contents of the report and the comments made by Members be noted and:

a) To implement the 'Think Family – Work Family' protocol (which promotes more 'joined up working' in responding to vulnerable children, young people *and adults*).
b) To improve the availability and accessibility of bereavement services.

36 Best Start Plan on a Page

The Board received the joint report of the Director of Public Health and the Director of Children's Services presenting the draft "Best Start Plan on a Page" – a broad preventative programme from conception to age 2 aimed at ensuring the best start for every baby. The Plan was presented for the Boards' information prior to it being circulated for discussion and consultation, including user engagement; and in readiness for a full report and discussion at the February 2015 Health and Wellbeing Board.

In presenting the report Dr Ian Cameron noted that the Maternity Strategy would be presented in February. It was agreed that the mother and baby mental health services would be included, in response to comments.

RESOLVED

a) To note the draft Best Start Plan on a Page for information prior to the Plan being circulated for discussion and consultation, including user engagement.
b) To invite the Plan to be brought back for full discussion with partners at the Board meeting scheduled for 4th February 2015.
c) To note that the Maternity Strategy would be presented to the Board meeting scheduled for 4th February 2015, to include reference to mother and baby mental health strategy

37 For Information - Delivering the Joint Health and Wellbeing Strategy: update report

The Board received a copy of the October 2014 “Delivering the Strategy” document; a bi-monthly report which gave the Board the opportunity to monitor progress on the Joint Health and Wellbeing Strategy (JHWS) 2013-15.

Gordon Sinclair (Leeds West CCG) drew attention to the report and in discussions; the Board noted the findings of the Commission into Child Poverty in respect of the phenomenon of in-work families in poverty and agreed that the "Due North" report be presented to a future HWB meeting. Finally, HWB congratulated Children's Services on the positive indicator in respect of the increased number of children gaining 5 GCSE

RESOLVED –

a) To note receipt of the October 2014 “Delivering the Strategy” JHWS monitoring document
b) To note the potential to present the “Due North” publication to a future meeting of HWB

38 Late Item - Proposed Congenital Heart Disease Standards and Service Specifications

The Chair introduced the Late Item of business - “Proposed Congenital Heart Disease Standards and Service Specifications” - which had been included on the agenda in order to highlight and widen the consultation which was due to close on 8 December 2014

In presenting the document, Moira Dumma (NHS England), highlighted the differences between the approach taken to the consultation process in 2012 and in 2014.

In discussing the report the HWB commented on the following

- The need to translate the documents into community languages, particularly for those communities with a high number of service users and the need to ensure the documents are available in 'easy read' versions
- Concern that the consultation had not been undertaken in conjunction with local authorities who had a proven track history of engaging with local communities through existing structures
- Concern that no resources were earmarked to support implementation
- The need to acknowledge that patients and public should have the opportunity to influence the service and systems
- The need to include consideration of how people are supported whilst being cared for at Leeds unit - which supports patients from across Yorkshire and the Humber
- The lack of reference to safeguarding in the consultation
- Access and interaction with the services outside of the usual Unit setting

RESOLVED –

a) To note receipt of the consultation document and to encourage participation in the public consultation
b) That, agreement be given for the Chair to draft a response to the consultation, based on the discussions at this meeting, on behalf of

HWB. A draft to be emailed to HWB members for ratification prior to submitting the response by the given deadline

39 Any Other Business

No matters of any other business were raised

40 Date and Time of Next Meeting

RESOLVED – To note the following arrangements:

a) A Board workshop session scheduled for Wednesday 26th November 2014
b) The next formal Board meeting to be held on Wednesday 4th February 2015 at 9.30am