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NHS
Stockport
Clinical Commissioning Group

Primary Care Commissioning Committee
Agenda

Date of Meeting:	**16 November 2016**	**Time**	**From**	**To**
			2.30pm	**4.30pm**
Venue:	**Boardroom, Regent House, Heaton Lane, Stockport**			
Attendees:	**Jane Crombleholme (Lay Member with responsibility for Patient and Public Participation)** **Christine Morgan (Lay Member for Primary Care Commissioning)** **Anita Rolfe (Executive Nurse)** **Gaynor Mullins (Chief Operating Officer)** **Mark Chidgey (Chief Finance Officer)** **Adam Firth (Locality Committee Representative)** **Vicci Owen-Smith (Clinical Director Public Health)** **Ranjit Gill (Chief Clinical Officer)** **Invitees in attendance: NHS England, Stockport Healthwatch, Stockport Council**			

*This meeting will be held in public. To register to attend please contact 0161 426 9900 or email ccg.reception@nhs.net

Item No.	Agenda Item	Format	Papers	Action required	Lead	Time
Meeting Governance						
1.	Apologies	Verbal	N/A	To receive and note	JC	2.30pm
2.	Declarations of Interest	Verbal	N/A	To receive and note		
3.	Approval of the Minutes of the Meeting held 2 November 2016	Minutes	Attached	To approve	JC	
4.	Actions Arising	Action Log	Attached	To receive and note	JC	
5.	Notifications of items for any other business	Verbal	N/A	To receive and note	JC	
Items of Business						
6.	Quality Update (Including Care Quality Commission Update)	Report	Attached	To consider and discuss	RR	2.40pm
7.	Terms of Reference	Report	Attached	To review and recommend	LL	3.10pm

				approval to Governing Body		
8.	Dr Lloyd – Practice Boundary Change	Report	Attached	To determine	AG	3.20pm
9.	General Practice Safeguarding Compliance	Report	Attached	To discuss	SG	3.40pm
Any Other Business						
10.	Any other business as raised in item 5.	Verbal	N/A	To receive and discuss	JC	4.00pm
Meeting Governance						
11.	**Date, time and venue of next meeting** The next meeting of the Primary Care Commissioning Committee will be held on: 4 January 2017					

NHS
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Primary Care Co-commissioning Committee
MINUTES of the meeting held on Wednesday 2 November 2016
1.00pm – 2.00pm
Boardroom, Regent House, Stockport

Present:

Jane Crombleholme, Lay Member, Chair of NHS Stockport CCG Governing Body **(Chair)**	(JC)
Christine Morgan, Lay Member Primary Care Commissioning	(CM)
Anita Rolfe, Executive Nurse	(AR)
Mark Chidgey, Chief Finance Officer	(MC)
Dr Peter Carne	(PC)

In attendance:

Cllr Tom McGee, SMBC	(JP)
Roger Roberts, Director of General Practice Development, NHS Stockport CCG	(RR)
Laura Latham, Board Secretary and Head of Governance, NHS Stockport CCG	(LL)
David Kirk, Stockport Healthwatch	(DK)
Cath Comley, Area Business Manager, NHS Stockport CCG	(CC)

MEETING GOVERNANCE	
1. Apologies	**Action**
Apologies were received from Ranjit Gill, Gaynor Mullins, Adam Firth and Vicci Owen Smith	**N/A**
1. Declarations of Interest	**Action**
Dr P Carne requested that it be noted that with regard to Item 6 that he was a General Practitioner at a Stockport based practice. He would however not be impacted on by the proposal for the Haider Medical Practice. The Chair agreed that he could remain present in the meeting.	**N/A**
3. Approval of the Minutes of the Meeting held on 7 September 2016	
The minutes of the Meeting held on 7 September 2016 were approved as an accurate record subject to the title of the Practice being changed in Item 6 to read 'Cheadle Hulme and Bridge House' not the Seabrook Practice.	
4. Actions Arising	
There were no actions arising.	
5. Notifications of items for any other business	
There were none on this occasion.	
6. Options Paper – Haider Medical Centre	

R Roberts presented an overview of the paper which had been circulated to members for initial views prior to inclusion in the agenda. He explained the context in which the Practice had been operating and the options which existed to procure a new provider or disperse the patient list across existing practices. The dispersal could take one of two forms which included advertising the dispersal with the required information about re-registering or advertise and include named practices which had indicated willingness to take on more patients. The second option was noted to the preferred option in the paper. He explained that the Local Medical Committee (LMC) had responded without support for any option, noting that timescales proposed were too short to manage a dispersal. The LMC's view had been that patients should be allocated a practice and provided with information about how to re-register if they wished to exercise their right to patient choice at that point. NHS England had confirmed that the proposal did not meet requirements regarding patient choice and therefore should not be pursued. • A Rolfe joins the meeting. M Chidgey clarified the practice list size as compared to the average practice in Stockport noting that the list of 1600 would be practicable for dispersal purposes. R Roberts noted that if the procurement option was pursued, there were no suitable premises from which to operate given the current premises state of repair. It was confirmed that the 3 month notice period had been adhered to. **Resolved:** That: 1. Option 2 as outlined in the report be approved.	
7. Any Other Business	
There was none on this occasion.	
8. Date and Time of Next Meeting	
The next meeting of the Primary Care Commissioning Committee will be held on 16 November 2016.	

(The meeting ended at 09.35am)

NHS
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Clinical Commissioning Group

Primary Care Quality Report

Report of the activity of the Primary Care Quality Group

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group

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Regent House

Heaton Lane

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Primary Care Quality Committee Report

1. Updates

1.1. There were two practices that were the subject of much discussion at the quality committee

1.2. Dr Sharma

1.2.1. This practice had received a CQC report indicating that it was inadequate. This had been followed up with contractual notices to improve. Dr Sharma the contract holder was also not on the performers list and therefore not able to deliver general practice services himself.

1.2.2. After much negotiation and getting to the point of serving notice to close the practice on a couple of occasions Dr Sharma agreed to take Dr Dawson into his partnership with the aim that the Dawson partnership would take over the running of the practice. Papers were served to make this a reality on 30th September and the new partnership came into force from the 1st November. From the point of serving papers to vary the partnership the Dawson practice effectively took over running the practice and put in doctor and nurse time to actively catch up with the work required to achieve QOF. Dr Sharma remains a partner and will attend his appeal to join the performers list in November and will come off the partnership at the end of November. At this time we expect a request for the Dawson practice to merge the Sharma practice into the main Heaton Moor contract. We have been asked to prepare the IT elements of this in advance to support this change.

1.3. Dr Lloyd

1.3.1. Dr Lloyd had been a single handed practitioner at Cedar House and went onto the contract with Dr Rafique at Haider medical practice, also a single handed practitioner, who went on to Dr Lloyds contract. Thus both contracts were in the names of both partners. Subsequently Dr Rafique left both partnerships and Dr Lloyd was left as a single handed practitioner with two contracts. The last meeting considered a merger of the contracts and did not support this. Following news of this Dr Lloyd decided to resign from the Haider contract but keep the Cedar House contract. At the extra meeting on 2nd November this was discussed and it was agreed that due to the size of the list and the lack of a satisfactory building from which to practice the list would be dispersed closing on 31st December.

1.3.2. The Quality Group discussed the situation. There had been negotiation to extend the time to get the closure delayed after the Christmas break but this had been unsuccessful. It was decided not to take this further as time was running out. The groups of patients who were most vulnerable were identified

and ways of ensuring that they are priority for re-registration discussed. It was agreed that an accelerated decision process to agree dispersal or re-procurement was required in advance of the next meeting on 16th November given that Christmas was also part of this time scale.

2. New Practices for review

2.1. As noted in the last report a further two practices were reviewed in the light of the QOF performance for 2015/16. One of these had a 'requires improvement' CQC report early in this round of visits and the CCG has been working with them since this time. The practice has taken on additional managerial support to address some of the issues raised. The usual review was undertaken and the clinical performance looked at through finger tips a public health information tool. The conclusion was that the issues in this practice are not clinical but managerial/ organisational and as such the additional managerial capacity should assist in this area. The committee was assured that there were no further requirements here other than a watching brief to ensure that the changes seen were maintained.

2.2. The other practice also received a CQC 'requires improvement' report. In this practice the clinical data was not so good. There have been a number of other concerns in this practice over the last few months. There was a suggestion that the partners were going to resign from the practice. There is another practice in the same building and informal discussions were held with them about the process should the partners decide to resign. No papers have been served to indicate a formal decision.

3. Concerns and Issues

3.1. We have a two partner practice currently running as single handed due to a partner resigning. The remaining partner suffered an unexpected bereavement. The support possible in this situation was discussed. There are additional issues with the practice and relationships with the care home it supports. The business manager and GP working with the team are supporting this practice.

3.2. Safeguarding compliance was discussed as a concern but is the subject of a separate paper on this agenda.

4. CQC update

4.1. The CQC report update is attached and the new requires improvement practice is discussed above being the practice with the potential for a merger with the practice in the same building.

4.2. It is known that the CQC team has been increased in November in Stockport and there will be a lot of visits undertaken. Their aim is to get all practices visited before the end of the year.

CQC Reports published

Practice	Date published	Safety	Efficiency	Caring	Responsive	Well led	Overall
Dr Azmy	29/10/2015	Good	Good	Outstanding	Good	Good	Good
Marple Medical Practice	12/11/2015	Good	Good	Good	Good	Good	Good
Bredbury Medical Practice	12/11/2015	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Marple Bridge	12/11/2015	Good	Good	Good	Good	Good	Good
Dr Gupta	19/11/2015	Good	Good	Good	Good	Good	Good
Gatley Medical Centre	26/11/2015	Good	Good	Good	Good	Good	Good
Marple Cottage	16/03/2016	Good	Outstanding	Good	Outstanding	Outstanding	Outstanding
Stockport Medical group	18/03/2016	Good	Good	Good	Good	Good	Good
Bramhall Park Medical Centre	05/04/2016	Good	Good	Good	Good	Good	Good
Dr Sharma	13/04/2016	Inadequate	Inadequate	Good	Requires Improvement	Inadequate	**Inadequate & Special measures**
Cale Green	16/04/2016	Requires Improvement	Good	Good	Good	Good	Good
Dr Raina Patel	02/06/2016	Requires Improvement	Outstanding	Good	Good	Good	Good
Archwood Medical Practice	30/06/2016	Good	Good	Good	Good	Good	Good
Dr Hazem Lloyd	07/07/2016	Requires Improvement	Good	Good	Good	Good	Good
Dr Raina Patel	04/08/2016	Good	Outstanding	Good	Good	Good	Good
Cheadle Medical Practice	21/08/2016	Good	Good	Good	Outstanding	Good	Good

Practice	Date published	Safety	Efficiency	Caring	Responsive	Well led	Overall
Dr Rachel Tomalin	11/09/2016	Good	Good	Good	Good	Good	Good
Alvanley Family Practice	11/09/2016	Good	Good	Good	Good	Good	Good
Heaton Norris Health Centre 2	20/09/2016	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Adswood Road Surgery	06/10/2016	Good	Good	Good	Good	Good	Good
Park View Group Practice	07/10/2016	Good	Good	Good	Good	Good	Good
Chadsfield Medical Practice	08/10/2016	Good	Good	Outstanding	Good	Good	Good

Terms of reference – NHS Stockport CCG Primary Care Commissioning Committee

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 NHS Stockport CCG. The delegation is set out in Schedule 1.

3. The CCG has established the NHS Stockport 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:
   - NHS Stockport Clinical Commissioning Group
   - Stockport Healthwatch -non-voting
   - Stockport Metropolitan Borough Council (via Health and Wellbeing Board) – non voting
   - NHS England – non voting

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 in accordance with the relevant provisions of section 13 of the NHS Act

   - 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 Governing Body of NHS Stockport 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 and procurement of primary care services in Stockport, 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 NHS Stockport CCG, which will sit alongside the delegation and terms of reference.

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

14. 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.

15. 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).

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

a) To plan, including needs assessment, primary [medical] care services in Stockport

b) To undertake reviews of primary [medical] care services in Stockport

c) To co-ordinate a common approach to the commissioning of primary care services generally;

d) To manage the budget for commissioning of primary [medical] care services in Stockport

e) To coordinate and oversee a common approach to the management of primary care estates

Geographical Coverage

17. The Committee will comprise the area covered by NHS Stockport CCG as defined within its Constitution.

Membership

18. The Committee shall consist of:

- The Lay Member with responsibility for Patient and Public Participation
- ~~A Lay member specifically recruited to the Committee~~The Lay Member for Primary Care
- The Nurse Member of the Governing Body
- The Chief Operating Officer
- The Chief Finance Officer
- A Locality Council Committee Chair or Vice-chair
- Deputy Director of Public Health
- Chief Clinical Officer
- Clinical Director General Practice Development

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19. The Chair of the Committee shall be the Lay Member ~~with responsibility for Patient and Public Participation~~for Primary Care

20. The Vice Chair of the Committee shall be the Lay Member ~~specifically recruited to the Committee.~~ With responsibility for Patient and Public Participation.

21. **The following will have a standing invitation to attend the meetings of this Committee in a non-voting capacity:**

- A Representative of the Stockport HealthWatch

- A Representative of the Stockport Health and Wellbeing Board on behalf the Local Authority
- A representative of NHS England

Meetings and Voting

22. The Committee will operate in accordance with the CCG's Standing Orders. The Board Secretary and Head of Governance 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.

~~22.~~23. GPs appointed to the Committee should not have voting rights in order to ensure conflicts of interest are managed effectively. This does not preclude GPs on the Committee from taking part in strategic discussions on primary care provided that conflicts of interest are appropriately managed.

24. Each remaining 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 casting vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

~~23.~~25. Where an urgent decision is required the provisions existing within the Constitution will be applied in order to discharge the functions of the Committee.

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Quorum

24.The quorum for the Committee shall be one third of the Committee Membership and must include one Lay Member and one Clinical Member of the Committee.

25. If the meeting is not quorate within thirty minutes of its planned start, the Chair of the meeting must decide to adjourn the meeting or to proceed and ensure all decisions are ratified at the next meeting.

Frequency of meetings

26. The Committee shall meet no less than four times a year. A meeting of the Committee can be called by any member in liaison with the Chair, with seven days' notice given. Papers will be distributed to members no later than seven days before the meeting.

27.Meetings of the Committee shall:

a) be held in public, subject to the application of 23(b);

b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the

Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

28. 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.

29. 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..

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

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

32. The Committee will present its minutes to the Greater Manchester Area Team of NHS England and report to the governing body of NHS Stockport CCG each month quarterly for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 27 above.

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

34. 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

35. The membership of the CCG has established a Governing Body in order to discharge its statutory functions. The Committee is accountable to the Governing Body. Membership of the Governing Body is representative of the membership through the elected Locality Chairs and through the appointment of Clinical Executive Directors and the Accountable Officer.

36. Appropriate consultation with patients and the general public is undertaken through the CCG's Patient Panel and in line with the national and locally adopted guidance

Procurement of Agreed Services

37. The CCG will make procurement decisions as relevant to the exercise of its delegated authority and in accordance with the detailed arrangements regarding procurement set out in the delegation agreement.

Decisions

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

39.The decisions of the Committee shall be binding on NHS England and NHS Stockport CCG.

40.The Committee will produce an executive summary report which will be presented to the Greater Manchester Team of NHS England and the governing body of NHS Stockport CCG quarterly for information.

Schedule 1 – Delegation as listed within the Body of the Terms of Reference

Schedule 2 - List of Members as included in the Body of the Terms of Reference.

NHS
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Report to: **NHS Stockport Primary Care Commissioning Committee**

Report from:

Date: **9th November 2016**

Subject: **Application to increase Practice Boundary (Y00912) Dr H Lloyd, Cedar House - Stockport**

Introduction

The purpose of this paper is to inform the Primary Care Commissioning Committee (PCCC) of an application received from Dr H Lloyd, Cedar House in Stockport to extend his practice boundary to include part of the catchment area at the Haider Medical Centre.

The PCCC is asked to consider all the information contained within this a paper and to reach a decision to accept or reject the application.

Background

On 19th September 2016, Dr Lloyd who is a single handed practitioner served notice in writing of his intention to terminate his GMS contract at the Haider Medical Centre with effect from 31st December 2016. Dr Lloyd has experienced difficulty in sustaining services across the two contracts for which he is sole provider (Cedar House and Haider Medical Centre) and due to issues relating to recruitment of an additional partner/salaried doctor and CQC registration of the premises the decision was taken to resign from the Haider Medical Centre contract.

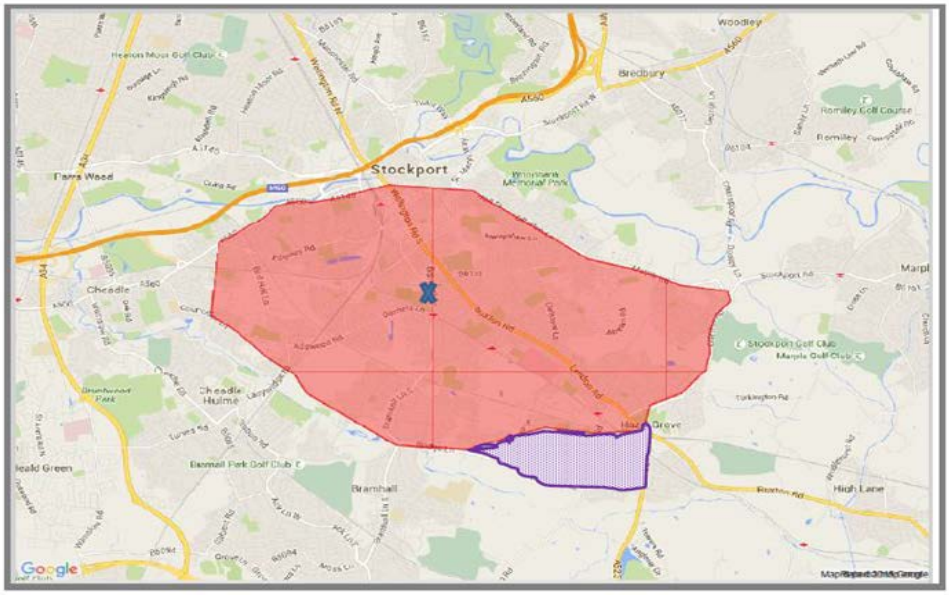
During subsequent discussions with the CCG Dr Lloyd indicated that he wished to continue to provide services to the patients currently registered with him at the Haider Medical Centre. The proposal to extend the practice boundary of Cedar House would allow patients to move to that practice and remain registered with Dr Lloyd should they choose.

Practice Application to extend Practice Boundary

Practice Application - Oct 16.docx

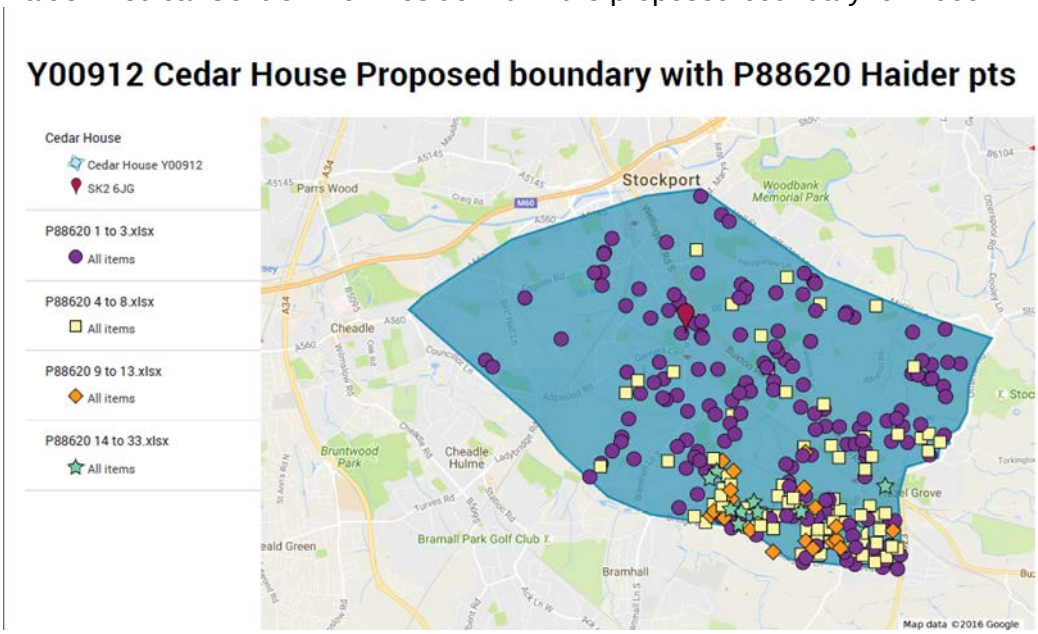
Proposed Changes to the existing boundary

Cedar House Surgery – Proposed Boundary Amendment – October 2016
Current Boundary (Red) Proposed Boundary Extension – (Purple)



Y00912 - Cedar House proposed boundary with P88620 - Haider Medical Centre patients

Map below shows the patients plotted by postcode. These patients are the patients from P88620 - Haider Medical Centre whom reside within the proposed boundary for Y00912 - Cedar House

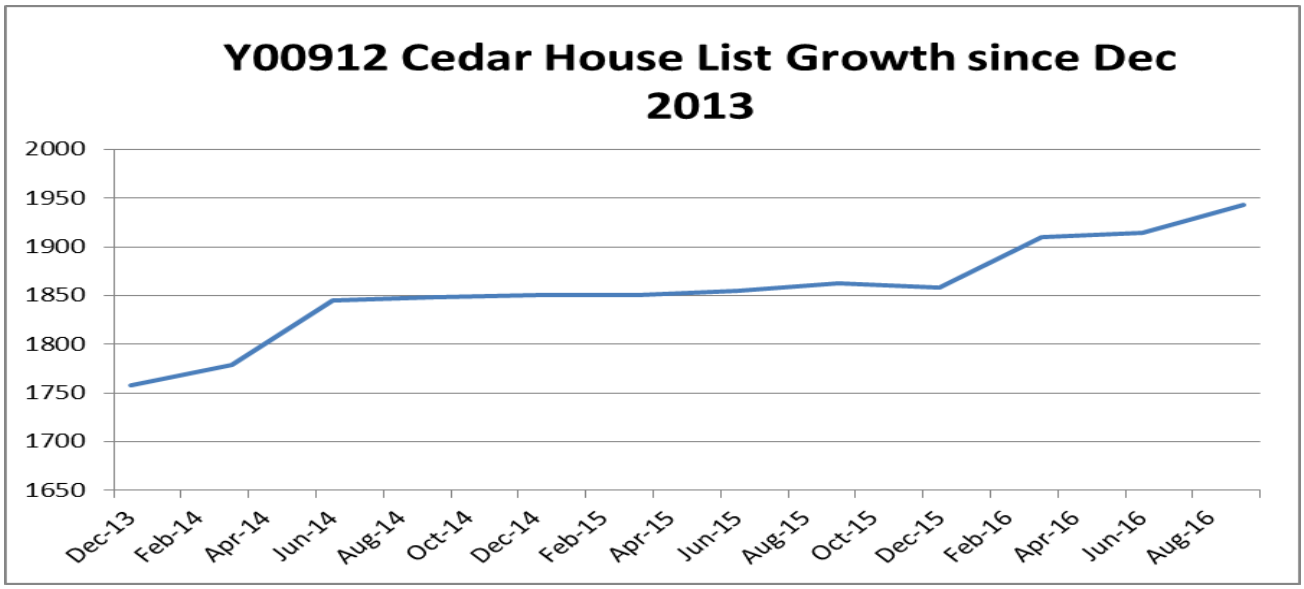


Surrounding Practice Boundaries

Cedar House Y00912 with surrounding Prac

Supporting Data

The Cedar House premises are situated in the Davenport area of Stockport and services are delivered via a GMS contract (1.00 FTE). The practice list size has increased from 1,758 in December 2013 to 1,943 patients September 2016 an increase of 185 patients (10.52%). The patient/GP ratio for the practice is 1858 per FTE; the average patient/GP ratio in Stockport is 1976 per FTE.



FTE to Practice List – comparison

Practice Code	List Size	FTE	List per FTE	Distance from practice
P88016	14165	10.05	1409	1.3 miles
P88026	12906	10.75	1201	2.4 miles
P88632	12557	5.52	2275	1.2 miles
P88013	13608	4.69	2901	0.8 miles
P88012	8508	4.25	2002	1.8 miles
P88615	1554	1	1554	1.8 miles

Stakeholder Engagement

The Local Medical Committee's (LMC), Healthwatch and neighbouring practices were contacted for their comments.

Date Response received back	Response received back from	Comments / Views
1.11.16	Jane Whitworth ~ Practice Manager – Stockport Medical Group, Stockport CCG	I confirm our practice has no objection to the proposed Cedar House increase in boundary.
2.11.16	Gavin Owen ~ Senior Officer – Healthwatch Stockport	I had exchanged a couple of emails with the CCG about this and Healthwatch has no comment to make on the proposed boundary increase. Healthwatch understands the boundary increase is to make it easier for Dr Lloyd's patients from Haider GP to transfer to Cedar House.
3.11.16	Gill Eggleston ~ Practice Manager – Dial House Medical Centre, Stockport CCG	I can confirm that we have no objections to Dr Lloyd increasing his boundary.
3.11.16	Paula Trow ~ Practice Manager – Beech House Medical Practice	We don't have a problem with this boundary extension.
3.11.16	Paul Stevens ~ Stockport LMC	The extension would appear to be a minor addition to what is already a large practice area. Provided the practice believes they can provide appropriate GMS services to patients from this additional area the LMC has no objections to the proposal.
3.11.16	Doreen Henbrey ~ Practice Manager – Vernon Park Surgery, Stockport CCG	I see no reason why this should cause any issues
4.11.16	Ian Stanyer ~ Practice Manager – Heaton Moor Medical Centre, Stockport CCG	The proposed area if fine with us
4.11.16	Kath Wilkinson ~ Practice Manager - Bramhall Park Medical Centre, Stockport CCG	no objections to Dr Lloyds's plans

Options for the Committee

1. Accept the extension to the Boundary as proposed

    - Accept the extension of the additional area to support capacity and reduce pressure on neighbouring practices and also provide patients that are currently registered with Dr Lloyd at Haider Medical Centre with the option of remaining registered with him (should they wish to do so) at Cedar House Surgery in Davenport.

2. Reject the application

    Reject the application on the grounds that Dr Lloyd's capacity may not be appropriate to manage an increase in patients at Cedar House Surgery in Davenport or that the committee believe he could not provide GMS services to the full area.

    The practice has a right to appeal within 28 days; if local resolution cannot be reached the NHS dispute resolution procedure must be followed. The practice can make a further application after 3 months, starting on the date of the committee's decision to reject the application, or the final determination following dispute resolution.

Recommendation

To approve the extension to the Boundary as proposed for the reasons outlined above. This supports patients choice and allows patients currently receiving care from Dr Lloyd to continue to be registered with him, if this is their wish.

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General Practice and Safeguarding

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

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Executive Summary

This briefing has been prepared for the Primary Care Commissioning Committee as a recommended action from the Quality Committee October 2016.

Context

NHS Stockport CCG assumed delegated commissioning status for general practice in April 2016:

Safeguarding Vulnerable People in the NHS – Accountability and Assurance 2015

Under delegated arrangements, CCGs will be responsible for ensuring that the GP services commissioned have effective safeguarding arrangements and are compliant with the MCA. NHS England will require assurance that such arrangements are in place …. Page 25.

CCGs must gain assurance from all commissioned services, both NHS and independent healthcare providers – page 21.

To fulfil this requirement, a self-assessment audit tool was devised by the Named GP, Dr James Higgins, based on the CCG tool completed by all CCG contracted services and CQC registration requirements and sent to all GP Safeguarding Leads, copied to practice managers with a covering letter. The tool had previously been discussed at the GP Safeguarding Leads briefing and no objections were raised. The team were really disappointed with the responses, less than 10. The deadline for completion has now passed. There has been no follow up requests as it was felt that a clear positional statement from the CCG was required.

The following quotes from parliamentary acts, statutory guidance, professional bodies under pins the CCG's responsibility to ask for this assurance:

Safeguarding Adults – The Role of NHS Commissioners 2011.

The role of the CQC complements that of commissioners in relation to safeguarding but does **not** replace it.

Section 11 Children Act 2004

Places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

This section goes on to outline specific duties for organisations including NHS organisations and CCGs

Working Together to Safeguarding Children March 2015 – Statutory Guidance

CCGs are the major commissioners of local health services and are responsible for safeguarding quality assurance through contractual arrangements with all provider organisations.

Role of the GP

GMC Guidance 2012 Protecting Children and Young People

Clarifies the responsibilities of all doctors

The RCGP/NSPCC Safeguarding Children Toolkit for General Practice 2014

GPs are, as independent contractors in the NHS, subject to the statutory duties under the Children Act 1989, 2004 to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

Care Act 2014 updated 2016

Adult safeguarding is about people and organisations working together.

Section 14.9
Safeguarding is not a substitute for commissioners regularly assuring themselves of the safety and effectiveness of commissioned services.

Section 14.36
GPs are often well placed to notice changes in an adult that may indicate they are being abused or neglected.

The RCGP has endorsed a Children, Looked After Children and Adult documents that clearly identify the role and competencies expected of health care staff, including staff in primary care, in safeguarding.

Conclusion

The above references are a selection of parliamentary acts, statutory guidance, professional cumcula expectations and good practice that clearly identifies the role of the commissioner and the duties of general practice. As a CCG we are:

- Delegated commissioners
- We hold a general practice development contract with our GPs in addition to their standard GMS contract, both which contain a safeguarding section.

Currently the CCG has very limited assurance that the practices within Stockport have effective safeguarding arrangements and are compliant with the MCA, as the majority of practices have yet to engage fully with the CCG safeguarding team to provide this assurance.

Additional Information

1. Two practices were identified by the CQC on initial visits as not having effective safeguarding arrangements in place.
2. Audit evidence provided by the local authority safeguarding children's unit identifies that a significant number of GPs do not respond to requests for information or attendance at initial child protection case conferences – CQC made a recommendation to the CCG to address this issue but despite a number of approaches this has not been achieved.
3. As a benchmark a similar tool was issued by the Named GP in Wigan and with the exception of one practice, returned the completed tool at the first request. Salford have had similar success.

Action Required

1. For the committee to accept and discuss the contents of this briefing.
2. For the committee to agree a CCG positional statement in respect to safeguarding assurance from General Practices i.e.:
   a) The CCG will support the team in pursuing this information
   b) The CCG accepts the risk of not having this assurance.

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