NHS
Southampton City
Clinical Commissioning Group

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Agenda – Part 1

Meeting: **Primary Medical Care Commissioning Committee**
Date: **13th June 2017**
Time: **09:30 – 10.30**
Location: **Conference Room, NHS Southampton HQ**

Time	Item No.	Subject	Lead	Item For: Discussion Decision Information	Attachment
09:30	1.	Welcome & Apologies			
	2.	Declaration of interests			
09:35	3.	Minutes of the Previous Meeting and Matters Arising	June Bridle	Decision	Attached
09:40	4.	Minutes of the Primary Care Operational Group	June Bridle	Information	Attached
09:45	5.	Local Improvement Scheme – Developing General Practice	Phil Aubrey-Harris	Decision	Attached
09:55	6.	Acute Visiting Service Scheme	Phil Aubrey-Harris	Decision	Attached
10:10	7.	LD Directed Enhanced Service	Phil Aubrey-Harris	Information	Attached
10:20	8.	Terms of Reference: Primary Care Operational Group Primary Medical Care Committee	John Richards	Decision	Attached
10:25	9.	Implications of General Medical Services PMS and contract changes for 2017/18	Phil Aubrey-Harris	Information	Attached
10:30	10.	Any other business			
Date of Next Meeting: 15th August 2017, 09:30 – 11:30, Conference Room, NHS Southampton HQ, Oakley Road, S016 4GX					

Please send apologies to: Sarah Spooner, Board Administrator, 02380 296075, Sarah.Spooner@southamptoncityccg.nhs.uk

MINDFUL EMPLOYER

Southampton City Clinical Commissioning Group

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Meeting Minutes

Primary Medical Care Commissioning Committee – Part 1

The meeting was held on Wednesday 12th April 2017, 14:00 – 15:00, Conference Room, Oakley Road, Ground Floor, Southampton, SO16 4GX

	NAME	INITIAL	TITLE	ORG
Present:	Henry Slater (Chair)	HS	Associate Lay member	SC CCG
	Peter Horne	PH	Director of System Delivery	SC CCG
	June Bridle	JB	Lay Member – Governance	SC CCG
	James Rimmer	JRimmer	Chief Financial Officer	SC CCG
	Stephanie Ramsey	SR	Director of Quality and Integration and Chief Nurse	SC CCG
	Dr Sue Robinson	SR	CCG Chair	SC CCG
	John Richards	JRichards	Chief Executive Officer	SC CCG
	Councillor Dave Shields	DS	Councillor	SCC
Apologies:	Kay Rothwell	KR	Deputy Finance Officer	SC CCG
	Jason Horsley	JH	Joint Director of Public Health	SC CCG
In Attendance:				
	Phil Aubrey-Harris	PAH	Head of Primary Care	SC CCG
	Lesley Gilder	LG	Patient Representative	Healthwatch
	Beccy Willis	BW	Head of Business	SC CCG
	Sarah Spooner (minutes)	SS	Board Administrator	SC CCG

1.	**<u>Welcomes and apologies</u>**	
	All members were welcomed to the meeting. Apologies were noted and accepted.	
2.	**<u>Declarations of Interest</u>**	
	A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship HS declared that he is a patient of Hill Lane practice. JB declared that she is a patient of Woolston Lodge surgery.	

	The Committee agreed that the conflicts of interest declared are indirect and no action is required.	
3.	**Minutes of the Previous Meeting and Matters Arising**	
	The minutes of the Primary Medical Care Commissioning Committee that took place on the 15th February 2017 were agreed as a true, accurate record of the meeting. **Matters arising** Page 3 – Any Other Business Impact from the changes to the GMS contracts for 2017/18 to be on the June agenda.	
4.	**Minutes of the Primary Care Operational Group (PCOG)**	
	The minutes of the Primary Care Operational Group were presented to the group to note. PAH confirmed that the LIS for Developing General Practice will be on the June Primary Care Commissioning Committee agenda for approval.	
5.	**Stoneham Lane Boundary Change**	
	The Committee received the Stoneham Lane Boundary Change papers. PAH talked through the highlights. JRichards queried the difference between the inner and outer boundaries. SRobinson confirmed that patients who live and are registered with a practice in the inner boundary who then move within the outer boundary are able to remain with the same practice. JB raised the importance of maintaining a dialog with West Hampshire CCG. However it was acknowledged that West Hampshire CCG are leading and SCCCG are supporting. JRichards suggested that a policy statement needs to be developed for future boundary changing decisions. The Committee supported the suggestion of a policy statement to be developed. The Committee approved the boundary change application. **Action: PAH to confirm date when the boundary change will take place.**	**PAH** **PAH**
6.	**Quality Improvement Schemes – Medicines Managers and Prescribing Incentive Scheme – Retrospective Approval**	
	The Committee received the Medicines Managers and Prescribing Incentive Scheme Quality Improvement Schemes (PIPS). PAH talked through the highlights of the paper.	

	The Committee noted that they are retrospectively being asked to approve the commissioning of the Quality Improvement Schemes from the 1st April 2017. It was suggested for future decisions the paper is received by the Committee prior to commencement. JRimmer queried the values of the different components of the schemes, whilst the values of medicines management is given it would be useful to understand the PIPs components. **Action: PAH to clarify the value of PIPs for 2017/18** JRimmer queried whether the member of staff supporting the Medicines Management team from an administrative perspective within GP practices needs to be a clinical member of staff. Committee members agreed that the role will be supervised and will not be undertaking clinical reviews, the role will be administrative and therefore does not need to be clinical. The Committee approved retrospectively the commissioning of the Quality Improvement Schemes from the 1st April 2017.	**PAH**
7.	**Any other business**	
	HS formally noted how successful the Informed Decision Making for Primary Care Commissioning Committees Workshop was in March.	
8.	**Date and venue of next meeting**	
	13th June 2017, 09:30 – 11:30, Conference Room, NHS Southampton HQ, Oakley Road, S016 4GX	

Signed as a true record

Signed: …….

Print Name: ……..

Designation: …….

Date: …….

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Meeting Minutes

Primary Care Operational Group

The meeting was held on Tuesday 4th April 2017, 14:30 – 16:00
Seminar Room, Oakley Road, Ground Floor, Southampton, SO16 4GX

	NAME	INITIAL	TITLE	ORG
Present:	Carol Alstrom (Chair)	CA	Associate Director for Quality	SC CCG
	Dr Sue Robinson	SR	CCG Clinical Lead	SC CCG
	Lisa Sheron	LS	Associate Director of System Delivery	SC CCG
	Kay Rothwell	KR	Deputy Chief Financial Officer	SC CCG
	Phil Aubrey-Harris	PAH	Head of Primary Care	SC CCG
	Donna Chapman	DC	Associate Director System Redesign	SC CCG
	Liz Bere	LB	Head of Medicines Management	SC CCG
	Michelle Lombardi	LM	Deputy Director of Primary Care	Wessex LMC
	Dr Laura Edwards	LE	Medical Director for LMC	Wessex LMC
	Carol Giles	CG	Assistant Contract Manager (Primary Care)	NHS England
In attendance:	Jess Yorke	JY	Primary Care Commissioning Development Manager	SC CCG
	Tina Woodcock	TW	Primary Care Commissioning Development Manager	SC CCG
	Beccy Willis	BW	Head of Business	SC CCG
	Sarah Spooner (Minutes)	SS	Board Administrator	SC CCG
Apologies:	Dawn Buck	DB	Head of Stakeholder Relations and Engagement	SC CCG
	Amanda Waite	AW	Primary Care Quality Lead	SC CCG

1.	**Welcome and apologies**	
	All members were welcomed to the meeting. Introductions made. Apologies were noted and accepted.	
2.	**Declarations of Interest**	
	A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship	

	No Declarations of Interest were declared to any items on the agenda.	
3.	**Minutes of the Previous Meeting and Matters Arising**	
	The minutes from the previous meeting dated 7th March 2017 were agreed as an accurate reflection with the following amendments: Page 1: to add Carol Glen to the list of attendees and remove Carol Giles and Lisa Sheron Page 3 (Item 7 – Practice Manager Advisory Group TORs): to change KR to JY. Page 3 (Item 8 – Residential Home LCS Report): To remove 'the group agreed to pilot option 2' and add 'There will be further work to be undertaken and it was suggested that the options are taken to the Practice Managers Advisory Group for feedback and a clinical lead to ensure the terminology is logical. The LMC raised some concerns and were happy to work with the CCG. Specification needs to include activity over and above core GMS.' **Action Tracker** The outstanding actions were reviewed and the action tracker updated.	
4.	**£3 Per head Transformational Proposals**	
	PAH gave a verbal update on the £3 per head transformational proposals. The proposal has been discussed at varies meetings at the CCG including Clinical Executive Group. PAH shared feedback with the group and informed that the next steps are to meet with Chris Sanford, Ali Robins and Mike Barnfield to agree a consensus following all feedback. The proposal will be revised to include the feedback and presented back to the CCG and GPs. The proposal will be presented at a future Primary Medical Care Commissioning Committee to sign off.	
5.	**Merger Update (Confidential)**	
6.	**Enhanced and Urgent Access** **- Project Plan**	
	The group received the Enhanced and Urgent Access papers. JY gave a verbal update on the procurement of Enhanced and Urgent Access service. There is a market warming event on 23rd May following which a decision will be made on 1 or 2 stage PQQ/ITT. JY highlighted that the project group is a sub group of PCOG and it was agreed a verbal update from the project group meeting to be provided at PCOG. CG raised concern around the timeline. JY confirmed that the 22nd August is our	

	clarification date. It was agreed that an update on the Enhanced and Urgent Access procurement is to be a standing item.	
7.	**Terms of Reference for Primary Care Operational Group**	
	The group received the current Terms of Reference (TORs) which are due for review. The group are asked to provide comment on elements that need updating. The group considered the membership and whether a lay member should remain or be removed. It was suggested and agreed to ask a chair from the PPG to attend the PCOG meetings. **ACTIONS:** • **JY to discuss with Dawn Buck on contacting the PPG chairs.** • **BW to change TORs to reflect that the lay member is not internal to the CCG.** • **BW to be added to membership.** There was a discussion on quorum and the minimum representation from each organisation. It was agreed to charge the quorum for a meeting of the Primary Care Operational Group to 6 members with 1 member external to the CCG. It was noted that JY and TW are in attendance at the meeting and this should be reflected in the minutes. It was agreed that an updated version of the TOR's to return to the next meeting in May	**JY** **BW** **BW** **JY/BW**
8.	**Local Improvement Scheme – Developing General Practice**	
	The group received the Local Improvement Scheme – Developing General Practice papers. There is a meeting with CCG and LMC colleagues on the 11th April. TW highlighted the success of a recent Diabetes workshop and the feedback which was received has been positively received. PAH and Moraig Forrest-Charde have been in discussions on Better Care and how Primary Care can support practices and work with clusters to improve better outcomes for patients. LS raised that the Cancer workshop had also been successful and there is clear evidence of the Primary Care Team working positively with the System Delivery Team. CG agreed to feedback comments directly to PAH. LE raised that the variable payment per registered patient is £1.04 on the cover sheet but £1.05 in the paper. PAH confirmed the paper is correct at £1.05.	**CG**

	LS raised that “frequent flyers” are now known as “frequent users”. DC asked for Section 3.3.2 to be corrected to say Solent and Southampton City Council Rehab and Reablement Service. The group agreed the next steps: • CCG and LMC to meet on the 11th April • Paper to return to the next Primary Care Operational Group in May • Paper to Primary Medical Care Commissioning Committee in May for sign off	
9.	**Streaming to Primary Care at ED**	
	The group received the letters from NHS England and NHS Improvement setting out the national requirement for streaming. PAH and LL updated the group on Primary Care Streaming at ED which is required to be in place by September 2017. This is being led by UHS. There is a Task & Finish Group in place which includes SCCCG and WHCCG commissioners.	
10.	**Practice Exception Report**	
	PAH gave a verbal update on the General Practice Exception Report. **East Southampton** Bath Lodge – list is formally closed West End Road – list is capped All affected practices have had written notification regarding expectation that list capping arrangements will cease from July 2017 subject to sufficient improvements being made. On the 31st March 2017 the CCG was approached informally by a practice regarding a potential application for list closure for 1 month only. **Bath Lodge and Chessel** The CQC report for Chessel practice has now been published. The CCG continues to monitor both practices with regular Quality assurance meetings and visits from the Quality team. Assurance was received at the last meeting that progress has been made in line with the remedial action plans. PAH confirmed that he has asked for assurance on the number of clinical sessions and the number of appointments being offered and made. DC queried what mitigation is in place to improve access for practices. PAH confirmed that the Winter pressure funding has been extended till April. PAH has written to the practices who are the highest users of the funding. DC raised that there is an issue with patients not able to access appointments who need referring to maternity services. DC will share evidence of this with	

	PAH and CA once received.	
11.	**Any other Business**	
	Southampton City CCG has met with West Hampshire CCG who are in approval of the boundary change proposal. This is on the Primary Medical Care Commissioning Committee agenda on the 12th April 2017. LS asked about the role, function and responsibility of SPCL (Federation). JY agreed to attend the next System Delivery Team meeting to discuss.	
12.	**Date and venue of next meeting**	
	Tuesday 2nd May 2017, 14:30-16:00, Seminar Room, Oakley Road, Southampton, SO16 4GX	

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Primary Medical Care Commissioning Committee

Date of meeting	13 June 2017
Agenda Item (number)	**5**

Developing General Practice Local Improvement Scheme (LIS)

Topic Area	Primary Care
Summary of paper and key information	The final version of the Local Improvement Scheme (LIS), Developing General Practice has been developed following the removal of the Avoiding Unplanned Admissions Directed Enhanced Service work streams and a meeting with the Local Medical Committee. This has caused delay to the issuing of this LIS. In order to limit the impact of the delay, the draft of the LIS has been shared with practices – pending Primary Medical Care Commissioning Committee approval. Once approved, a final communication will be forwarded to practices and their sign-up will be pursued
Key/Contentious issues to be considered and any principal risk(s) relating to this paper (Assurance Framework/Strategic Risk Register reference if appropriate)	Each year, there has been discussion about the fairest way to fund the LIS given the mixed requirements of time away from the practice, which is more difficult to achieve for smaller practices, and population-based activities, which impact more significantly on larger practices. The 2016/17 scheme is paid as a fixed sum per practice of £13,100. There have been a number of mergers this year which has resulted in a reduction in the overall total of practices however the number of larger practices has increased. A payment structure which reflects population size is therefore proposed in 2017/18. The keys risk is practice engagement. This is influenced by the specification and the payment structure. The final document must be sufficiently attractive to encourage practice buy-in. Disengagement has the potential to impact on successful delivery of wider system goals.
Are there any potential conflicts of interest that the	None

committee need to be aware of?	Southampton City Clinical Commissioning Group
Please indicate which meetings this document has already been to, plus outcomes	Primary Care Operational Group(PCOG) – October 2016 / December 2016/ January 2017, February 2017, March 2017, April 2017, May 2017, June 17. Meeting with LMC following April PCOG meeting,
HR Implications (if any)	None
Financial Implications (if any)	Total budget: LIS DGP 2016/17 £419,200 plus 2% uplift LIS NCA 2016/17 £15,000 TOTAL £442,584 Feedback from practices indicated that a payment based on registered list size is more favourable than the fixed fee approach used in 2016/17, as this will better reflect the proportion of workload required. A number of options were worked up to assess the impact of the transition from a single practice payment to one based on population. Moving to a population payment in one step was found to have significant financial impact on the smaller practices; the preferred option is therefore for a fixed element, recognising that the resource required for some parts of the scheme is the same regardless of practice size, and a variable element to reflect the workload associated with population-based activities. Details are set out below: Fixed payment of £5,500 paid upon sign-up. Variable payment of £1.07 per weighted population (at 1 January 2017) payable on assessment of evidence of meeting the 80% threshold.
Public involvement – activity taken or planned	No direct PPI at this stage
Equality Impact Assessment required / undertaken	Completed
Report Author (name and job title)	Tina Woodcock – Primary Care Commissioning Manager
Committee Sponsor	Phil Aubrey-Harris Head of Primary Care
Date of paper	25 May 2017
Actions requested / Recommendations	The committee is asked to approve the LIS

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LOCAL IMPROVEMENT SCHEME

Name of Local Improvement Scheme	Developing General Practice
Commencement date	1 April 2017
Duration	1 year
Lead commissioner	Tina Woodcock Primary Care Commissioning Development Manager

1. Introduction

1.1 **Strategic context**

This local improvement scheme (LIS) has been developed to support primary care engagement in a range of activities to promote the following overarching goals:

- ✓ Putting individuals and families at the centre of their care and support, meeting needs in a holistic way
- ✓ Providing the right care, in the right place, at the right time, and enabling individuals and families to be independent and self-resilient wherever possible.
- ✓ Making optimum use of the health and care resources available in the community
- ✓ Intervening earlier and building resilience in order to secure better outcomes by providing more coordinated, proactive services.
- ✓ Focusing on prevention and early intervention to support people to retain and regain their independence

1.2 The LIS is aligned with Southampton City Clinical Commissioning Group's strategic objectives:

Better Care strategy

Southampton's overriding vision is to join up care and support for each and every unique person in the city. The model is primarily based upon collaboration between Southampton City Council, Southampton CCG, primary care, Solent NHS Trust, Southern Health Foundation Trust, University Hospitals Southampton and community and voluntary organisations. This vision seeks to completely transform the delivery of care in Southampton so that it is better integrated, delivered as locally as possible and person centred. Engagement, locally tailored transformation and delivery of new care models will be driven through six locally facing cluster teams.

Primary Care Strategy

Our vision is to build a model of general practice in our city that will be the strong, effective and sustainable foundation of our integrated health and social care system. Our primary care strategy, Transforming General Medical Services in Southampton, identifies a number of key work streams which will help us move towards this vision. These include a greater emphasis on primary care working at scale, prevention and self-care and integration / collaboration with aligned services.

2. Objectives

- ✓ To develop more effective commissioning through supporting GP engagement within the work of the CCG.
- ✓ To improve health outcomes for people living with Diabetes and other long term conditions
- ✓ To improve health outcomes for people living in the city through practices working collaboratively with partners at a cluster level, targeting and testing new ways of working
- ✓ To promote supported self-management (inclusive of carers and patients wider networks) for people with complex needs or who are vulnerable and at risk of high resource use
- ✓ To deliver person centred care in a more integrated and collaborative way, achieving better outcomes for our patients
- ✓ To achieve better outcomes for people with cancer to promote timely diagnosis and early intervention on cancer pathways

3. Scope of the scheme

The scheme brings together the local investments in practice development and cancer audit previously deployed via Local Improvement Schemes, to fund a new scheme focused on improving outcomes in areas that are priorities for the CCG including:

1. CCG member engagement.
2. Long term conditions accreditation scheme.
3. Better Care and cluster working
4. Improving cancer outcomes.

3.1 CCG member engagement

3.1.1 **Introduction**

The funding supports GPs and practice staff to build awareness and knowledge of commissioning developments and to 'grow' commissioning skills.

3.1.2 **Specification**

GPs and other practice staff are required to engage with the CCG in opportunities to develop their skills and knowledge in the commissioning of local health services. Practices are required to use resources available to improve awareness of commissioning principles, challenges and initiatives through proactive engagement with the CCG via, but not limited to; GP Forums, CCG Communications, FYI Friday, and TARGET heads up. Practices are also required to provide solution-focused and constructive feedback to the CCG where problems are identified with commissioned services so they can be investigated and appropriate action taken to resolve.

3.1.3 **Expected outcomes and demonstrating achievement**

Each practice will nominate a lead to attend and engage in the discussions of meetings. Representatives then have a responsibility to cascade information within practice teams using available internal communication opportunities, and to respond to commissioning intentions. A minimum level of attendance at commissioning forums is not specified, however there will be an expectation of a reasonable level of engagement and improved commissioning awareness.

The CCG will evaluate the contribution of practices to its decision making in order to inform the future development of engagement processes and to assess practices commitment to this element of the LIS. The CCG will engage with practices through the course of the year and feedback if felt there is lack of engagement in this component. If this is the case practices may be asked to provide additional information to demonstrate engagement and/or plans to remedy the situation.

3.2 Long term conditions accreditation scheme

3.2.1 **Introduction**

This scheme builds on previous work to improve the quality of care for adults with diabetes, heart failure and/or COPD and is part of a wider programme of work including specialist community and hospital based services to improve health outcomes through an integrated approach to care. Practices have a key role to play in outcomes as outlined in National Diabetes Audit (NDA) and outcomes relating to good management and care for those with COPD and heart failure, as per NICE Quality Standards QS9 for Heart Failure and QS10 for COPD

3.2.2 **Specification**

Practices are expected to continue efforts to improve outcomes for patients with long term conditions (LTCs) through the consideration of evidence based best practice as outlined in NICE and RCGP clinical guidelines for Diabetes, COPD and heart failure. Practices should also utilise recommended self-management tools to support people to manage their LTCs. Engagement with specialist teams and training (see below) will support practices with knowledge and skills around current best practice guidance and self-management tools.

Quality / Clinical Improvement Activity (e.g. Audit)

3.2.3	Practices will undertake at least two quality / clinical improvement activities (e.g. audit) relating to an indicator of LTC care e.g. BMI in diabetes to improve outcomes for this group of patients. The subject of these activities will be at the practices discretion depending on the areas identified for improvement **Training** A GP and nurse from each practice should undertake a minimum of 6 hours training respectively on management of LTCs. The training needs to be split across the three areas (i.e. diabetes, COPD and heart failure) to meet the practice needs based on the LTC register sizes. This training is separate and in addition to training delivered at TARGET. **Engagement with Specialist Teams** Practices are expected to engage with Specialist LTC Teams. The purpose of these visits will be to promote the confidence and skills of practice staff and to develop relationships with specialist services. Practices should arrange visits (2 visits with Diabetes team and 1 each with COPD and HF team). Practices should agree the agenda relevant to practice education and collate and forward relevant any relevant data prior to the visit. Visits could take the form of a joint clinic / MDT to discuss complex cases and should include at the least the nominated GP and nurse leads for LTCs. There will be some flexibility on Heart Failure and COPD required visit based on the individual practice registered size for these LTCs. Practices are also asked to be mindful of the new Diabetes Prevention Programme coming on line and are encouraged to take advantage of this service for identified patients. **Expected outcomes and demonstrating achievement** Successful delivery of this section of the LIS will improve outcomes for people with LTCs through: ✓ Continued commitment to recognised best practice (i.e. NICE guidelines) ✓ Quality improvement activities / audit to improve local care processes within the practice ✓ Increased knowledge and skills within practice team through engagement in relevant training ✓ Increased engagement between practice and LTC specialist teams Practices are expected to engage in the fulfillment of all aspects of the specification above and are required to provide evidence of training, engagement with specialist teams and quality / clinical improvement activities - see reporting template appendix A. Practices are also required to provide baseline and year-end MIQUEST/GRASP Diabetes reports - including percentage of patients accessing key care processes and treatment targets for diabetes. Individual work books will be shared with practices showing their position compared to city averages at the beginning and end of the year. Details of these submissions are described in the reporting template appendix A.
3.3	**Better Care and cluster working**
3.3.1	**Introduction** Better Care and cluster working is now in its second year of mobilisation. The CCG recognises that General Practice is a cornerstone of any future model of out-of-hospital care. This component of the LIS is intended to support GP leadership and practice participation within local cluster arrangements to promote better outcomes and experience for patients through driving the development of new service/care models that: ✓ Are tailored to individual and community needs to promote health and wellbeing ✓ Promote self-care and reduce the unnecessary use of health and care resources ✓ Involve high levels of collaboration and integration thereby promoting effective MDT's ✓ Target groups in the local population where there is the most opportunity to improve outcomes ✓ Rely on the implementation of best practice and evidence based models of more integrated

	care, through engagement with the wider Better Care programme and beyond ✓ Are more sustainable through the effective deployment of valuable resources ✓ Promote job satisfaction, recruitment, retention and continued development of staff and promote their functioning at the top of their registration/competency
3.3.2	**Specification** This component of the LIS supports GP and practice engagement within Better Care clusters. Practices are required to commit to collaborate with other practices within their clusters and other relevant local partners (e.g. Social Services, Community Health Services, Voluntary orgs) to: ✓ provide clinical leadership and active and appropriate participation in local cluster partnership governance arrangements (i.e. cluster meetings and associated activities). ✓ identify groups within the local population, through consideration of data, for whom it is identified there is the most significant opportunity to improve outcomes and experience. ✓ develop proposals for new initiatives that will change care delivery/clinical management and/or influence patient behaviour to improve outcomes for the target group(s). Consideration of best practice and evidence base to support the development of service initiatives. For GPs and practices to take a key role in the implementation of identified initiatives at a cluster level working in partnership with other local practices and relevant local partners. ✓ participate in the evaluation of service initiatives at a cluster level in partnership with other local practices and relevant local partners. ✓ to refine successful developments/initiatives and to embed them on a sustainable basis. which could be achieved through a range of differing approaches. Work to date within clusters has identified some target groups within local city populations for whom it is expected that there is a significant opportunity for developing improved outcomes through more integrated working: ✓ Patients who are "frequent users" (including secondary, primary, mental health care) ✓ Patients, aged below 65 years without a diagnosis of osteoporosis who at risk of falling ✓ Mental health including young adults with low level anxiety ✓ Patients who are at the end of life ✓ People with multiple long term conditions ✓ Vulnerable adults (including patients with learning disabilities and patients who are highly dependent upon their carers, paid or unpaid) ✓ Children (including children with history of short stay admissions and wheezy children) It is expected that cluster level initiatives to improve outcomes for identified target groups (such as those above) should build on collaborative work to date. This might include (but not be exclusively limited to) case finding, coordinated care planning, prevention, self-care, primary care working at scale, increased integration of services and further development of a local MDT response.
3.3.3	**Expected outcomes and demonstrating achievement** Practices are required to nominate a lead to attend the cluster meetings in which their practice resides and to engage and work collectively within the cluster. Practices are required to work within their cluster group to use available data to identify at least two target groups at cluster level for whom there is evidence of significant opportunity to improve health outcomes. Practices are required to work within their cluster to design and test new ways of working with target groups with a view to improving their outcomes. Both qualitative and quantitative information could be used to demonstrate outcomes including feedback from other partners within the cluster working arrangements. Practices are required to contribute to a suitable report documenting the identification of the target group, changes in care processes applied, outcomes and future recommendations. The report, written by a nominated lead within the cluster, will be received and assessed at a Cluster meeting. The CCG will engage with practices through the course of the year and feedback if it felt there is lack of engagement in this component. If this is

the case practices may be asked to provide additional information to demonstrate engagement and/or plans to remedy the situation.

3.4 Improving cancer outcomes

3.4.1 **Introduction**

Southampton is shown to have higher than average diagnosis of cancers through emergency presentation at stages 3 and 4. For 2015 the English average for cancers diagnosed through emergency presentation was 19.8%, for Southampton City CCG the figure was 22.8%. The city has a below average uptake of screening programmes for breast, cervical and bowel cancers as shown in table 3.4 below. There is a particular challenge around hard to reach groups.

	Target	England average	Southampton average
Bowel screening	60%	57.9%	56% (lowest in Wessex)
Cervical screening	80%	72.7%	68.7% (joint lowest in Wessex)
Breast screening	70%	Not available	67% (lowest in Wessex)

Table 3.4 showing Southampton screening rates for cancers compared to England (2016 data

3.4.2 **Specification**

This section of the LIS is intended to engage practices in the improved uptake of cancer screening programmes in the city and to bring Southampton City CCG more closely aligned to national averages. This will be achieved through use of communication, engagement and education materials, and 'flags' on the clinical system to prompt discussions. Practices are required to identify a practice "Cancer Champion" to promote cancer awareness and share via NLRS (national learning reporting system) significant events arising from cancer diagnosis via emergency presentation.

3.4.3 **Expected outcomes and demonstrating achievement**

Practices are required to proactively engage with non-responders to encourage them to attend screening as required (practice to determine appropriate method), and evidence participation in national and local awareness and screening promotion campaigns. The CCG may require evidence of activities undertaken to improve screening rates. This may include evidence of utilising data sources and/or use of audits to determine whether their actions (as above) have had any positive impact on outcomes and reflect on any challenges with patients. The CCG will evaluate the number of cancers diagnosed at stages 3 and 4 and through emergency presentation. Significant events arising from cancer diagnosis via emergency presentation are reported to the CCG via NRLS (national learning reporting system). A form has been developed to facilitate your in-house process of significant event analysis.

4. Funding and payment arrangements

4.1 **Funding**

The scheme is funded in two parts:

- ✓ £5,500 per practice, recognising that the resource required for some parts of the scheme is the same regardless of practice size.
- ✓ £1.07 per weighted population (as at 1 January 2017), reflecting the workload associated with population-based activities.

4.2	**Payment** £5,500 will be paid as an aspiration payment on sign-up to the scheme and by 30 June 2017 in recognition of the resources required to deliver the scheme. The variable element of the funding will be paid as an achievement payment by 30 June 2018. The threshold for achievement will be 80% on the CCGs assessment of participation and supportive evidence provided. Partial payment will be calculated where there is evidence of partial achievement. The reporting template is attached at appendix A.
5.	**Appendices, related documents and standards**
	Appendix A – Reporting template  LIS 2017-18 reporting template-Fi Appendix B – Significant event form  SEA template.docx
6.	**Termination of agreement**
	This Local Improvement Scheme can be terminated by either the CCG or the Practice at any time during the defined period providing written notice of at least 3 months is given prior to termination for reasons of poor service delivery, or inability to fulfil contractual agreement.
7.	**Dispute and resolution**
	If a dispute arises between the parties to this agreement the following approach will be taken to reach resolution: 1. A discussion between the Practice GP Lead and a designated staff member of the CCG. 2. If no resolution can be met then advice from the LMC will be sought for an impartial resolution. 3. If no resolution can be met then a meeting will be arranged between the Practice GP Lead, GP Board Member of the CCG and representative of the LMC to agree a mutually acceptable compromise.

LOCAL IMPROVEMENT SCHEME 2017 – Developing General Practice

Signatories

Practice Name: ……...

Practice Code: ……...

Practice GP Commissioning Lead(s): Signed: ……

Print Name: ……..

Date:……

CCG Board Member: Signed:

Print Name:

Date:

Please return a copy of the signature page to SOCCG.PCCommissioning@nhs.net by 30 June 2017

NHS
Southampton City
Clinical Commissioning Group

Primary Medical Care Commissioning Committee

Date of meeting	13 June 2017
Agenda Item (number)	**6**

GP Acute Home Visiting Service

Topic Area	General Practice Forward View (GPFV) investments; £3 per head transformation fund over two years.
Summary of paper and key information	An acute visiting service is one of the schemes proposed by a group of Southampton GPs following GP Forum discussions on the GPFV investments and supporting practices to work at scale. A pilot scheme has been co-produced by Southampton City Clinical Commissioning Group and Southampton Primary Care Ltd (SPCL) with a view to proof of concept and testing the impact of such a service on the wider health system. Canvassing by SPCL has shown support for the proposal from practices and other stakeholders. It is proposed to mobilise a pilot service in quarter 2 2017/18 providing 24 GP home visits per weekday across the city. These visits will provide timely assessment and treatment of acutely ill patients, with a view to improving both the patient experience and the flow of activity through other urgent care and support services throughout the day. Funding of £415,000 has been identified in 2017/18 and 2018/19 (£830,000 in total). Subject to approval, contract documentation will be developed including specification and measurable outcomes to inform evaluation.
Key/Contentious issues to be considered and any principal risk(s) relating to this paper (Assurance Framework/Strategic Risk Register reference if appropriate)	• Timely mobilisation. • Sustainability and risk of service closure in 2018/19. • Fit with Integrated Enhanced and Urgent Care from May 2018.

Are there any potential conflicts of interest that the committee need to be aware of?	Need to be mindful of possible links to the Integrated Enhanced and Urgent Care Service which is currently out to procurement.
Please indicate which meetings this document has already been to, plus outcomes	**Primary Care Operational Group – 7 March 2017.** For information and to raise awareness of service options proposed. **Primary Care Operation Group – 6 June 2017.** Recommendation for approval.
HR Implications (if any)	SPCL will be responsible for recruitment.
Financial Implications (if any)	The funding is mandated for the CCG in 2017/18 and 2018/19 via the GPFV. The funding gap in 2018/19 between the full year proposed service cost and the identified GPFV transformation fund is £120,120. This figure could change as the result of recommendations following service review and evaluation. Work is ongoing to identify possible solutions to long term financial sustainability. These could include GP contribution or investment of QIPP savings in secondary care.
Public involvement – activity taken or planned	None at this stage. Patient feedback will be an important part of the evaluation of this pilot.
Equality Impact Assessment required / undertaken	Completed
Report Author (name and job title)	Alison Howett Senior Primary Care Commissioning Manager
Committee Sponsor	Phil Aubrey-Harris Head of Primary care
Date of paper	6 June 2017
Actions requested / Recommendations	The Committee is asked to approve the proposal to pilot a GP acute home visiting service in the city using transformation funds identified in the GP Forward View.

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A proposal for an acute visiting service in primary care

Background

The General Practice Forward View[1] (GPFV) outlined a package of investment in general practice with a view to increasing the proportion of investment going into primary care and securing sustainable GP services. One of the elements of this package was for funding to support practices in redesigning services, including a requirement for Clinical Commissioning Groups (CCGs) to provide transformational support at £3 per registered patient from within its allocation to be spent over a two-year period. This equates to a sum of £415,000 which has been identified for 2017/18 and 2018/19 (£830,000 in total).

The GP Forum in October 2016 focused on the GPFV investments and how the ten high impact changes, highlighting opportunities for practices to work together at scale as part of the Time for Care programme, might be implemented locally. Following the discussion GPs were invited to put forward proposals for investment of the CCG transformation funding. A small group of practices in Central locality worked together to identify possible transformation schemes. One of these was a home visiting service for patients with acute health needs. Southampton Primary Care Ltd (SPCL) has canvassed practices across the city to gauge interest and, on the strength of broad support, drawn up a proposed specification for an acute visiting service (AVS) based on a successful model operating in Portsmouth. The CCG is working closely with SPCL to design and to implement a pilot with a view to evaluation and commissioning of a sustainable service if the pilot is successful. This scheme is intended to support practices in their delivery of home visits and not to replace the practice's own visiting arrangements in their entirety.

Proposed specification

The service will provide four GPs to be deployed across the city with central nursing support supplied via the SPCL hubs as required. The hours of operation will be 10.00-13.00 Monday to Friday. The duty doctor in the practice will assess the need for a home visit and have the option to undertake the visit themselves or pass it to the visiting service. This recognises that some visits will be more appropriately delivered by the practice, e.g. maintaining continuity of care for patients at end of life or where there is a need to co-ordinate integrated community services for a patient with complex co-morbidities. Visit requests will be processed by a visit co-ordinator within the SPCL central hub using a simple electronic template. Requests will be accepted where an outcome is deemed to be achievable within 30 minutes. Exclusions are; children, acute mental health, palliative care or other situations requiring continuity of care.

The acute visiting service (AVS) will provide an average 24 GP home visits per 3-hour session Monday to Friday, across the city, totalling 120 per week (30 minutes each). The AVS staff will have full access to patient records using mobile technology. Staff will use their own vehicles and be reimbursed for business mileage at the current rate. Normal home visiting equipment, medicines and prescriptions will be provided by SPCL. Clinical governance will be managed using existing SPCL policies and protocols.

[1] General Practice Forward View. NHS England. April 2016

Benefits

The duty doctor in a practice operates under extreme pressure and has multiple conflicting priorities to manage within a very limited time. Although patients are asked to request home visits early in the morning, the actual visit often does not happen until much later in the day. The most significant benefit of an efficient AVS will be provision of more timely home visits, enabling treatment plans to be initiated much earlier in the day. Where a hospital admission is indicated, this can be arranged in the morning, improving capacity planning and demand management in other emergency services. This will reduce the strain on ambulance services in the afternoon and improve patient flows through the emergency hospital services.

Earlier interventions will facilitate early assessment, investigation and discharge to an appropriate health professional in the community. The impact on patient experience is expected to be positive as a result of reduced delay, earlier discharge to community services and reduced risk associated with hospitalisation.

There is support for the AVS model from other services. Links with partner organisations are already established and include Community Wellbeing Team, Solent Community Teams (nursing, matrons, COPD, diabetes) and Urgent Response Service (rapid response, rehab and reablement), allowing an integrated approach to home visiting. Example: facilitate evening hospital discharge with arrangements for GP home visit the following morning.

Risks

The AVS is not intended to replace the existing local home visiting arrangements. Demand for the service will be closely monitored to ensure practices have fair and equitable access.

Anecdotal evidence suggests recruitment will not be challenging and existing SPCL staff could be deployed if needed; however this has not yet been fully tested.

Allocation of home visits to the appropriate health professional (GP or ANP) will be key to securing the best outcome for the patient. Each has a specific skill set and manages risk in a different way. Outcomes will be closely monitored to ensure continued effectiveness and SPCL propose a feedback loop to support a suitable learning environment for staff.

Funding is time-limited so sustainability plans are key to longer term provision. An evaluation framework will be developed through collaboration between the CCG and SPCL.

Cost

The budget available totals £830,000 to be deployed over two years; £415,000 in both 2017/18 and 2018/19.

The full year cost of the proposed model provided by SPCL is £535,120 with an additional start-up cost of £16,910.

The options available to provide the pilot within the available financial envelope are:

a. Adapt the model – could dilute the service, therefore compromising a full and thorough evaluation of the pilot.
b. Phase the funding at the start and end of the pilot – preferred option.

Options for tapered funding with emphasis on winter pressures 2017/18 are set out in the illustrative financial profile below. Discussions on picking up the funding in 2018/19 are ongoing.

2017 06 06 AVS financial profile-PCC.x

Timescale

The preference is for phased mobilisation during quarter 2 of 2017/18. It is expected that the service will be fully operational and embedded by the end of quarter 2 to maximise support for winter pressures, allow enough time to fully evaluate the pilot and make plans for sustainability if successful.

Plans are in place to promote the pilot with practices and partner organisations. SPCL are working with the CCG communications team to support this important stage of mobilisation.

Evaluation

Monitoring will be regular and ongoing throughout the pilot period. Suggested indicators (quantitative and qualitative) to support evaluation include:

- Capacity data
- Referral activity by practice/other provider (accepted/rejected/inappropriate)
- Visits completed – incl. response time, post discharge visits to support integrated care pathway
- Non-elective admissions, ED attendances and delayed discharges – comparative data
- Ambulance conveyances and delays – comparative data
- Patient feedback – telephone follow up, comments, compliments, complaints
- Practice experience of using service
- Audit of outcomes – incl. admission with LOS<24hrs and subsequent admission within 24 hrs of visit
- Admissions deemed to be avoided
- Case study examples

NHS
Southampton City
Clinical Commissioning Group

Primary Medical Care Commissioning Committee

Date of meeting	13 June 2017
Agenda Item (number)	**7**

Learning Disabilities Health Checks Directed Enhanced Service

Topic Area	Action plan to improve uptake of the Learning disabilities health check directed enhanced service (LD DES) and improve the quality of health checks delivered.
Summary of paper and key information	The CCG has set a target to complete health checks for 60% of the population with LD by end of March 2018 (DES period 2017-18), with a view to working towards the national target of 90% by 2020. A programme of prioritised planned visits will take place during 2017/18. Published guidance, a toolkit, templates, technical guidance and promotional material is available. Southampton Primary Care Ltd (SPCL) has offered support to practices to deliver the requirements of the DES.
Key/Contentious issues to be considered and any principal risk(s) relating to this paper (Assurance Framework/Strategic Risk Register reference if appropriate)	• Practices engagement with SPCL in supporting the completion of health checks. • Undertaking visits within the timeframe • Addressing any quality concerns arising from the visits • Financial implications as detailed
Are there any potential conflicts of interest that the committee need to be aware of?	None
Please indicate which meetings this document has already been to, plus outcomes	Primary Care Operational Group – 6 June 2017 - agreed to forward to the Primary Medical Care Commissioning Committee for information
HR Implications (if any)	None

Financial Implications (if any)	Total expenditure 2016-17 = £66,352 Estimated expenditure for 2017-18 = £103,040, a variance of £36,688.
Public involvement – activity taken or planned	None at this stage.
Equality Impact Assessment required / undertaken	Not required.
Report Author (name and job title)	Tina Woodcock Primary Care Commissioning Manager
Committee Sponsor	Phil Aubrey-Harris Head of Primary Care
Date of paper	6 June 2017
Actions requested / Recommendations	For information only. Information provided to update the Committee on the action plan to improve uptake of the Learning Disabilities DES and the quality of health checks delivered.

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Clinical Commissioning Group

Learning Disabilities Health Checks DES 2017-18 – Action Plan

Background

The learning disabilities health checks directed enhanced Service (LD DES) is a nationally commissioned service that was first offered in 2012-13, following recognition that this was a cohort of patients who may otherwise go unnoticed by health care providers. We currently have 1,226 patients on the LD register.

Practices must establish and maintain a register of patients aged 14 and over with a learning disability, based on the practice QoF register and any other patients known to Social Services. The scheme requires providers to identify a GP and practice nurse to undertake training on the completion of health checks, followed by inviting the patients to attend and the completion of an action plan in collaboration with the patient. Health checks should be offered and completed on an annual basis for a nationally agreed payment. Templates and communication materials are available for practices.

Southampton City CCG has always been an outlier on collated tables showing uptake, with an initial uptake of 14% in 2012-13 and some practices opting not to offer the service. Over recent years, due to joint working with Southampton City Council and Southern Health NHS Trust, the uptake has increased slightly, although we still remain an outlier.

Southern Health NHS Trust undertook a CQUIN review of LD health checks completed in 2014 in a sample of practices; the disparity in the quality of recording amongst practices raised concerns. Additional supporting materials and training was offered as a result. During 2016-17 a list revalidation exercise was established and completed for all practices.

There is a national target of achieving 90% by 2020. The uptake for 2016-17 showed our highest achievement to date of 47%. We have set a target of 60% by March 2018, with a view of working towards the 90% by 2020. A joint action plan by commissioners has been developed which identifies specific actions for each practice based on their achievement in 2016/17.

In 2012-13 80% of practices participated in the LD health check DES; this rose to 93% in 2016-17.

Action plan

All practices will be visited during the course of the year. The aim of this visit will be to:

- establish their current process
- understand any issues (communication/IT/training etc.)
- review the quality of the health checks to ensure the important information is captured and that any actions identified are followed through
- establish the level of support they require to achieve the increase in uptake

All practices will be sent the revised toolkit and clinical templates and reminded of the required Read codes (new health check code this year).

Southampton Primary Care Ltd (SPCL) has offered to undertake the health checks through sub-contracting arrangements with the practices. It is therefore anticipated that the DES will have 100% coverage in 2017/18. Arrangements are already in place with two practices that have not previously engaged; other practices are offered the same opportunity.

Visits have been prioritised based on the data reported in 2016/17.

Cohort 1 by 31 July 2017 (11 practices)

Cohort 2 by 31 October 2017 (9 Practices)

Cohort 3 by 31 December 2017 (9 practices)

Risks

The funding per health check for 2017-18 has increased from £116 to £140. The increase in fees along with anticipated increase in uptake will impact on the delegated primary care budget. In 2016-17 the total expenditure was £66,352, which equated to 572 health checks (47%). The target of 60% represents 736 health checks and expenditure of £103,040, an increase of £36,688.

There remains a residual risk that practices will choose not to participate or that the annual health checks completed will not meet acceptable quality standards. This risk will be mitigated by constructive and supportive discussions at the visits and close monitoring of uptake throughout the year. It should be noted that this is an annual health check therefore review dates for many of those already completed will not become due until later in the year.

The plan to visit all 29 practices by the end of December 2017 is dependent upon good engagement with the practices and their willingness to schedule the visit. Members of the CCG primary care team have built good relationships with practices and will provide the necessary support to achieve this.

Any quality concerns identified during the visit will be discussed and resolved at the visit where possible. Further follow up, support and ongoing monitoring will be provided as necessary.

NHS
Southampton City
Clinical Commissioning Group

Primary Medical Care Commissioning Committee

Date of meeting	13 June 2017
Agenda Item (number)	**8**

Primary Care Operational Group & Primary Medical Care Committee Terms of Reference

Topic Area	Governance
Summary of paper and key information	The Primary Care Operational Group (PCOG)Terms of Reference have been reviewed by PCOG with a couple of amendments that are in tracked changes for ease. The Primary Medical Care Committee Terms of Reference are here for formal sign off after going to Part 2 of the Primary Medical Care Commissioning Committee last time
Key/Contentious issues to be considered and any principal risk(s) relating to this paper (Assurance Framework/Strategic Risk Register reference if appropriate)	None
Are there any potential conflicts of interest that the committee need to be aware of?	None
Please indicate which meetings this document has already been to, plus outcomes	Primary Care Operational Group
HR Implications (if any)	N/A
Financial Implications (if any)	N/A

Public involvement – activity taken or planned	N/A
Equality Impact Assessment required / undertaken	N/A
Report Author (name and job title)	Rebecca Willis Head of Business
Committee Sponsor	John Richards Chief Executive Officer
Date of paper	30 May 2017
Actions requested / Recommendations	The Committee are asked to ratify both sets of Terms of Reference

NHS
Southampton City
Clinical Commissioning Group

SOUTHAMPTON CITY CCG PRIMARY CARE OPERATIONAL GROUP

TERMS OF REFERENCE

1. INTRODUCTION

1.1 Southampton City Clinical Commissioning Group (CCG) was approved by NHS England for delegated primary care commissioning arrangements from 1 April 2016.

1.2 The Southampton City CCG Primary Medical Care Commissioning Committee (henceforth referred to as 'the Committee') functions as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

1.3 The Primary Care Operational Group has been established as a sub-group of the Committee and will:

- Provide a strategic forum to develop commissioning plans and commissioning opportunities for the development and delivery of high quality local primary care services
- Oversee and co-ordinate the delegated arrangements, ensuring delivery of the delegated functions in line with the statutory framework.
- Manage the day to day business associated with the commissioning and contracting of primary care in line with the statutory framework.

2. STATUTORY FRAMEWORK

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

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

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

a) Management of conflicts of interest (section 14O);
b) Duty to promote the NHS Constitution (section 14P);
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
d) Duty as to improvement in quality of services (section 14R);
e) Duty in relation to quality of primary medical services (section 14S);
f) Duties as to reducing inequalities (section 14T);
g) Duty to promote the involvement of each patient (section 14U);
h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2).

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

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

3. ROLE OF THE PRIMARY CARE OPERATIONAL GROUP

The role of the Primary Care Operational Group is to oversee and co-ordinate the operational delegated arrangements, ensuring delivery of the delegated functions in line with the statutory framework including:

- GMS, PMS and APMS contracts (including Direct Enhanced Services (DESs))
- The review and planning on whether to establish new GP practices (including branch surgeries) in an area for decision/ratification by the Committee;
- Reviewing practice mergers and practice closures and making recommendations to the Committee for approval
- Reviewing variations to Practice boundaries and making recommendations to the Committee
- Management of poorly performing GP Practices, including liaison with CQC
- Premises cost directions functions; premises and strategic estates planning
- Reviewing and making decisions on 'discretionary' payment (e.g., returner/retainer schemes).
- Commissioning urgent primary care for out of area patients
- Developing proposals for new or revised Locally Commissioned Services and Local Improvement Schemes.
- Developing proposals for reinvestment of PMS premium funding released as a consequence of the PMS review process.
- Reviewing data and information in relation to quality of Primary Care with a view to reporting exceptions to the CCG Clinical Governance Committee.
- Ensure meaningful engagement of patients and the public in decision making
- Develop general practice services to ensure continuous quality improvement
- Development of procurement opportunities for Primary Care Services

4. GEOGRAPHICAL COVERAGE

4.1 The Primary Care Operational Group will comprise the area of Southampton City CCG, as defined in the CCG's Constitution.

5. SCOPE OF AUTHORITY AND DECISION-MAKING

5.1 The Group will make decisions and recommendations on proposed developments and investments to the Committee as per the scheme of delegation (see **Appendix 1**).

6. MEMBERSHIP

6.1 The Primary Care Operational Group shall consist of:

Clinical Lead for Primary Care
Head of Primary Care Development
Associate Director of System Delivery
Associate Director from the Integrated Commissioning Unit
Communications Manager and/or Head of Stakeholder Relations and Engagement
Deputy Chief Financial Officer
Associate Director of Quality
Medicines Management Lead
Head of Business
NHS England (Wessex) representative
Wessex LMCs representative
Patient representative

6.2 A suitable Chair and Vice-Chair will be identified from within the membership.

6.3 Other attendees will be invited on an ad hoc basis to provide input and expertise to discussions on specified agenda items.

7. MEETINGS

7.1 The Administration Team will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than five working days before the date of the meeting. When the Chair of the Operational group deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

7.2 Each member of the Primary Care Operational Group shall take part in discussions to make decisions and recommendations to the Committee; the aim of the Primary Care Operational Group will be to achieve consensus recommendations/decisions wherever possible. In the event that a consensus cannot be reached, the matter will be referred to the Committee.

8. QUORUM

8.1 The quorum for a meeting of the Primary Care Operational Group shall be ~~four~~ six members, one of whom will be external to the CCG.

9. FREQUENCY OF MEETINGS

9.1 Meetings will normally be held every month.

9.2 Additional meetings of the Primary Care Operational Group may be held on an exceptional basis at the request of the Chair, supported by any three members of the Group.

10. GENERAL OBLIGATIONS

10.1 Members of the Primary Care Operational Group have a collective responsibility for the operation of the Operational group. They will participate in discussion,

review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

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

10.3 The Primary Care Operational Group may call additional experts to attend meetings on an ad hoc basis to inform discussions.

10.4 Members of the Primary Care Operational Group shall respect confidentiality requirements as set out in the CCG's Constitution and Standing Orders.

10.5 Conflicts of interest (real or perceived) will be managed in accordance with SCCCG Conflict of Interest Policy.

10.6 The Primary Care Operational Group will present its minutes to the Primary Care Commissioning Committee at each meeting for information.

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

10.8 It is envisaged that these Terms of Reference will be reviewed from time to time, reflecting experience of the Group in fulfilling its functions – initially six months and then on an annual basis.

11. ACCOUNTABILITY OF THE OPERATIONAL GROUP

11.1 The Primary Care Operational group is a sub-group of the Primary Care Delegated Commissioning Committee.

11.2 The Group is a decision making forum, making decisions on behalf of the Primary Care Delegated Commissioning Committee in line with the Scheme of Delegation (Appendix A).

12. PROCUREMENT OF AGREED SERVICES

12.1 The detailed arrangements for procurement of agreed services will follow the Standing Financial Instructions and Standing Orders of the Clinical Commissioning Group. These reflect the arrangements within the CCG's constitution and the delegation agreement with NHS England. The Group will adhere to these arrangements. Decisions regarding procurement will not be made by the Group but will be referred to the Primary Care Delegated Commissioning Committee (for final approval).

13. RECOMMENDATIONS

13.1 The Primary Care Operational group will make recommendations to the Committee within the bounds of its remit.

September 2016

Review due: April 2018~~7~~

Appendix 1 – Scheme of Delegation

Scheme of delegation-Primary Ca

NHS
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Clinical Commissioning Group

Primary Care Commissioning Committee
Terms of Reference

Introduction

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

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

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

4. It is a committee comprising representatives of the following organisations:
    - Southampton City CCG
    - Southampton City Council (Health and Wellbeing Board)
    - Southampton City Council (Public Health)
    - Healthwatch, Southampton

Statutory Framework

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

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

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

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

g) Duty to promote the involvement of each patient (section 14U)
h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2).

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

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

9. The Committee is established as a committee of the Board of Southampton City CCG in accordance with Schedule 1A of the "NHS Act".

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

Role of the Committee

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

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

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

14. This includes the following:

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

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

a) To undertake strategic planning, including local needs assessment, of primary medical care services in Southampton,
b) To undertake reviews of primary medical care services in Southampton
c) To co-ordinate a common approach to the commissioning of primary care services;
d) To undertake public engagement and consultation in the development of primary medical services;

e) To assure equitable access to high quality primary medical care that delivers improved outcomes and reduced health inequalities; and
f) To manage the budget for commissioning of primary medical care services in Southampton.

Geographical Coverage

16. The Committee will comprise Southampton City CCG only.

Membership

17. The Committee shall consist of:

- Lay Member for Patient and Public Involvement (Chair)
- Lay Member for Governance/Conflicts of Interest Guardian
- Associate Lay Member (Deputy Chair)
- CCG Accountable Officer or nominated deputy
- CCG Chief Finance Officer or nominated deputy
- CCG Chief Nurse or nominated deputy
- CCG Director of System Delivery or nominated deputy
- Director of Public Health or nominated deputy

The Chair of the Committee shall be the Lay Member for patient and public involvement.

The Vice-Chair of the Committee shall be the Associate Lay Member. However in exceptional circumstances a Chair will be appointed from the membership.

Other non-voting members invited to meetings of the Committee are:

- Clinical Lead for Primary Care
- Head of Primary Care Development
- Practice Manager representative
- A representative from HealthWatch
- A representative of the Southampton Health and Wellbeing Board
- A representative of NHS England

Meetings and Voting

18. The Committee will operate in accordance with the CCG's Standing Orders. The Secretariat to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 7 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

19. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible. In the event of urgent decision making please refer to the urgent decision making process.

Quorum

The Committee will be quorate when 3 voting members, including 1 Lay Member, are present.

Frequency of meetings

20. Meetings in public will normally be bi monthly with a seminar in the intervening months. Additional meetings of the Committee may be held on an exceptional basis at the request of the Chair.

21. Meetings of the Committee shall:
    a) be held in public, subject to the application of 21(b);

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

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

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

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

25. Members of the Committee shall respect confidentiality requirements as set out in the CCG's Constitution.

26. The Committee will present its minutes to Wessex Local Office of NHS England and the Governing Body of Southampton City CCG bi-monthly for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 23 above.

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

28. It is envisaged that these Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions. NHS England may also issue revised model terms of reference from time to time.

Accountability of the Committee

The Primary Care Commissioning Committee is a delegated committee of the Clinical Commissioning Group Board, and its powers are set out in the CCG's Constitution.

For the avoidance of doubt, in the event of any conflict between the terms of this Scheme of Delegation and Terms of Reference and the Standing Orders of Standing Financial Instructions of any of the members, the latter will prevail.

Procurement of Agreed Services

The detailed arrangements for procurement of agreed services will follow the Standing Financial Instructions and Standing Orders of the Clinical Commissioning Group. These reflect the arrangements within the CCG's constitution and the delegation agreement with NHS England. The Committee will adhere to these arrangements.

A register of procurement decisions will be published including details of the decision who was involved in the decision making and a summary of how any conflicts of interest were managed in line with The Procurement, Patient Choice and Competition Regulations.

Decisions

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

30. The decisions of the Committee shall be binding on NHS England and Southampton City CCG.

31. The Committee will produce an executive summary report which will be presented to Wessex Local Office of NHS England and the Governing Body of Southampton City CCG bi-monthly for information.

32. A register of interests and decisions will be published in line with NHS Southampton City CCG Standards of Business Conduct and Managing Conflicts of Interest Policy

Exceptional Circumstances

CCG audit chairs can however serve on the primary care commissioning committee provided appropriate safeguards are put in place to avoid compromising their role as Conflicts of Interest Guardian. Ideally the CCG audit chair would also not serve as vice chair of the primary care commissioning committee. However, if this is required due to specific local circumstances (for example when there is a lack of other suitable candidates for the role), this will need to be clearly recorded and appropriate further safeguards may need to be put in place to maintain integrity of their role as Conflicts of Interest Guardian in circumstances where they chair all or part of any meetings in the absence of the primary care commissioning committee chair.

~~November 2016~~
March 2017

Appendix 1 – Decision Making Processes

Decision Making Processes-FINAL.ppt:

Appendix 2 – Scheme of Delegation

Scheme of delegation-Primary Ca

NHS
Southampton City
Clinical Commissioning Group

Primary Medical Care Commissioning Committee

Date of meeting	13 June 2017
Agenda Item (number)	**9**

Implications of General Medical Services / Primary Medical Services contract changes for 2017-18

Topic Area	Core General Medical Service (GMS) / Primary Medical Services (PMS) contracts changes
Summary of paper and key information	The following paper offers a summary of changes to the GMS / PMS contracts for 2017-18 as negotiated and agreed by the General Practice Council and NHS Employers. The changes were announced in February 2017. The paper is drawn from Wessex Local Medical Committee's website which offers a useful summary of the contract changes and implications
Key/Contentious issues to be considered and any principal risk(s) relating to this paper (Assurance Framework/Strategic Risk Register reference if appropriate)	Removal of Avoiding Unplanned Admissions Directed Enhanced Service and incorporation of frailty aspects in core contract
Are there any potential conflicts of interest that the committee need to be aware of?	None
Please indicate which meetings this document has already been to, plus outcomes	None
HR Implications (if any)	None

Financial Implications (if any)	Changes are accommodated for 17/18 with allocation uplift. As per previous discussion at Primary Medical Commissioning Committee Seminar, May 2017 – paper previously circulated embedded below:  ITEM 2.1_ Delegated Primary Medical Comm
Public involvement – activity taken or planned	None by CCG
Equality Impact Assessment required / undertaken	Not undertaken
Report Author (name and job title)	Phil Aubrey-Harris Head of Primary Care
Committee Sponsor	Phil Aubrey-Harris Head of Primary Care
Date of paper	25 May 2017
Actions requested / Recommendations	The committee is asked to note the contract changes

Changes to GMS and PMS contracts for 2017-18

This paper is drawn from Wessex LMC Website and offers a useful summary of contract changes. Note figures quoted are at national level. The text should be credited to Wessex LMCs and their perspectives on each component have been left in to offer a useful primary care perspective.

Changes to investments for 2017/8

The estimated £238.7 million investment into the contract nationally for 2017/18 covers a number of elements, including:

Global sum

- An increase to the global sum for all practices to account for expenses and to result in an intended 1% pay uplift for GPs and practice staff
- £3.8m to cover increased superannuation costs of 0.08% pension admin charges
- £5 million to cover workload associated with the overseas visitors administration changes
- £1.5 million to cover workload involved in completion of the workforce survey
- £2 million to cover increased workload for bagging/labelling of records as a result of changes to the Primary Care Support England Service
- An estimated cost of £58.9 million to cover the increase in population growth

In addition global sum will increase as a result of further recycling of correction factor and seniority funding

Directly reimbursed to practices

- £22.5 million to reimburse full CQC fees
- £1 million to cover costs for those practices subject to Business Improvement District levies

Paid through SFE

- £30 million to cover increases in GP indemnity costs
- £6.2 million to include morbidly obese in eligible cohort for influenza vaccinations
- Estimated £8 million to cover increases in payments for locum reimbursement to cover maternity and sickness leave
- £1 million for the new GP retainer scheme

Avoiding Unplanned Admissions (AUA) a DES

This will be discontinued on 31st March 2017 and the funding for this (about £157m) will be added to the global sum. Practices will be expected to focus more on managing patients who are identified as living with severe frailty. There will not be any claim forms to complete as this will now form part of the practices core funding.

In place of the AUA DES, practices should focus on providing clinically appropriate care to a much more limited group of patients of 65 years and over who are living with severe frailty. Practices will need to use an appropriate tool of their choosing, for example the Electronic Frailty Index (eFI) to identify patients who are living with moderate or severe frailty. For those patients identified as living with severe frailty, the practice will deliver a clinical review providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions.

In addition, where a patient does not already have an enriched Summary Care Record (SCR) the practice will promote this seeking informed patient consent to activate the enriched SCR.

NHS England will collect data on these patients. This data will not be used for performance management in any way. There is no requirement to record patients with moderate frailty but where this is done this data will be collected.

The key element to this is that practices are able to apply their own clinical judgment in the management of this group of patients with significant clinical needs.

CQC fees

It is true to say that CQC has not been the most popular initiative that has been imposed on general practice but what has caused widespread outrage has been the proposal to increase the fees for CQC by 7 fold. From April 2017 there will be full reimbursement of practices' total CQC fees.

Indemnity fee rises

An additional £30m will be added to practice budgets based on a per patient basis and not weighted. This is intended to cover the increase in indemnity costs for all GPs working in the practice including salaried GPs.

Expenses and Pay uplift

The agreed expenses uplift is expected to provide a pay uplift if 1% which is in line with the public sector pay increases for 2017/8. An amount will be added to the global sum to deliver this. There will be £2m added to the global sum to take account of the additional work undertaken by practices relating to record transfer by the primary care support services provide by Capita. There has been much publicity about the additional costs to the employer in relation to teh NHS Superannuation which although is only 0.08% amounts to a cost pressure of £3.8m across England and this sum will also be added to the global sum. Most practices currently contribute on a voluntary basis to the workforce census, this will now become a contractual requirement and to fund this an additional £1.5m will be added to the global sum.

Sickness reimbursement

This will no longer be discretionary but will become a practice entitlement. The qualifying criteria based on list size, which has often prevented practices being able to claim a payment to cover locum costs will be removed. Payment will commence after 2 weeks absence. GPs within the existing practice can provide cover. So this now mirrors existing maternity cover arrangements.

The amount payable will be up to £1734.18 per week again in line with current maternity cover arrangements. This should reduce the need and costs of locum insurance and help meet the costs of salaried GPs sickness cover.

Maternity reimbursement

This will no longer be pro rata reimbursement. Practices will only need to submit an invoice and they will receive either the full amount or the maximum payable sum.

Learning disability DES

The payment is to undertake an annual health check for this vulnerable group. The fee increases from £116 to £140. It is hoped the uptake will increase.

Extended hours DES

You will have all read the headlines about the practices that close for 1/2 a day a week yet get paid extra to open in the evening and weekends. We apparently have 4 in Wessex and on further investigation the majority are not practices who have closed for a 1/2 day but practices who work from 23 sites where one site is closed for 1/2 a day and full access to services is delivered from the other site.

New conditions will be put in place that will mean practices who regularly close for 1/2 a day per week, will not ordinarily qualify to provide the DES (exception as will be branch sites). This will be implemented in October 2017.

Access to healthcare

As part of the agreement last year to take this forward, the GPC has agreed to help identify patients with a non-UK EHIC (European Health Insurance Card) or S1 form. This will allow the NHS to claim back fees for hospital based care from the countries or origin where the UK has reciprocal arrangements. Patients will not be charged themselves. An additional £5m will be added to the global sum recurrently to support this contract change. New patients will be asked to self declare whether they hold a non-UK issued EHIC or a S1 form on a revised GMS1 form, his information will be added to the patient's medical record and a copy of the form and supplementary questions will be sent to NHS digital.

GP retainer scheme

There is a new and improved retainer scheme which will commence in April. The aim will be retain GPs especially those towards the end of their career.

Retired QoF Indicators

The LMC has supported the GPC and asked practices to continue to provide this data, accepting that it will have limited value as practices will only code information that has clinical value. The vast majority of practices in Wessex have supported this approach. The provision of this data will now become a contractual requirement.

Practices will not be assessed against these indicators or retired enhanced services in any way.

Registration of former prisoners

It is planned to improve the communication between prisons and practices to enable an earlier transfer of clinical information about a registering patient. This should improve the initial management of these patients when they first present to the practice, as they practice should know what they have previously been prescribed and treated for whilst in prison.

Business Improvement District Levy

Some local councils have imposed a local levy on all businesses in their area, called the business improvement district levy. Practices in these areas have been required to pay this. From April 2017 practices will be able to claim a reimbursement for the payments that they make.