## AGENDA

<table>
<thead>
<tr>
<th>Ref</th>
<th>Item</th>
<th>Enclosure</th>
<th>Led By</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Apologies for Absence</td>
<td>Verbal</td>
<td>Chair</td>
<td>Noting</td>
</tr>
<tr>
<td>2.</td>
<td>Declarations of Interest</td>
<td>Verbal</td>
<td>Chair</td>
<td>Consider / Discuss</td>
</tr>
<tr>
<td>3.</td>
<td>Notification of Any Other Business</td>
<td>Verbal</td>
<td>Chair</td>
<td>Noting</td>
</tr>
<tr>
<td>4.</td>
<td>Minutes of the meeting held on 14 November 2019</td>
<td>Enc A</td>
<td>Chair</td>
<td>Approval</td>
</tr>
<tr>
<td>5.</td>
<td>Matters Arising not on the Agenda</td>
<td>Verbal</td>
<td>Chair</td>
<td>Consider / Discuss</td>
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<tr>
<td>6.</td>
<td>Action Tracker</td>
<td>Enc B</td>
<td>Chair</td>
<td>Consider / Discuss</td>
</tr>
<tr>
<td>7.</td>
<td>Finance &amp; Contracting:</td>
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<tr>
<td>7.1</td>
<td>Interim Exception Report</td>
<td>Verbal</td>
<td>Mrs Tingle</td>
<td>Noting</td>
</tr>
<tr>
<td>7.2</td>
<td>Estates Update</td>
<td>Enc C</td>
<td>Mrs Ogle</td>
<td>Noting</td>
</tr>
<tr>
<td>7.3</td>
<td>Primary Care Delivery Group – Merger Workshop</td>
<td>Enc D</td>
<td>Mrs Ogle/Mr Roberts</td>
<td>Noting</td>
</tr>
<tr>
<td>8.</td>
<td>Quality:</td>
<td></td>
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<tr>
<td>8.1</td>
<td>Interim Exception Report</td>
<td>Verbal</td>
<td>Mrs Ibbeson</td>
<td>Consider / Discuss</td>
</tr>
<tr>
<td>8.2</td>
<td>General Practice Nurse Development Strategy Action Plan</td>
<td>Enc E</td>
<td>Mrs Head</td>
<td>Consider / Discuss</td>
</tr>
<tr>
<td>8.3</td>
<td>GP Template Safeguarding Policy</td>
<td>Enc F</td>
<td>Mr Russell</td>
<td>Approval</td>
</tr>
<tr>
<td>9.</td>
<td>Strategy and Planning:</td>
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<tr>
<td>9.1</td>
<td>Primary Care Networks Development</td>
<td>Enc G</td>
<td>Mrs Ogle</td>
<td>Approval / Consider / Discuss</td>
</tr>
<tr>
<td>9.2</td>
<td>Proactive Care 20/21</td>
<td>Enc H</td>
<td>Mr Roberts</td>
<td>Approval</td>
</tr>
<tr>
<td>10.</td>
<td>Forward Planner</td>
<td>Enc I</td>
<td>Chair</td>
<td>Noting</td>
</tr>
<tr>
<td>Ref</td>
<td>Item</td>
<td>Enclosure</td>
<td>Led By</td>
<td>Action Required</td>
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<tr>
<td>11</td>
<td>Risk Register</td>
<td>Enc J</td>
<td>Mrs Ogle</td>
<td>Noting</td>
</tr>
<tr>
<td>12</td>
<td>Any Other Business</td>
<td>Verbal</td>
<td>Chair</td>
<td>Consider / Discuss</td>
</tr>
</tbody>
</table>

**Date and Time of Next Meeting**
Thursday 13 February 2020, Board Room, Sovereign House at 12.30pm

**QUORACY:**
Primary Care Commissioning is 4 Members including a minimum of 1 Lay Member inclusive of the Chair (or Vice Chair in the Chair's Absence)

Noting
Minutes of the Primary Care Commissioning Committee (Public)
Held on Thursday 14 November 2019 at 12.30pm
In the Boardroom, Sovereign House, Heavens Walk, Doncaster, DN4 5HZ

Voting Members Present:
Mrs Linda Tully Lay Member (Chair)
Mrs Sarah Whittle Lay Member
Mrs Hayley Tingle Chief Finance Officer
Mr Anthony Fitzgerald Director of Strategy and Delivery

Non-Voting Members Present:
Mrs Carolyn Ogle Associate Director of Primary Care & Commissioning
Mr Karl Roberts Primary Care Manager
Mrs Andrea Ibbeson Head of Quality & Designated Nurse for Children’s Safeguarding & LAC
Mr Paul Barringer NHS England Representative
Dr Dean Eggitt Local Medical Committee Representative
Mrs Jill Telford Healthwatch Representative
Dr Manjushree Pande Locality Lead GP

In Attendance:
Miss Emma Ross Primary Care Support Officer – Engagement
Mrs Lisa Frisby Senior Finance Manager

1. Apologies for Absence

Apologies for absence were received from:
- Mrs Jackie Pederson Chief Officer
- Mr Andrew Russell Chief Nurse
- Mrs Zara Head Lead Nurse Primary Care Quality

2. Declarations of Interest

The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NHS Doncaster Clinical Commissioning Group (CCG).

Declarations declared by members of the committee are listed in the CCG’s Register of Interests. The Register is available either via the secretary to the Governing Body or the CCG website at the following link: www.doncasterccg.nhs.uk

The meeting was noted as quorate.
 Declarations of interest from sub committees / working groups:
None declared.

 Declarations of interest from today’s meeting:
None declared.

3. Notifications of Any Other Business
   • None raised

4. Minutes From Previous Meeting held 10 October 2019
The minutes of the last meeting held on 10 October 2019 were approved as an accurate record with the following amendment:
   • Mrs Jill Telford was in attendance at the meeting

The minutes were signed by the Chair.

5. Matters Arising not on the Agenda
No matters arising.

6. Action Tracker
The Committee discussed and updated each item on the Action Tracker. The latest updates can be viewed on the Action Tracker.

7. Finance and Contracting
7.1 Full Quarterly Report including QIPP
Mrs Tingle discussed with the Committee the previously distributed paper, in particular the underspend finances were currently forecasting. Additional expenditure was to be agreed which would impact the current figure. This would include additional spending around PCNs, and an underspend on premises. It was projected that this would be fully spent.

Mrs Tingle discussed other influences on this such as QOF (Quality and Outcomes Framework) and Enhanced Services and a claw back from Inland Revenue and finally some funding back from The Oakwood Surgery which was originally set aside for a Chronic Disease Pilot.

The Committee discussed the projected underspend relating to Proactive
Care due to two practices in the East PCN currently not offering this service. There was a potential one practice may apply to offer this service due to an upcoming contractual change. This funding could also be an opportunity to pilot something new, however this option had not yet progressed.

The Primary Care Commissioning Committee noted the paper.

7.2 The Flying Scotsman – Contract Extension

The Committee were presented with a paper requesting a decision to be made with regards to a contract extension for Practice Surgeries Ltd. The GP Core Contract had been aligned with the Urgent and Emergency Care Services. The option was to extend for 5 years then an additional 5 years.

The Committee noted that this practice delivers the Special Allocation Scheme and also provide support to Hesley Group patients; this practice was unique in a number of ways. A significant number of practice patients do not speak English as their first language, the practice would also like to discuss their boundary as they currently cover all of Doncaster.

The Committee agreed in principle the contract extension subject to further discussions with the Practice Group Ltd and the GP and Practice Manager at the Flying Scotsman. It was noted that there was an outstanding contract variation relating to finance which had not yet been actioned.

Mrs Ogle

7.3 Estates Capital Update

The Committee were presented with a paper to note around the Estates Implementation Plan.

Simon Barnes, Interim Estates Program Director has established a Program Delivery Board which will bring together knowledge across Doncaster and feed into the Strategic Estates Group which is chaired by the Local Authority, regionally this group was felt very useful due to the partners involved. Priority areas were currently under discussion.

The Committee noted the paper.

7.4 Dynamic Purchasing System

The Committee were updated on the Dynamic Purchasing System which had been produced nationally, Doncaster CCG would look to implement this in round three noting this was not a mandated move. This would
allow work to be undertaken around the entry criteria to allow Doncaster to be comfortable that all system partners could be moved over.

7.5 Resilience Funding – Criteria

A paper was presented to the committee following a recent action which would allow the CCG to have a consistent approach should practices wish to apply for any identified funding. This would allow practices to self-refer. The guidance for this had been adapted from the NHSE England Resilience Funding from 2018/19.

The Committee thanked Mr Roberts for his work and this but noted any request for funding would need to be approved by the Senior Management Team. Mr Roberts agreed to reflect this change in the document.

The Committee approved the guidance subject to this amendment being made. The paper would be shared with Clinical Directors, the LMC and be posted on the website.

7.6 Local Enhanced Services Review

The Committee were presented with a paper to note on the Local Enhanced Services Review. Mr Roberts explained that all Tier 1 & 2 specifications had been made more robust with wording and clearer expectations for practices and the CCG. Dr Nabeel Alsindi and Mrs Zara Head had been involved in the clinical updates and Medicines Management Team in the medications updates. Practices managers had also been involved in this piece of work.

The Committee thanked Mr Roberts for his work on this and noted the update.

Mrs Tingle agreed to work with Mr Roberts on the vasectomy service finances.

7.7 Extended Access Contract Extension

A paper was presented around the Extended Access service provided by Primary Care Doncaster Ltd. Nationally it has been agreed that funding for the existing extended hours DES and for the wider CCG commissioned extended access service would fund a single, combined access offer as an integral part of the Network Contract DES from April 2021.

The current contract with Primary Care Doncaster Ltd was due to terminate on 30 September 2020 meaning this would leave a gap of 6 months between the current APMS contract ending and the new requirements under the national contract framework.
The committee were asked to extend the contract for 6 months to align the contract with the national requirements.

The Committee approved the extension of the Primary Care Doncaster LTD contract to end on 31 March 2021.

8. Quality

8.1 Full Quarterly Report

The Primary Care Quality report was presented to the Committee, the report was taken as read and highlights were given on the low numbers of reports for Initial Child Protection Conferences, there were still delays in Social Care Teams requesting this in a timely manner which then impacts the number of days the GP practices have to reply. There were no themes in practices so it was presumed this was a workload issue. The team continue to liaise with the Children’s Trust and Practices.

The Committee discussed on-going issues around Woundcare and the potential that practices would give notice to cease offering this service. The Committee requested an update at the February 2020 meeting.

The Committee enquired if recent flooding had any effect on Doncaster practices, Mrs Ibbeson was aware of some initial issues which Mrs Head and the Primary Care Team were able to support practices with, some work would need to be done on the back of this as buddy practices in the same area were unable to support each other, a conversation would be started with practices around this.

Mrs Ibbeson asked for it to be noted that practices had been very accommodating and responsive to system partners during the floods. The Committee asked that this was communicated to practices.

The Committee noted the report.

9. Strategy and Planning

9.1 GP Forward View Update

The Committee received and noted the quarterly GPFV update. In particular progress with online consultation was noted. Mrs Smith had now commenced in post to support implementation and although timescales are tight the implementation plan was in place to ensure delivery within timescale. The Extended access annual performance report was included in the distributed papers, the Committee discussed the number of unused appointments and how they were released to
practices. Work was ongoing around education for practice non clinical staff on booking/offering these slots to patients.

Dr Dean Eggitt discussed a paper which had been distributed to the committee around Primary Care Resilience and a potential pilot for Primary Care Rapid Access Support and Help (PC RASH) which would allow much needed staff in Primary Care rapid access to physical and mental health support, with the aim of avoiding long waiting lists and allow front line staff to return to work quicker, this service could allow access to course of counselling or a first outpatient appointment.

The paper detailed the pathway, strengths, weaknesses, opportunities and threats.

The Committee were unanimously supportive of a service but nervous around the equity with other services commissioned by the CCG. Dr Eggitt confirmed he would on the back of a potential pilot be looking to share the evaluation with NHS England. It was agreed that a pre and post assessment questionnaire be used to evaluate the service. Dr Eggitt confirmed the LMC would be happy to undertake this.

The Committee requested Dr Eggitt & Dr Alsindi work together on how this would develop noting the support for this proposal.

9.2 Primary Care Networks Update

The Committee considered the paper updating on the Primary Care Networks (PCN’s) noting the CCG had now received a signed Network Agreement for The Practice Group and this would now be re-signed by all Central PCN Practices.

The CCG was still waiting clarification around using the proactive care funds for frailty work for the East PCN.

The deadline for community pharmacists to transition from NHSE to PCNs had been extended to the end of November 2019.

Mrs Ogle discussed the upcoming Primary Care Event which was arranged in conjunction with PCD to allow time for PCNs to come together to understand how they work closer moving forward with other partners. Mr Fitzgerald updated the committee on the meeting with Clinical Directors of PCNs this week. It had been a useful meeting but much more needed to be done.

The Committee requested ICS Primary Care Board Meeting Minutes are a standing agenda item on the confidential agenda moving forward.

9.3 DRAFT Primary Care Delivery Group Minutes

The Committee noted the DRAFT Primary Care Delivery Group Minutes held on 23 October 2019.
10. **Forward Planner**

The Committee noted the Forward Planner and

- Wound Care – February 2020

Was added.

11. **Any New Potential Risks**

The Chair asked the Committee if they would like to raise any new potential risks. Practice resilience already being included on the register as a whole meant no new risks needed to be identified.

12. **Any Other Business**

The Committee was informed that Chris Empson & Gemma Munce on behalf of the CCG had been shortlisted for a prestigious award for their work on the PC Matrix. The Committee wished them the best of luck.

13. **Date and Time of Next Meeting**

Thursday 12 December 2019, 12.30pm in the Boardroom at Sovereign House.
<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Action/Agenda Ref</th>
<th>Action</th>
<th>Lead / Action For</th>
<th>Timescale</th>
<th>Completed (RAG) and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 June 2019</td>
<td>AP28</td>
<td>Mrs Pederson to discuss the possibility of sending a collective letter from the South Yorkshire &amp; Bassetlaw CCG's to NHS England in response to the cost pressure following the uplift, with Mrs Tingle.</td>
<td>Jackie Pederson / Hayley Tingle</td>
<td>Aug-19</td>
<td>To Action</td>
</tr>
<tr>
<td>8 August 2019</td>
<td>AP38</td>
<td>Dr Joseph to share any updated smoke-free promotional materials with Primary Care and the Community.</td>
<td>Victor Joseph</td>
<td>Mar-20</td>
<td>In Progress</td>
</tr>
<tr>
<td>8 August 2019</td>
<td>AP44</td>
<td>Work to be done on the VTS Nurse Scheme to ensure Nurses are retained in Doncaster, post training.</td>
<td>Zara Head</td>
<td>Sep-20</td>
<td>In Progress</td>
</tr>
<tr>
<td>8 August 2019</td>
<td>AP49</td>
<td>Urgent procurement framework to be tested at the next Primary Care Commissioning Committee Workshop and added to the forward planner.</td>
<td>Kelly Smith</td>
<td>Mar-20</td>
<td>In Progress</td>
</tr>
<tr>
<td>12 September 2019</td>
<td>AP53</td>
<td>Mrs Head to produce a General Practice Nurse Development Strategy Action Plan and bring this to a future meeting.</td>
<td>Zara Head</td>
<td>Dec-19</td>
<td>In Progress</td>
</tr>
<tr>
<td>12 September 2019</td>
<td>AP54</td>
<td>Mrs Head to contact Primary Care Doncaster Ltd to connect the General Practice Nurse Development Strategy with the Primary Care Networks.</td>
<td>Zara Head</td>
<td>Dec-19</td>
<td>In Progress</td>
</tr>
<tr>
<td>10 October 2019</td>
<td>AP57</td>
<td>Mrs Tooley to amended the Covert Medication section of the Quality Toolkit for Care Homes.</td>
<td>Karen Tooley</td>
<td>Nov-19</td>
<td>To Action</td>
</tr>
<tr>
<td>10 October 2019</td>
<td>AP63</td>
<td>Mr Fitzgerald, Mrs Pgle and Dean Eggitt to meet to discuss TARGET backfill.</td>
<td>Carolyn Ogle</td>
<td>Nov-19</td>
<td>To Action</td>
</tr>
<tr>
<td>10 October 2019</td>
<td>AP65</td>
<td>Mrs Ogle to write out to all Practices as a reminder of contractual obligation in terms of registering and removal of patients, and share this with the LMC.</td>
<td>Carolyn Ogle</td>
<td>Nov-19</td>
<td>To Action</td>
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<tr>
<td>10 October 2019</td>
<td>AP67</td>
<td>Mrs Ogle to discuss the expenditure of the Network’s £1.50 per head at the next Primary Care Doncaster Contracting Meeting and with 4Doncaster PCN.</td>
<td>Carolyn Ogle</td>
<td>Nov-19</td>
<td>To Action</td>
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<tr>
<td>14 November 2019</td>
<td>AP70</td>
<td>Mr Roberts to share Resilience Funding Criteria with CDs, LMC and posted on website.</td>
<td>Karl Roberts</td>
<td>Dec-19</td>
<td>To Action</td>
</tr>
<tr>
<td>14 November 2019</td>
<td>AP71</td>
<td>Mrs Tingle to work with Mr Roberts on vasectomy service finances</td>
<td>Mrs Tingle</td>
<td>Dec-19</td>
<td>To Action</td>
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<tr>
<td>14 November 2019</td>
<td>AP72</td>
<td>Mrs Ibbeson to communicate with general practice to thank them for cooperation during floods.</td>
<td>Mrs Ibbeson</td>
<td>Dec-19</td>
<td>To Action</td>
</tr>
<tr>
<td>14 November 2019</td>
<td>AP73</td>
<td>Primary Care Resilience proposal to be worked on by Dr Eggitt &amp; Dr Alisindi</td>
<td>Dr Eggitt/Dr Alisindi</td>
<td>Dec-19</td>
<td>To Action</td>
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<tr>
<td>14 November 2019</td>
<td>AP74</td>
<td>ICS Board Meeting Minutes to be standing item on confidential forward planner.</td>
<td>Mrs Ogle</td>
<td>Dec-19</td>
<td>To Action</td>
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<tr>
<td>Meeting name</td>
<td>Primary Care Commissioning Committee</td>
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<tr>
<td>Meeting date</td>
<td>12th December 2019</td>
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<tr>
<td>Title of paper</td>
<td>Estates Implementation Plan Update</td>
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<tr>
<td>Executive / Clinical Lead(s)</td>
<td>Hayley Tingle, Chief Finance Officer</td>
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<tr>
<td>Author(s)</td>
<td>Simon Barnes, Interim Estates Programme Director, Carolyn Ogle, Associate Director of Primary Care &amp; Commissioning</td>
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**Status of the Report**

To approve [ ]  
To consider/discuss [ ]  
To note [✓]

**Purpose of Paper - Executive Summary**

The purpose of this paper is to provide a monthly update to the Committee on the implementation of the local estates strategy.

**Recommendation(s)**

The Primary Care Commissioning Committee is asked to note the update.

**Report Exempt from Public Disclosure**

Yes [ ]  No [✓]

**Impact analysis**

<table>
<thead>
<tr>
<th>Quality impact</th>
<th>Support to improve the quality of the primary care infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality impact</td>
<td>Not applicable</td>
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</tbody>
</table>

*An Equality Impact Analysis/Assessment is not required for this report.*

An Equality Impact Analysis/Assessment has been completed and approved by the lead Director for Equality and Diversity. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.
An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.

<table>
<thead>
<tr>
<th>Sustainability impact</th>
<th>To secure sustainability of the primary care estate</th>
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<tbody>
<tr>
<td>Financial implications</td>
<td>Recurrent revenue consequences are a consideration with each scheme. Capital funding comes through ICS or NHS England</td>
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<tr>
<td>Legal implications</td>
<td>Premises Cost Directions</td>
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<tr>
<td>Management of Conflicts of Interest</td>
<td>Will be preserved through the Committee’s constitution</td>
</tr>
<tr>
<td>Consultation / Engagement (internal departments, clinical, stakeholder and public/patient)</td>
<td>To be undertaken as plans emerge</td>
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<tr>
<td>Report previously presented at</td>
<td>Not applicable</td>
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<tr>
<td>Risk analysis</td>
<td>None identified at this stage</td>
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<tr>
<td>Corporate Objective / Assurance Framework</td>
<td>CO3 ensuring that the primary care element of the primary care system is sustainable.</td>
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**Primary Care Statutory Duties (only)**

[Complete this section if submitting a report to Primary Care Commissioning Committee / Primary Care Delivery Group. For any other committee, delete this row on the report template.]

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<th>Statutory Duty</th>
<th>Section</th>
<th>Tick Relevant Box</th>
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<tbody>
<tr>
<td>Management of Conflicts of Interest</td>
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<tr>
<td>Duty to promote the NHS Constitution</td>
<td>14P</td>
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<tr>
<td>Duty to exercise its functions effectively, efficiently and economically</td>
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<tr>
<td>Duty as to improvement in quality of services</td>
<td>14R</td>
<td>✓</td>
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<tr>
<td>Duty in relation to quality of primary medical services</td>
<td>14S</td>
<td>✓</td>
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<tr>
<td>Duties as to reducing inequalities</td>
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<tr>
<td>Duty to promote the involvement of each patient</td>
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<td>Duty as to patient choice</td>
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<td>Duty as to promoting integration</td>
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<td>Public involvement and consultation</td>
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<tr>
<td>GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual</td>
<td>83</td>
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<tr>
<td>Action</td>
<td>Code</td>
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<tr>
<td>Action such as issuing branch/remedial notices, and removing a contract</td>
<td>83</td>
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<tr>
<td>Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”)</td>
<td>83</td>
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<tr>
<td>Design of local incentive schemes as an alternative to the Quality Outcomes Framework</td>
<td>83</td>
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<tr>
<td>Decision making on whether to establish new GP practices in an area</td>
<td>83</td>
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<tr>
<td>Approving Practice mergers</td>
<td>83</td>
<td></td>
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<tr>
<td>Making decisions on ‘discretionary’ payment (e.g., returner / retainer schemes)</td>
<td>83</td>
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<tr>
<td>To plan, including needs assessment, primary medical care services in Doncaster</td>
<td>83</td>
<td></td>
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<tr>
<td>To undertake reviews of primary medical care services in Doncaster</td>
<td>83</td>
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<tr>
<td>To co-ordinate a common approach to the commissioning of primary care services generally</td>
<td>83</td>
<td></td>
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<tr>
<td>To manage the budget for commissioning of primary medical care services in Doncaster</td>
<td>√</td>
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</table>
Overview
The Doncaster Primary Care Estate Strategy Implementation and Improvement Plan was published in May 2019 and progress has now commenced delivering the plan.

The following sets out activities that have been undertaken in month and will be progressed in the following month.

Outputs and update for November 2019
1. The focus for November has been to develop the programme board terms of reference, agree attendees, arrange the first meeting.

2. Continue to progress the options appraisals for the Bentley, Rossington and Mexborough schemes.

3. A number of Primary Care Network (PCN) projects to be progressed under the Integrated Care System (ICS) programme.

4. The CCG attended the November Strategic Estates Group (SEG), updating the meeting on progress on the Bentley, Rossington and Mexborough schemes. In addition, space utilisation and void space across partner estate was discussed and will form an ongoing agenda item at future meetings.

5. The CCG met with the Harworth Group who are developing the former Harworth colliery site for housing. The master plan has a parcel of land identified for health use. The site will be appraised in the usual way through the options appraisal work.

6. November ICS Estates Programme Board held, and the CCG attended.

7. The CCG is assisting several GP practices with property matters.

Focus for December 2019
1. Continue to monitor progress with the Bentley, Rossington & Mexborough options appraisals.

2. Responding to the ICS Programme Board requests.

3. First DCCG Estates Programme Delivery Board (ESDP) scheduled for the 16th December.
4. The CCG is to co present with Community Health Partnerships on the work done on utilisation of bookable space at the South Yorkshire & Bassetlaw (SYBL) December board meeting.

5. Progress prioritised BAU property matters

6. Ongoing development of the project approvals process
**Doncaster CCG: Mergers from the commissioner’s point of view**

Wednesday 27 November 2019
Boardroom, Sovereign House, Heavens Walk, Doncaster, South Yorkshire DN4 5HZ

<table>
<thead>
<tr>
<th>08.45</th>
<th>Arrival</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.00</td>
<td>Welcome and aims of the session</td>
</tr>
</tbody>
</table>

**What is meant by merging?**

Things practices will need to think about, to include:
- Which contract remains
- Organisational form
- Practice inner and outer boundaries
- Premises
- Decision-making
- Partnership deed
- Patient engagement

<table>
<thead>
<tr>
<th>10.30 – 10.45</th>
<th>Refreshments</th>
</tr>
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</table>

CCG’s process for consideration of merger applications, to include:
- Finance – seniority, QOF, premises costs
- Services commissioned
- Contract variations
- Implications to dispensing, if relevant
- Patient engagement or consultation
- In-year mergers
- Informing other stakeholders/organisations of a merger
- IT

**The role of PCSE in mergers**

**Final questions**

<p>| 12.30 | Close |</p>
<table>
<thead>
<tr>
<th>Meeting name</th>
<th>Primary Care Commissioning Committee</th>
</tr>
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<tbody>
<tr>
<td>Meeting date</td>
<td>12th December 2019</td>
</tr>
<tr>
<td>Title of paper</td>
<td>Doncaster General Practice Nurse Development Strategy Action Plan</td>
</tr>
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</table>

| Executive / Clinical Lead(s) | Andrew Russell – Chief Nurse  
Andrea Ibbeson, Head of Quality & Designated Nurse for Safeguarding Children |
| Author(s)                     | Andrea Ibbeson, Head of Quality & Designated Nurse for Safeguarding Children and Zara Head Lead Nurse Primary Care Quality |

**Status of the Report**

<table>
<thead>
<tr>
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<td>To note</td>
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**Purpose of Paper - Executive Summary**

The purpose of this action plan is to inform the Primary Care Commissioning Committee of the activities undertaken by Doncaster CCG to support the development of General Practice Nurses in Primary Care. The intention of the action plan is to offer assurance to the Committee in respect of the work undertaken that looks to promote quality care across primary care services.

**Recommendation(s)**

Primary Care Commissioning Committee is asked discuss the progress and challenges in respect to implementation of the Doncaster General Practice Nurse Development Strategy in line with the General Practice Nursing 10 point plan.

**Report Exempt from Public Disclosure**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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If yes, detail grounds for exemption:

**Impact analysis**

<table>
<thead>
<tr>
<th>Quality impact</th>
<th>The ongoing work around the General Practice Nurse 10 point plan is envisaged to have a positive impact on quality in primary care services by building on strengths of nurses and nurturing leadership skills.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality impact</td>
<td>An Equality Impact Analysis/Assessment is not required for this report. Ticked.</td>
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Tick relevant box

| X |
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An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.

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<thead>
<tr>
<th>Sustainability impact</th>
<th>Positive, supporting sustainability of General Practice by supporting quality improvement and general practice nurse development</th>
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<tbody>
<tr>
<td>Financial implications</td>
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<tr>
<td>Legal implications</td>
<td>None identified</td>
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<tr>
<td>Management of Conflicts of Interest</td>
<td>Through the committees constitution</td>
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<tr>
<td>Consultation / Engagement (internal departments, clinical, stakeholder and public/patient)</td>
<td>Engagement has been undertaken with nurses around scoping the General Practice Nurse Development Strategy.</td>
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<tr>
<td>Report previously presented at</td>
<td>None</td>
</tr>
<tr>
<td>Risk analysis</td>
<td>No current risks identified in this report</td>
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<tr>
<td>Corporate Objective / Assurance Framework</td>
<td>CO1 - CO4</td>
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<th>Section</th>
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# Doncaster General Practice Nurse Development Strategy Action Plan

<table>
<thead>
<tr>
<th>Challenge</th>
<th>How challenge will be met</th>
<th>Date to action</th>
<th>Progress</th>
<th>Date Actioned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Training and Development</strong></td>
<td>Forge stronger relationships with training providers such as universities and the training hub to ensure the training needs of GPNs are recognised and local training is available. Close working relationships to continue with the Primary Care Workforce Hub.</td>
<td>Already in place</td>
<td>Continually in progress</td>
<td>Already in place</td>
</tr>
<tr>
<td><strong>Ensure access for all GPNs to training and professional development.</strong></td>
<td>TARGET training is available across Doncaster for all GPNs. To look at ways how other training can be cascaded.</td>
<td>Already in place, continually looking at ways to improve.</td>
<td>Continually in progress</td>
<td>Already in place</td>
</tr>
<tr>
<td><strong>Promotion of GPN competencies.</strong></td>
<td>Dedicated Comms planned</td>
<td>January 2020</td>
<td>IN PROGRESS</td>
<td>March 2020</td>
</tr>
<tr>
<td><strong>All GPNs to have access to structured clinical supervision to enable sharing of best practice and learning.</strong></td>
<td>To look at how this can be implemented. Had discussions with the newly appointed Lead Nurse at Primary Care Doncaster and this may also be influenced by the GPN Ambassador role.</td>
<td>June 2020</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Enc E**
<table>
<thead>
<tr>
<th>Having a way to identify available places on required training courses.</th>
<th>To look at how this can be implemented</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2 Recruitment and retention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the amount of placements for pre-registration nurses in General Practice in Doncaster.</td>
<td>Working with Primary Care Workforce Hub to support practices wishing to provide placements for pre-registration student nurses. Having a mentor award in the General Practice Nurse Awards in February to promote the role.</td>
<td>Already in place. Always promoting this.</td>
</tr>
<tr>
<td>Celebrate the complexity and skill set of the GPN role, both with the general public and with universities.</td>
<td>Dedicated comms planned for January 2020 along with the GPN Awards in February 2020</td>
<td>March 2020</td>
</tr>
<tr>
<td>Ensure GPNs are viewed as a valuable member of the MDT.</td>
<td>Dedicated comms planned and above and development of the GPN voice through the GPN Ambassador Role.</td>
<td>March 2020</td>
</tr>
<tr>
<td>Ensure that the professional ongoing need for support and training is recognised.</td>
<td>By strengthening the nurse voice in PCNs By working with PCD/practices Empowering nurses, the GPN Ambassador Role</td>
<td>June 2020</td>
</tr>
<tr>
<td>Recognising the value of experienced GPNs and supporting retention with a flexible approach.</td>
<td>To look at how this can be evidenced and supported. Many practices are already supporting flexible working and looking at ways to support and retain experienced GPNs.</td>
<td>June 2020</td>
</tr>
<tr>
<td>3 Leadership</td>
<td>Supporting GPNs to recognise their potential.</td>
<td>GPN Ambassador Role as below</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>The promotion of GPNs leading across networks as a voice for the nursing community.</td>
<td>ICS bid to NHSE was successful to develop a GPN Ambassador network The aim of the GPN Network Ambassador is to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Ensure there is a recognised GPN lead within each network to support the PCN clinical director/network members with decision making which impacts GPN/HCA workforce. Also to have greater understanding around strategic direction of the network and potential input as appropriate;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Be the point of contact for the Federation/CCG/ICS to cascade communication and information to and from GPNs;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Establish and continue to sustain GPN nurse network meetings allowing opportunities for shared learning, clinical supervision and to support the development of a cohesive network community;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Scope and support areas of training that maybe bespoke to the network or on a ICS platform to help enable and structure future training;</td>
<td></td>
</tr>
</tbody>
</table>
5. Liaise with other GPN Ambassadors to offer mentorship, support and share learning;

6. Regularly review the role acknowledging it will continually evolve and develop as per changes with CCG/Primary Care Network/ACP and overall effectiveness and engagement.

The following requirements will be a condition of the GPN Ambassador (GPNA) in order to fulfil the role:

- Have motivation, commitment and purpose to drive up ambitions for the GPN community
- Hold a desire to understand and build valuable leadership skills
- Be open to self-awareness and professional development
- Require a passion for the role of ambassador
- Possess a curiosity into the wider context of nursing for example general practice nursing at ICS level
- Can demonstrate support from own practice to undertake the role

| GPNs to lead and drive innovation and transformation. | As above | June 2020 | IN PROGRESS |
Support GPNs to work at different organisational levels, from their own practices to across networks, working at scale. This will open up opportunities in pathway design, service leadership, education, training, research and the development of specialist skills.  

<table>
<thead>
<tr>
<th>4 Communication</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear communication pathways for changes in services and updated national and local guidance.</td>
<td>To look at how this can be implemented, in discussion with the newly appointed lead nurse at Primary Care Doncaster. Looking at newsletters and ways of communication with the Communication Team.</td>
</tr>
<tr>
<td>An easy and accessible way to communicate and share learning with other GPNs in Doncaster.</td>
<td>To look at how this can be implemented, in discussion with the newly appointed lead nurse at Primary Care Doncaster. Looking at newsletters and ways of communication with the Communication Team. The GPN Ambassador role may be a conduit in Primary Care Networks.</td>
</tr>
<tr>
<td>Embrace the development of GPNs across networks to build strong, sustainable working relationships.</td>
<td>GPN Ambassador Role as above</td>
</tr>
<tr>
<td>5 Support</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>GPNs to feel valued and supported both in practice and by the general public.</td>
<td>Dedicated communications GPN awards in February</td>
</tr>
<tr>
<td>Regular clinical supervision to be accessible to all GPNs with protected time.</td>
<td>To look at how this can be implemented, in discussion with the newly appointed lead nurse at Primary Care Doncaster. The GPN Ambassador role may be a conduit in Primary Care Networks.</td>
</tr>
<tr>
<td>All GPNs in Doncaster to feel as though they have a collective voice and can shape the future of health care.</td>
<td>Collectively with all the above</td>
</tr>
<tr>
<td>Meeting name</td>
<td>Primary Care Committee</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------</td>
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<tr>
<td>Meeting date</td>
<td>12th December 2019</td>
</tr>
<tr>
<td>Title of paper</td>
<td>GP Safeguarding Children and Adults Policy and Guidance (Template)</td>
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<tr>
<td>Executive / Clinical Lead(s)</td>
<td>Andrea Ibbeson, Head of Quality / Designated Nurse for Safeguarding Children and Looked After Children</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Dr Lee Oughton, Named GP for Safeguarding Gill Wood, Deputy Designated Nurse for Safeguarding Children and LAC</td>
</tr>
</tbody>
</table>

**Status of the Report**

| To approve | X |
| To consider / discuss |   |
| To note |   |

**Purpose of Paper - Executive Summary**

The purpose of the policy is to outline how GP Practices will fulfil its statutory, moral and ethical duty to safeguard and promote the welfare of all its patients.

**Recommendation(s)**

The Primary Care Committee is asked to:

Approve the GP Safeguarding Template

**Report Exempt from Public Disclosure**

Is the report Exempt from Public Disclosure?

Yes [ ] No [X]

**Impact analysis**

<table>
<thead>
<tr>
<th>Quality impact</th>
<th>[Identify any quality impact]</th>
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<tbody>
<tr>
<td>Equality impact</td>
<td>[Summary of impact, if any, of CCG’s duty to promote equality and diversity based on Equality Impact Analysis (EIA). All reports relating to new services, changes to existing services or CCG strategies / policies must have a valid EIA and will not be received by the Committee if this is not appended to the report]. [Identify any equality impact – positive, negative or neutral]</td>
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<tr>
<td>Corporative Objective / Assurance Framework</td>
<td>The report links to Strategic Objective 2 in relation to Quality &amp; Patient Safety</td>
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[Complete this section if submitting a report to Primary Care Commissioning Committee / Primary Care Delivery Group. For any other committee, delete this entire section / row on the report template.]

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Safeguarding
Children and Adults

Policy and Guidance
(Template)

[Insert Practice Name]
# DOCUMENT CONTROL

## CONTROL RECORD [or insert practices own version]

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<th>Title:</th>
<th>Safeguarding Children &amp; Adults Policy and guidance in [Insert Practice Name]</th>
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<tr>
<td>Purpose:</td>
<td>This policy outlines how [Insert Practice Name] will fulfil its statutory, moral and ethical duty to safeguard and promote the welfare of all its patients</td>
</tr>
<tr>
<td>Audience:</td>
<td>All staff, students, volunteers of [Insert Practice Name]</td>
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<tr>
<td>Version:</td>
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<tr>
<td>Status:</td>
<td>Template for use by Primary Care Independent Contractors developed for use across South Yorkshire and Bassetlaw</td>
</tr>
<tr>
<td>Owner:</td>
<td>NHS Doncaster Clinical Commissioning Group</td>
</tr>
<tr>
<td>Authors:</td>
<td>NHS Doncaster CCG Safeguarding Team</td>
</tr>
<tr>
<td>Superseded Documents:</td>
<td>Safeguarding Vulnerable People Policy September 2015</td>
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<tr>
<td>Main Changes from Previous Versions:</td>
<td>Title: Safeguarding Children and Adults Policy and Guidance Working Together to Safeguard Children 2018 Referral pathways</td>
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<td>Groups Consulted:</td>
<td>Designated and Named professionals, Named GPs, NHS Doncaster CCG Safeguarding Executive Lead.</td>
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<tr>
<td>Method:</td>
<td>Intranet ✓ Other: GP E-bulletin ✓</td>
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<td>Intranet</td>
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5. Definitions ................................................................................................................... 6  
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APPENDIX 1 – SAFEGUARDING ADULT AND CHILD FLOW CHART  
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SAFEGUARDING POLICY STATEMENT

[Insert Practice Name]

This practice is fully committed to safeguarding the welfare of all people irrespective of gender, age, disability, sexual orientation, race, language, religion, ethnic or social origin.

As a practice we recognise our responsibilities to take all reasonable steps to promote safe practice and protect people from harm, abuse, neglect and/or exploitation.

All staff and volunteers in this practice will endeavour to safeguard people by:

- Making patients aware that we take protecting them and the public seriously and will respond to concerns about health and welfare
- Working together to encourage an ethos which embraces difference and diversity
- Respecting and empowering people to be safe from harm and/or abuse
- Recognising and reducing the risk to people experiencing domestic abuse
- Sharing information about concerns with agencies who need to know and involving people appropriately in that sharing
- Following national and local safeguarding children and adults policies and procedures including safe recruitment of all our staff
- Providing effective management for our staff by ensuring they have access to supervision, support and training as appropriate to their identified need
- Supporting people to make their own decisions and by making best interest decisions for those who cannot make decisions for themselves
**Introduction**

This policy is in line with the national and local expectations of safeguarding and promoting health and welfare.

This policy outlines how [Insert Practice Name] will fulfil its statutory, moral and ethical duty to safeguard and promote the welfare of all its patients. This policy is in accordance with the Doncaster Safeguarding Adults Board (DSAB) and the Doncaster Safeguarding Partners (Working Together 2018, previously Local Safeguarding Children Board (LSCB)) policies and procedures.

1.1 [Insert Practice Name] fully endorses the belief that safeguarding is everyone’s responsibility. In line with this, we will:

- Have clear lines of accountability for safeguarding people
- Have robust arrangements in place for appropriate checks on staff and volunteers
- Have procedures for dealing with allegations of abuse against members of staff and volunteers
- Ensure that our staff receive appropriate learning and development opportunities in line with national and local expectations
- Ensure that safeguarding policies and appropriate whistle-blowing procedures (known as Freedom to Speak Up) are in place, and
- Encourage a culture that enables concerns about safeguarding and promoting welfare to be discussed

We will ensure that all our staff adhere to local safeguarding adults and children policies and procedures, have access to necessary support and advice, and that all our staff are aware of and have access to relevant clinical colleagues with expertise in safeguarding:

[Insert names of GP practice leads and deputies for each of the safeguarding areas]

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1.2 We will deliver safe care throughout a person’s life span; we will do this in the privacy of people’s homes, in the surgery, in the community, in care homes and in hospices. We accept that the people in our care and their families are often at their most vulnerable and we intend to ensure that our staff and volunteers all work toward making a positive difference to people’s lives.

1.3 We will ensure that all staff are able to recognise domestic abuse and sexual exploitation. Our staff will be able to empower patients to reduce their risk of harm by referral to the appropriate services and support.

1.4 Where people lack capacity to make their own decision, we will consult appropriately in order to make best decisions that support the provision of care, treatment and services in the least restrictive manner.

Roles And Responsibilities

[Insert Practice Name] believes that everyone has a right to be safeguarded from abuse, maltreatment or neglect and that safeguarding is everyone’s responsibility. [Insert Practice Name] will therefore ensure that their contribution to safeguarding and promoting welfare is discharged effectively to support the rights of all patients/clients.

Whilst it is everyone’s responsibility to safeguard, some members of [Insert Practice Name] have additional roles to further support our commitment to safeguarding:

**Clinical Lead / Deputy [Insert Names]**

- Overall responsibility for developing, reviewing and implementing safeguarding vulnerable people policies and procedures of the practice
- Undertake required regular safeguarding training
### Practice Manager [Insert Name]
- Act as a co-ordinator supporting all staff in conjunction with the Lead Clinical and Lead Deputy
- Act as a Single Point of Contact (SPOC) for partner agencies
- Assist Lead Clinician and Deputy in updating and embedding policies and procedures
- Align recruitment processes and HR Policies to include safe recruitment and retention requirements e.g. suitability for post, training and induction of existing and new staff, including volunteers
- Arrange for appropriate staff updates/training and monitor attendance

### Clinicians
- Maintain professional responsibility in the identification and notification of suspected abuse / neglect / maltreatment incidents
- Undertake safeguarding training requirements (external as well as in-house) in line with national and local requirements

### Admin & Clerical Staff / Volunteers
- Attend relevant training to ensure they can recognise the signs and symptoms of abuse, neglect and/or maltreatment
- Make themselves familiar with the practice’s safeguarding vulnerable people policies and procedures to understand their responsibilities
- Report any concerns or allegations of abuse, neglect and/or maltreatment to the Practice Manager (if Practice Manager is not available, to Lead Clinician or Deputy to avoid delay)
- Prepare a factual report if required

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### Safeguarding Roles And Competencies For Healthcare Staff

To protect people from harm, all healthcare staff must have the competences to recognise abuse and to take effective action as appropriate to their role. It is the duty of employers to ensure that those working for them clearly understand their contractual obligations within the employing organisation, and it is the **responsibility** of employers to facilitate access to training and education which enable the organisation to fulfil its aims, objectives and statutory duties effectively and safely. [Insert Practice Name] adheres to the children and adults best practice guidance documents published in 2019 (children) & 2018 (adults) by the Royal Colleges.
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Data Protection and Management of Confidential Information

[Insert Practice Name] is committed to its obligations in the management of information in accordance with the Data Protection Act 1998 & General Data Protection Regulations (GDPR). [Insert Practice Name] is aware of “Information sharing” guidance, and ensures all staff are aware and adhere to this guidance. We have a duty to respect and protect the confidentiality of information relating to an individual that we acquire in the course of our professional activities. Patient information will only be disclosed without consent in exceptional circumstances e.g. where the safety of a vulnerable client/patient is considered to override this.

Legal and professional obligations will not generally prevent the sharing of confidential information if:

The person, parent or carer and/or the child consent to disclosure,

The public interest in safeguarding the vulnerable client’s welfare overrides the need to keep the information confidential. Where there is a clear risk of significant harm to a vulnerable client or to others the public interest test will almost certainly be satisfied. However there are exemptions in relation to Counter Terrorism & Prevent.

Disclosure is required by law or under an order of the court.

There may be occasions where consent cannot be obtained or is withheld (for example, the person refusing consent may be the perpetrator of the abuse). In deciding whether there is a need to share information, the vulnerable person’s best interests must be the overriding consideration.

The information shared will be proportionate and the patient/client’s identity will not be revealed unnecessarily. Information relevant to the concerns about the patient/client will only be disclosed to other professionals or agencies involved in the patient/client’s care on a ‘need to know’ basis. Where we are unsure whether confidential information should be disclosed, we will discuss the matter with the Local Designated or Named Professionals, named in Doncaster Safeguarding Partners Flowchart (Appendix 1), or other experienced safeguarding colleagues. We will record fully any decision about whether or not to share information including the rationale and evidence considered in coming to our decision.

Current guidance suggests that written records relating to safeguarding issues should be stored as part of the patient/client’s permanent medical records, either manually or on computer, or both. This is a change to historical recommendations. [Insert Practice Name] is alert to this fact and that this guidance may be reviewed or amended in the future and must seek the guidance of the local CCG in all instances.

When any patient moves to a new practice ALL the record should be transferred, particularly any safeguarding information. Both the paper record and the electronic record should be passed to the new Practice via Primary Care Support England (PCSE) in line with agreed procedures.

In order to comply with the data protection act, it is likely that third party information will be stored within these records and the normal duty of non-disclosure of this third party information may apply when information is to be released – it may be appropriate at such times to take advice.

How to Record Safeguarding Concerns in the Notes

All clinicians in the practice are responsible for ensuring that information relating to safeguarding is regularly updated utilising Standard Read codes. Read codes for safeguarding can be found in the Child Safeguarding Toolkit and Adult Safeguarding Toolkit.


**Definitions**

[Insert Practice Name] will always act in the patient/clients best interest, irrespective of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. We will do this by ensuring that we do not make assumptions about their level of capacity based on age, appearance or medical condition.

[Insert Practice Name] will encourage all patients/clients to participate as fully as possible in their care, giving due consideration to their wishes and feelings. We will ensure that additional consideration is given to anyone with increased vulnerability, this includes:

**For children and young people**

A child is anyone who has not yet reached their 18th birthday (Children Acts, 1989 and 2004). ‘Children’ therefore means ‘children and young people’ throughout. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital, in prison or in a Young Offenders’ Institution, does not change his or her status as a child or entitlement to services or protection under the Children Act 1989.

Safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment;
- Preventing impairment of children’s health or development;
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care;
- Taking action to enable all children to have the best outcomes (Working Together to Safeguard Children, 2018, HM Government)

Child protection is a part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are at risk of suffering, significant harm.

Children in need are defined under section 17 of the Children Act 1989, as those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services (section 17(10) of the Children Act 1989), plus those who are disabled. The critical factors to be taken into account in deciding whether a child is in need under the Children Act 1989 are:

- What will happen to the child’s health or development without services being provided;
- and
- The likely effect the services will have on the child’s standard of health and development.

**For Adults**

The definition of a vulnerable adult was revised within the Care Act 2014 and is now referred to as an adult at risk. This replaces the No Secrets guidance (DH, 2000).

Safeguarding Duties apply to an adult who:

- Has needs for care and support and
- Is experiencing, or at risk of, abuse or neglect, and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect
Protection Of Workers Who Report Concerns

[Insert Practice Name] agrees that confidentiality is central to the trust between staff and patients and is an essential part of good care. Without assurances about confidentiality, children, young people and adults, may be reluctant to get the medical attention or to provide health staff with the information they need to provide good care. However [Insert Practice Name] accepts that confidentiality is not an absolute duty. You can share confidential information about a person if any of the following apply:

You must do so by law or in response to a court order

The person the information relates to has given you their consent to share the information (or a person with parental responsibility)

The person has given consent if the information is about a child who does not have the capacity to give consent, or a Best Interest meeting has agreed that information can be shared in the persons best interests under the Mental Capacity Act 2005

The safeguarding concerns are of such a nature as to be in the public interest to share e.g. MARAC/MAPPA

[Insert Practice Name] will support staff in reporting safeguarding concerns through its agreement to adhere to the Local Safeguarding Children and Local Safeguarding Adults Board policies and procedures and through its internal Human Resources Policies and Procedures, namely the Freedom to Speak Up (Whistle Blowing Policy) as long as the staff member’s report was not malicious or vexatious.

Review Of Safeguarding Policy

The Lead Clinician for [Insert Practice Name] safeguarding and the Practice Manager [Insert Name] will review our Safeguarding Policy and procedures on a regular basis (not less than 3 yearly).

[Insert Name of Lead Clinician] and [Insert Name of Practice Manager] will ensure that [Insert Practice Name] complies with Doncaster Clinical Commissioning Group Safeguarding policy as well as Doncaster Safeguarding Partnership (Children and Adults) policies and procedures.
1. SECTION 1: SAFEGUARDING CHILDREN

Context

[Insert Practice Name] believes that every child has the right to grow up and develop to their full potential in a secure, safe, family environment, free from harm, abuse, neglect or exploitation and to be involved in any decision which may directly affect them.

Children’s rights will always be protected and we will do what is reasonable to safeguard the child’s health, development and welfare and any actions we take will represent the best interests of the child. The rights of children and young people to confidentiality will be maintained unless we consider that they could be at risk of abuse and/or harm.

The Lead Clinician and their Deputy for safeguarding children and young people is [Enter Names] will work with the Practice Manager, [Enter Name] to develop and review safeguarding practices, implementing changes appropriately and speedily if/when required.

All staff and volunteers of this practice will know what to do and who to go to if they have any concerns regarding a child’s safety. Appendix 1 sets out the referral Flow Chart and contact details for relevant health professionals. Expectations of health care professionals working with this [Insert Practice Name] can be found in the Intercollegiate guidance, Safeguarding Children and Young People: Roles and Responsibilities for Health Care Staff (2019).

[Insert Practice Name] complies fully with the NICE Guidelines When to Suspect Child Maltreatment 2009. All clinicians in this Practice will adhere to the GMC Guidance (2018) Protecting children and young people: The responsibilities of all doctors, acknowledging that safeguarding children is a difficult area of practice that can involve making decisions that are emotionally challenging, complicated by uncertainty and sometimes go against the wishes of parents.

All staff within this Practice will be aware of how to access:

- This policy document
- Local Safeguarding Board Policies and Procedures
- Support and advice from local safeguarding professionals and
- Safeguarding Children training relevant to their role

Categories Of Abuse

There are 4 categories of child abuse:

- **Physical** - This includes hitting, shaking, poisoning, burning or drowning, fabricated or induced illness
- **Sexual Abuse** - This includes forcing or enticing a child to take part in sexual activities; for example, inappropriate touching, rape, buggery, exposure to indecent images, or encouraging sexualised behaviour
- **Emotional Abuse** - This includes persistent ill treatment of a child which affects their emotional development; for example, making a child feel worthless, unloved or inadequate
- **Neglect** - This includes persistent failure to meet the physical and/or psychological needs of a child; for example, failing to provide adequate food, warmth, shelter, clothing, emotional
Notifying Concerns About a Child/Children

All Staff should have access to the Doncaster Safeguarding Partners (Working Together 2018, formerly Doncaster Local Safeguarding Children Board) Multi-Agency Threshold Descriptors to support decision making regarding the appropriate referral route. [https://doncasterscb.proceduresonline.com/pdfs/multi_age_levels_need.pdf]

All staff and volunteers of [Insert Practice Name] must follow the process within Appendix 1 (‘What to do If you’re worried a child is being abused A flow chart for referral’) if they have any concern about the well-being/safety of a child.

Reasons for concerns where maltreatment or abuse could be considered include:

A child clearly alleges abuse
A child has an injury not consistent with the event reported as causing it
A pre-mobile child has an injury without clear accidental explanation
A third party makes an allegation of abuse
Concerns regarding sexual abuse even though there is no direct allegation
Concerns about a child living with or having contact with a person posing a risk
Neglect
Abandonment
Child refused urgent medical treatment
Emotional abuse
Genital mutilation and forced marriage
Child at risk of sexual exploitation
Children whose parents/carers have mental health problems
Children who are pregnant
Domestic violence/honour based violence
Children whose parents/carers are substance users
Children with disabilities
Missing families
Non-attenders for immunisations and Health Professional clinics or hospital appointments etc.
Children not brought to appointments
Bullying at home or at school, including via computers or mobile phones
Frequent surgery or hospital attenders e.g. frequent minor illnesses, frequent "accidents" etc.
Fabricated/induced illness
Unaccompanied Children from abroad (ie not with their parents)
Parents/carers who are hostile and uncooperative in your attempts to treat their child/ren
It is good practice to be open and honest with parents/caregivers about any concerns, the possible need for a referral, information sharing between agencies, and the accompanying need for a check of the list/register of children who are subject to a child protection plan. According to research being open with parents and/or caregivers from the outset results in better protection for the child. Where appropriate, all reasonable efforts should be made to inform them beforehand. However, an inability to inform parents and/or cares should not prevent a referral being made.

There are some rare cases where it **will not** be appropriate to discuss concerns with parents/caregivers before referral. In such situations, the timing of contact with parents/caregivers will be agreed with children's social care and/or the police once the referral has been made.

Situations where it **would not** be appropriate to inform family members prior to referral include where:

- Discussion would put a child at risk of significant harm
- There is evidence to suggest that involving the parents/caregivers would impede the police investigation and/or children's social care enquiry
- Sexual abuse is suspected
- Fabricated or induced illness is suspected
- Discussion would place one parent at risk of harm e.g. in cases of domestic abuse
- Human trafficking/modern slavery is suspected

Please note this list is not exhaustive

The Lead Clinician and/or Practice Manager should seek advice from the any of the community based Designated or Named Professionals, if unsure as to what actions should be taken next.

**Child Protection Case Conferences**

Doncaster Safeguarding Partners (Working Together 2018, formerly Doncaster Local Safeguarding Children Board) Child Protection Procedures state the production of a written report is a minimum expectation of any professional invited to a Child Protection Case Conference. The purpose of such a report is to provide details of the subject child’s health, development and wellbeing.

All reports are shared with the Chair of the Case Conference, the parents of the child and, where appropriate, the child, a minimum of 2 days prior to the conference. While it is acknowledged that Initial Child Protection Case Conferences can be convened at short notice, all efforts should be made to share the report (direct contact) or the content of the report (by telephone) with the family and to attend where possible. In view of the length of time involved in the Review Conference process, it should be the rarest of events, that a parent has not seen a report prior to a Review Conference.

**Training**

Staff at [Insert Practice Name] will be offered training appropriate to their role, in line with best practice. Safeguarding Children training is in line with national expectations.
Conclusion

[Insert Practice Name] will be proactive in its responsibility to identify and notify cases of suspected child abuse/neglect/maltreatment incidents. We will ensure that our staff undertake safeguarding children and young people training requirements (external as well as in-house) in line with national guidance.

SECTION 2: LOOKED AFTER CHILDREN

Context

Children who become looked after are the same children who have been identified as children in need and may also have been subject to child protection procedures. The child’s adverse experiences before entering care are compounded by separation and; loss, as well as placement moves.

Children looked after by the local authority may be subject to a care order under section 31 of the Children Act 1989, or may be voluntary accommodated, through an agreement with their parents, under section 20. The issue of parental responsibility (PR) is different between these two groups as the local authority only has PR for those children subject to care orders.

Since the implementation of the Legal Aid, Sentencing and Punishment of Offenders Act 2012, all children who are remanded into custody in England and Wales automatically become looked after.

Children and Young people who are looked after are a particularly vulnerable group and both require and deserve a quality specialist health provision. This group of vulnerable children have considerable needs for secondary and tertiary paediatric care, including mental health.

Contribution of Primary Care


Primary care teams have an essential role in identifying the health care needs of a looked-after child. They often have prior knowledge of the child, of the birth parents and of carers, helping them to take a child-centred approach to health care decisions.

GP practices should:

Provide primary care services for looked after children and the lead record for a looked after child should be the GP held record

Maintain a record of the health assessment and contribute to any necessary action within the health plan

Provide summaries of the health history of a child who is looked after, including information on immunisations and covering their family history where relevant and
appropriate, and ensure that this information is passed promptly to health professionals undertaking health assessments

Ensure timely access to a GP or other appropriate health professional when a looked-after child requires a consultation

Make sure the GP-held clinical record for a looked-after child is maintained and updated and that health records are transferred quickly if the child registers with a new GP practice, such as when he or she moves into another CCG area, leaves care or is adopted

Ensure that treating a looked after child as a temporary resident is avoided as the medical record is not available to the treating medical practitioner. Where this is not possible the treating practitioner should talk to the child’s named GP to avoid treating the patient "blind".

SECTION 3: CHILD SEXUAL EXPLOITATION (CSE)

Context

The identification of child abuse is not simple and often comprises of a complex mixture of medical symptoms, behavioural characteristics and background factors. In addition to the categories of abuse identified above there have been a number of high profile cases of child sexual exploitation, including concerns raised within the health service such as those around Jimmy Savile. All staff employed, seconded or volunteering in [Insert Practice Name] must be vigilant to child sexual exploitation as this form of abuse and corruption can have significant long term health consequences.

Child sexual exploitation is nationally and locally a high priority therefore all staff in [Insert Practice Name] should be made aware of the list of potential signs and indicators that may identify this type of abuse. Any concerns should follow 1.3 above ‘Notifying Concerns About a Child/Children’.

Child Sexual Exploitation Warning Signs and vulnerabilities Checklist

Child Sexual Exploitation Warning S

SECTION 4: SAFEGUARDING ADULTS

Context

[Insert Practice Name] believes that their staff have a responsibility to reduce the risk of harm, abuse, neglect or exploitation to adults. Their dignity and personal identity should be respected and they should be encouraged to be involved in any decision which may directly affect them.
The Clinical Lead responsible for Safeguarding Adults is [Insert Clinical Lead Name] who will work with the Practice Manager, [Insert Practice Manager Name] to develop and review this policy, implementing changes appropriately and speedily.

All staff of this practice will know what to do and who to go to if they have any concerns regarding the safety of an adult who they consider to be at risk of harm. The South Yorkshire Safeguarding Adults Procedures detail the practicalities of how to ensure individual safeguarding cases are managed correctly.

All staff within this Practice will be aware of how to access:

- This policy document
- South Yorkshire Safeguarding Adults Procedures
- Support and advice from local safeguarding professionals

**Definition**

The definition of someone who was previously known as a ‘vulnerable’ adult has been revised within the Care Act 2014. This replaces the No Secrets guidance (DH, 2000) and is now known as an adult at risk.

Safeguarding Duties apply to an adult at risk who meets the following 3 point test:

- Has needs for care and support and
- Is experiencing, or at risk of, abuse or neglect, and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect

If an adult meets the above criteria they will be assessed and considered for support through the safeguarding procedures.

It is key to remember that:

- Anyone can be an abuser. Abusers can be family members, partners, friends, neighbours, people who work or volunteer in health or social care services, or strangers
- Abuse can happen anywhere. It can happen at home, at work, in a nursing or residential home, in hospital and is usually carried out by a person in trust to the individual
- Abuse can happen once, a few times or lots of times. It can be deliberate or unintentional. It might be the result of a lack of training, knowledge or understanding or as a result of non-paid carer breakdown (carer stress).

**Six Key Principles**

Six key principles underpin all Adult Safeguarding work. These principles should inform the ways in which you work:

- **Empowerment** - People being supported and encouraged to make their own decisions and informed consent. “I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.”
- **Prevention** - It is better to take action before harm occurs. “I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.”
- **Proportionality** - The least intrusive response appropriate to the risk presented. “I am sure that the professionals will work in my interests as I see them, and they will only get involved as much as needed.”
Protection - Support and representation for those in greatest need. “I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.”

Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. “I am confident that professionals will work together and with me to get the best result for me.”

Accountability - Accountability and transparency in delivering safeguarding. “I understand the role of everyone involved in my life and so do they.”

Categories of Abuse
The following are forms of adult abuse within the Care Act:

Physical - Hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions

Sexual - Rape and sexual assault or sexual acts to which the adult at risk has not consented, or could not consent, or was pressured into consenting

Psychological - Emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks

Financial or material - Theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits

Neglect and acts of omission - Ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating

Discriminatory - Racist, sexist, that based on a person’s disability, and other forms of harassment, slurs or similar treatment

Organisational (replaces institutional) – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example or in relation to care provided in one’s own home. This may range from one off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practice within an organisation

Self-Neglect this covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding

Because Self-Neglect is now a category of abuse, the process of Vulnerable Adults Risk Management is now included within the safeguarding process. For further information on how to manage cases within this model please refer to the Rotherham Safeguarding Adult Procedures.

Modern slavery encompasses slavery, human trafficking, forced labour and domestic servitude. Slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment (See also section 9)

Domestic Abuse including psychological, physical, sexual, financial, emotional and so called honour based violence (see also section 6)

The following are also recognised as abuse, but not identified separately within the Care Act. They fall under Discriminatory abuse. There are established processes to deal with these in Rotherham: Hate crime can be reported via telephone 101 or 999 in case of emergency or online:
Further advice can be gained by calling the 24/7 telephone hate crime reporting line on 01302 736666

**Hate crime** – Hate crimes and incidents are taken to mean any crime or incident where the perpetrator’s hostility or prejudice against an identifiable group of people is a factor in determining who is victimised. A person may be targeted because of hostility or prejudice towards that person’s: disability, race or ethnicity, religion or belief, sexual orientation or transgender identity. The crime can be committed against a person or property and a victim does not have to be a member of the group at which the hostility is targeted. In fact, anyone could be a victim of a hate crime.

**Mate crime** – is similar to hate crime other than a perpetrator purports to be a friend or mate of the victim

**Internet abuse** – adults exposed to abuse through digital media

**What To Do If You Have Concerns about an Adult at Risk of Harm or Neglect**

Refer to South Yorkshire Safeguarding Adults procedures which contain the details of how to raise a concern, what happens after a concern has been raised and what input is expected from individuals during this process. _ [https://www.doncaster.gov.uk/services/adult-social-care/safeguarding-adults-policy-and-procedures](https://www.doncaster.gov.uk/services/adult-social-care/safeguarding-adults-policy-and-procedures)_

The Care Act requires that the Local Authority **MUST** make enquiries or cause others to do so if it believes an adult meets the criteria of the Care Act or is at risk of abuse or neglect. A Section 42 (Care Act) enquiry must take place. This could be a telephone call, e-mail exchange or requires a multi-agency meeting. The Local Authority will identify and ‘cause’ the most appropriate organisations or people to undertake the enquiry. The Lead GP for the practice should, wherever possible, make themselves available to support requests for Section 42 enquiries.

**Management of Adults Not Meeting the Criteria for Adult at Risk processes**

If an adult does not meets the criteria above they may still have need for support. It is important to optimise this adult’s safety by working in a multi-agency team to share information and develop a holistic and efficient plan covering their social and health needs.

There are a number of processes to support these adults e.g. Domestic Abuse via such as MARAC and the Vulnerable Adults Risk Management (VARM) process.

**Vulnerable Adults Risk Management (VARM)**

Consider where an adult is utilising services frequently and existing care management and health and social care involvement has failed to resolve the issues.

**Local Authority Designated Officer (LADO)**

Despite all efforts to recruit safely there will be occasions when allegations of abuse against vulnerable people will be raised. The allegations may relate to the person’s behaviour at work, at home or in another setting. All allegations of abuse of vulnerable people by those who work with either children or adults must be taken seriously.

The Local Authority Designated Officer (LADO) sits within children’s social care. It is their responsibility to investigate concerns when a referral is made to them regarding any member of staff.

For adults, the process is known as “People in a Position of Trust” (PiPoT) and is managed via [insert practice name]’s HR process.
You should speak immediately to your line manager or a member of the safeguarding team if you witness, hear or become aware that a colleague has:

- Behaved in a way that has harmed a child/vulnerable adult, or may have harmed a child/vulnerable adult;
- Possibly committed a criminal offence against or related to a child/vulnerable adult;
- Behaved towards a child/vulnerable adult in a way that indicates that they may pose a risk of harm to children/vulnerable adult; or
- Concerns arise about the person’s behaviour with regard to his/her own children/vulnerable adult;
- Concerns arise about the behaviour in the private or community life of a partner, member of the family or other household member.

Jim Foy is the Senior Designated Officer for LADO.

**Whistleblowing**

Whistleblowing is the reporting of unsafe or illegal practices in the workplace. You have a responsibility to report things that you feel are not right, are illegal, or if anyone at work is neglecting their duties. Speaking to your manager will normally be your first step. However, if it is this person’s work that you are concerned about you can seek support from a more senior person or from someone outside of the workplace. You can find more information within the CCG’s Whistleblowing Policy.

Further information: [https://doncasterscb.proceduresonline.com/p_alleg_against_staff.html](https://doncasterscb.proceduresonline.com/p_alleg_against_staff.html)

**Training**

Staff at [Insert Practice Name] will be offered training appropriate to their role, in line with Safeguarding Adult Competencies. DMBC offers multi-agency training for commissioned providers of care see [https://dscp.org.uk/professionals/training](https://dscp.org.uk/professionals/training).

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**SECTION 5: MENTAL CAPACITY ACT (MCA)**

**Context**

[Insert Practice Name] is committed to ensuring that individuals coming into contact with its services are treated with dignity and respect and that they and their families/carers receive appropriate care and support. This includes consideration of gender, race, any disability, sexual orientation, age and religion or belief.

The Mental Capacity Act (MCA 2005) provides a statutory framework to empower and protect people aged 16 years and over, who are temporarily or permanently unable to make some, or all of their own decisions. Guidance on the MCA is provided in a ‘Code of Practice’ which can be found at: [https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice](https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice). As the Code has statutory force all health care staff have a legal duty to have regard to it.

The Lead Clinician and their Deputy for the MCA are [Enter Names]. They will work with the Practice Manager, [Enter Name] to ensure that all staff are informed of the MCA and receive sufficient training and support in order to undertake their role.

All staff and volunteers in this practice will know what to do and who to go to if they have any concerns regarding capacity issues. The MCA Flow Chart is an overview of the process to follow when assessing capacity.
All staff in this Practice will be aware of how to access:

- This policy document
- The supporting Code of Practice
- Support and advice from local MCA professionals

**Key Principals of the MCA**

The five key principles emphasise the fundamental concepts and core values of the MCA. These must always be borne in mind when working with, or providing care or treatment for people who lack mental capacity.

The five key principles are:

- A presumption of capacity
- The right for people to be supported to make their own decisions
- The right for people to make what might be seen as eccentric or unwise decisions
- Doing things for those who lack capacity that are in their best interests
- Choosing the least restrictive intervention

**The MCA and Children and Young People**

There is an overlap between the MCA and the Children Act (2004) for 16 and 17 year olds and parents or others with parental responsibility should be consulted where applicable and appropriate. Although the MCA does not generally apply to children under 16 years, there are two exceptions:

- The Court of Protection can make decisions about the property and affairs of a child where it is likely that the child will lack capacity to make those decisions when they reach 16 years of age
- The criminal offence of ill-treatment or wilful neglect also applies to children under 16 who lack capacity as no lower age limit is specified for the victim

**Assessments of Capacity**

A healthcare professional who has reason to believe that an individual lacks capacity should be able to provide proof. They need to be able to show that the person lacks capacity to make a particular decision, at the time it needs to be made by using the two-stage test of capacity:

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn’t matter whether the impairment or disturbance is temporary or permanent.)
- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

**Assessing Best Interest**

The MCA provides a checklist of factors that decision-makers must work through in deciding what is in a person’s best interests when a person is found to be lacking in capacity for that particular decision.

The ultimate responsibility for working out best interests lies with the decision-maker.

**Decision-Makers**

The decision-maker is determined by the nature and complexity of the decision to be made. Day-to-day care decisions may be made by the carer most directly involved with the person at the time where the person lacks capacity for those decisions. Where nursing care is provided, the member of the healthcare team responsible for delivering the care will be the decision-maker.
decision involves the provision of medical treatment, the doctor or other member of the healthcare team responsible for carrying out the particular treatment or procedure is the decision-maker. The decision-maker must involve an Independent Mental Capacity Advocate (IMCA) for decisions about serious medical treatment or certain changes of accommodation where the person lacks capacity and there is no family member or friend to consult or where there are disagreements. If a Lasting Power of Attorney (LPA) has been made for health and welfare and registered or a deputy appointed under a court order, the attorney or deputy will be the decision-maker for decisions within the scope of their authority.

Major Decisions
The aim of the IMCA service is to provide independent advocacy to protect people lacking decision-making capacity at the time such decisions need to be made and the person has nobody to support or represent them. If necessary, the IMCA can challenge the decision-maker on behalf of the person lacking capacity. An IMCA must be appointed to support a person who lacks capacity and has no family or friends to consult where it is proposed that the person:

- Needs serious medical treatment
- Is moved into long-term care of more than 28 days in hospital
- Is moved into long-term care of more than eight weeks in a care home
- Is moved (for more than eight weeks) to different accommodation, such as a different hospital or care home

In England, the NHS has been given powers to extend the IMCA service to specific situations if they are satisfied that an IMCA would provide particular benefit. These are:

- Care reviews about accommodation or changes to accommodation, and
- Safeguarding adult cases (even if the person who lacks capacity has family and/or friends)

Making Referrals to the IMCA Service
Rotherham Advocacy service is provided by Absolute Advocacy. This service provides independent advocacy for people who lack capacity and who do not have family or friends who can speak on their behalf for decisions that need to be made about serious medical treatment or significant changes in residency. An IMCA may be instructed to support someone who lacks capacity to make decisions concerning care reviews where there is nobody else to consult and for the protection of adults at risk whether or not family, friends or others are involved. Contact can be made via details at https://www.voiceability.org/services/doncaster/independent-mental-capacity-advocacy-imca.

Designated Decision-Makers
The MCA identifies two types of decision-makers who have authority to make decisions: Lasting Power of Attorney (LPA) and Court Appointed Deputies. Further information can be found at the Office of the Public Guardian found at https://www.gov.uk/government/organisations/office-of-the-public-guardian

Restraint
The MCA defines restraint as any restriction of liberty or movement (whether or not the person resists) and the use of threat of force where an incapacitated person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm and the restraint used is proportionate to the likelihood and seriousness of the harm and is the least restrictive approach.

Deprivation of Liberty Safeguards (DoLS)
The Deprivation of Liberty Safeguards are an amendment to the MCA (2005) and came into force on 1 April 2009. From this point, a managing authority (care home or hospital) must seek authorisation from a supervisory body (local authority) in order to lawfully deprive a person of their liberty. The supporting Code of Practice can be found at:


However, Practice staff are reminded to refer to judgements handed down on 19 March 2014 by the Supreme Court in order to comply with the law following the revised test about the meaning of a deprivation of liberty (e.g. P v Cheshire West), which is of particular relevance to those who are involved in the care of individuals who may lack capacity as it is significant in in the determination of whether arrangements made for the care and/or treatment of an individual amounts to a deprivation of liberty. The Supreme Court has clarified that there is a deprivation of liberty for the purposes of Article 5 of the European Convention of Human Rights if the individual is under continuous supervision and control and is not free to leave (the acid test) and the individual lacks capacity to consent to these arrangements. In such cases, managers in care homes and hospitals (managing authorities) will need to apply to the Local Authority (supervisory body) for authorisation. The Court of Protection can also make an order authorising a deprivation of liberty in domestic settings such as supported living arrangements. GP’s should be notified of all such authorisations made on behalf of their patients.

Criminal Offences
The MCA has introduced a criminal offence of ill treatment and wilful neglect of a person who lacks capacity. There is no specific lower age limit. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

Training
[Insert Practice Name] will be proactive in its responsibility for identifying capacity concerns. We will ensure that our staff undertake MCA training requirements (external as well as in-house) as appropriate.

SECTION 6: DOMESTIC ABUSE

Context
[Insert Practice Name] believes that their staff have a responsibility to reduce the risk of harm arising from domestic abuse. Their dignity and personal identity should be respected and they should be encouraged to be involved in any decision which may directly affect them.

The Clinical Lead responsible for Safeguarding Adults and Domestic Abuse is [Insert Clinical Lead Name] who will work with the Practice Manager, [Insert Practice Manager Name] to develop and review this policy, implementing changes appropriately and speedily.

All staff of this practice will know what to do and who to go to if they have any concerns regarding an individual at risk of domestic abuse. The South Yorkshire and Bassetlaw Safeguarding Adults procedures detail the practicalities of how to ensure individual cases are managed correctly.

All staff within this Practice will be aware of how to access:

- This policy document
- South Yorkshire Safeguarding Adults Procedures
- Support and advice from local professionals
Definition
The Department of Health definition is:
“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality” https://www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals

Categories of Abuse
This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial, emotional. This definition includes so called ‘honor’ based violence, female genital mutilation (FGM) and forced marriage.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

What to do if You Have Concerns About Domestic Abuse

The website details how to raise an alert, details what happens to cases after referral and what input is expected from individuals during this process. This includes indicating the suspected level of harm the victim may be suffering.

For confidential advice, information and support, call the Domestic Abuse Hub on 01302 737080
National Domestic Violence 24/7 Helpline (freephone): 0808 2000 247
If there are any children involved when Domestic Abuse is disclosed or suspected there will be a need to contact children’s social care.

MARAC: Multi – Agency Risk Assessment Conferences
MARAC multi-agency meetings are where victims of domestic abuse who are at high risk of harm and death are discussed to make plans to improve their safety. Representatives from agencies such as health, housing, social and police are present as well as domestic abuse services. They are held frequently so any requests for information need to be prioritised.

Managing Data and Confidentiality
The principles of the data protection act apply when managing data related to domestic abuse.

If a patient is at high risk of harm (and therefore being referred to MARAC), it is appropriate to share relevant information without their expressed consent if unable to acquire it. The BMA Confidentiality Guidance supports this in section 37. http://www.bma.org.uk/support-at-work/ethics/confidentiality-and-health-records

The following quote from the MARAC information sharing protocol clarifies this more specifically
Consent should be obtained wherever possible before sharing information at the MARAC. Where consent to share all or part of the information is withheld, or it is not possible to request consent, the
common law duty of confidentiality permits confidential information to be shared [without consent] where it is required by law or where it is in the public interest to do so. However, sharing information without consent should only be undertaken in exceptional circumstances; in all other circumstances an individual's wishes not to share their information should be respected.

Examples of sharing information in the public interest include:

- Where a child is believed to be at risk of harm (Children Act 1989)
- Where there is a risk of harm to anyone
- Where information is required for the prevention, detection or prosecution of a crime

**Domestic Homicide Reviews (DHR)**

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

Following a domestic homicide a review may be carried out. Details of the full process can be found at the in the guidance ‘Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised – applicable to all notifications made from and including 1 August 2013’.


The author of each agency’s review (eg GP) creates a chronology of all contacts the victim, perpetrator, and any other relevant people had with the practice. Any member of staff may be interviewed as part of a DHR. The Practice Manager and the clerical staff will be involved in making the appropriate records available for the author of their section of the DHR. On completion of a DHR the relevant recommendations are disseminated to every practice in Rotherham. The Practice Manager and Clinical Lead in each practice are then encouraged to implement the recommendations made.

**Training**

Staff at [Insert Practice Name] will be offered training appropriate to their role, in line with best practice.

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**SECTION 7: PREVENT**

**Context**

The *Prevent* Strategy is a cross-Government policy that forms one of the four strands of CONTEST – the Government’s counter terrorism strategy. With over 1 million contacts with patients every 36 hours, the NHS is key to the support and delivery of the Government’s *Prevent* Strategy and we will need to work hard to embed it fully into everyday safeguarding activity, including mandatory training.

*Prevent* is central to the Safeguarding agenda and therefore needs to be a priority within Safeguarding policies, procedures and training.

As a significant health provider of NHS Services you as a Practice may find it useful to consider the Department of Health (2012) publication *Building Partnerships, Staying Safe.*


This guidance includes a self-assessment tool which is linked to the Care Quality Commission Essential Care expectations, in particular Outcome 7.

**Training**
NHS England Grab Guide

NHS England PREVENT Training Framework
Levels of training have been linked to the Intercollegiate document on roles and responsibilities of healthcare staff. Details of training requirements/courses for Prevent can be found at:

Referral:

<table>
<thead>
<tr>
<th>Referral</th>
<th>Phone</th>
<th>Name</th>
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<tbody>
<tr>
<td>101 – Police</td>
<td>0800 555111 – Crime stoppers</td>
<td>999 – Emergency only</td>
</tr>
<tr>
<td>Counter Terrorism Hotline</td>
<td>0800 789321 (if the refer wants to remain anonymous)</td>
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</tr>
<tr>
<td>Contact Prevent South Yorkshire (Monday to Friday 8am - 4pm), Tel: 0114 2523217. E-mail: <a href="mailto:prevent@southyorks.pnn.police.uk">prevent@southyorks.pnn.police.uk</a></td>
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SECTION 8: FEMALE GENITAL MUTILATION (FGM)

Context
FGM is an illegal, extremely harmful practice and a form of child abuse and violence against women and girls. It is not an issue that can be decided on by personal preference.

The Department of Health (March 2015) has published updated guidance, Safeguarding Women and Girls at risk of FGM, to support NHS organisations to develop or review safeguarding policies and procedures around female genital mutilation (FGM). It is based on existing best practice within the NHS and has been developed in partnership with health and social care professionals, and professional bodies.

[Insert practice name] approach to safeguarding against FGM is multi-agency and multi-disciplinary. We will work with partners in social services and the police.


Reporting
If any child (under 18) or adult has symptoms or signs of FGM, or if there are good reasons to suspect they are at risk of FGM having considered their family history or other relevant factors, [Insert practice name] will follow existing safeguarding procedures.
[Insert practice name] acknowledges its statutory duty to report any patient identified as having FGM performed to NHS Digital and ensure the practice is registered to complete this requirement. The practice will also inform the police if the patient is less than 18 years of age.

Any new patient identified as having had FGM should have an alert placed on their electronic record using the appropriate code.

Further information:
https://doncasterscb.proceduresonline.com/p_fem_gen_mutil.html
Training

All clinical staff at [Insert Practice Name] will be offered FGM training as appropriate to their role and responsibilities http://www.e-lfh.org.uk/programmes/female-genital-mutilation/

SECTION 9: TRAFFICKING AND MODERN SLAVERY

Context
Modern Slavery is the illegal trade of human beings for the purposes of commercial sexual exploitation or reproductive slavery, forced labour, or a modern-day form of slavery.

Who is trafficked?
British and foreign nationals can be trafficked into, around and out of the UK. Children, women and men can all be victims of modern slavery.

Why are people trafficked?
Children, women and men are trafficked for a wide range of reasons including:

- Sexual exploitation
- Domestic servitude
- Forced labour including in the agricultural, construction, food processing, hospitality industries and in factories
- Criminal activity including cannabis cultivation, street crime, forced begging and benefit fraud
- Organ harvesting

How might you encounter a victim of modern slavery?
A person may tell you about their experience
You detect signs that suggest a person may have been trafficked
A trafficked person may be referred to you

Signs of trafficking for adults, children and young people include:
A person being accompanied by someone who appears controlling, who insists on giving information and coming to see the health worker

The person:
Is withdrawn and submissive, seems afraid to speak to a person in authority and the accompanying person speaks for them
Gives a vague and inconsistent explanation of where they live, their employment or schooling
Has old or serious injuries left untreated. Has delayed presentation and is vague and reluctant to explain how the injury occurred or to give a medical history
Is not registered with a GP, nursery or school
Has experienced being moved locally, regionally, nationally or internationally
Appears to be moving location frequently
Their appearance suggests general physical neglect
They may struggle to speak English

In addition:

Children and young people
- Have an unclear relationship with the accompanying adult
- Go missing quickly (sometimes within 48 hours of going into care) and repeatedly from school, home and care
- Give inconsistent information about their age

Adults
- Have no official means of identification or suspicious looking documents

**Contribution of Primary Care**

All staff in every health care setting could spot a victim of modern slavery
All staff have a duty of care to take appropriate action and legal obligation in the case of children under 18
All immediately necessary treatment should be provided

**If you suspect that your patient may be a victim of modern slavery, take the following action:**

Children and young people under 18 years
For concerns about a child or young adult follow all child protection guidelines and speak to your designated Child Protection Lead. Please note that health professionals have a legal obligation to safeguard children that present to them.
Out of hours, contact your Local Children’s Social Services or police service, specifically highlighting your concern for child trafficking.
Consider referral to your hospital paediatric team for admission.

Adults
For concerns about an adult, contact SPA 01709 822330
Consider a referral to the National Referral Mechanism.
You can also contact the Salvation Army 24 hour confidential helpline for professional advice and support and referrals on 0300 303 8151 operating 7 days a week
Only make referrals if the person is able to give consent and has agreed to the referral
Consider using maternity services to admit pregnant women for observation

Department of Health Guidance
Appendix 1 – Safeguarding Adult and Child Flow Chart

SAFEGUARDING FLOWCHART FOR REFERRALS
WHAT TO DO IF YOU ARE WORRIED ABOUT AN ADULT OR CHILD

- Gather available information that would support your suspicion
- Discuss with your manager & safeguarding lead and/or other senior Colleagues as you think appropriate
  Beware not to alert any potential abuser that may put the Child/Adult at further risk
- For children: consider the detailed Doncaster Safeguarding Children Partnership multi-agency levels of need.

CONCERNS

RESOLVED

Consider further action/referral to ensure services are provided by own and partner agencies for continued support

If you feel there is an immediate risk CALL 101 OR 999

For general information, advice and guidance about Safeguarding Adults call the Safeguarding Adults unit on: 01302 736296
Or contact and emergency out of hours number: 01302 796000
You can also complete an online form at: https://www.doncaster.gov.uk/services/adult-social-care/safeguarding-adults-contents-page

Urgent concerns regarding a child or young person’s Mental Health
If you have urgent concerns regarding a child or young person’s mental health, please call the duty team on: 01302 796191

Urgent Safeguarding concerns
- For urgent safeguarding concerns please call the duty team on : 01302 737777

Use the form on the Doncaster Children’s trust website if you have a concern about a child or want to enquire about Early Help. You can complete the form which will go to One Front Door and you will get one of two responses. https://www.doncasterchildrenstrust.co.uk/worried-about-a-child
### Useful Safeguarding Contacts – Children & Young People

**Designated Professionals**
- Andrea Ibbeson
  - Head of Quality & Designated Nurse for Safeguarding Children & LAC
  - 01302 566105
- Gill Wood
  - Designated Nurse for Safeguarding Children & LAC
  - 01302 566276
- Dr Lee Oughton
  - Named GP for Safeguarding
  - 01302 566054
- Dr Naeem Ashraf
  - Designated Doctor for Looked after Children
  - 01909 502677
- Dr Bushra Ismaiel
  - Designated Doctor for Safeguarding
  - 01302 366666

**Rotherham Doncaster & South Humber Safeguarding Children Admin Team**
- Maria Alexander, Secretary
  - Childrens, 01302 798198
- Julie Woodward, Assistant
  - Secretary Childrens, 01302 798419

**Looked After Children Team (LAC)**
- Paula Walker
  - Named Nurse for Looked After Children
  - 01302 796000

**Rotherham Doncaster & South Humber Safeguarding Children Team**
- Dr Navjot Ahluwalia
  - Named Doctor Safeguarding Children
  - 01709 447619
- Kate Baxendale
  - Nurse Consultant
  - 01302 566164
- Julie Lodge
  - Associate Nurse Director
  - Children’s Care Group
  - 01302 798010
- Julie Toft
  - Named Nurse Children – Rotherham
  - 01202 706767
- Susan Halliday
  - Named Nurse/Professional
  - Children – Doncaster
  - 01302 796023
- Charlotte Harrison
  - Named Nurse Children – North Lincolnshire
  - 01307 768198
- John Bushell
  - Named
  - Nurse/Professional
  - Children – Doncaster
  - 01307 746071

### Doncaster & Bassetlaw Teaching Hospital
- Dr Lavleen Chadha
  - Named Doctor for Safeguarding Children
  - 01302366666
- Elizabeth Boyle
  - Named Nurse for Safeguarding Children
  - 01302 642436
- Admin Office for Safeguarding Children
  - 01302 642437
  - DBH-HR.safeguarding@nhs.net

### Useful Safeguarding Contacts – Adults

**NHS Doncaster CCG**
- Ian Boldy
  - Deputy Chief Nurse & Designated
  - Nurse for Safeguarding Adults
  - 01302 566099
- Leah Denman
  - Lead Nurse for All Age Individual
  - Placements & Safeguarding Adults
  - 01302 566164

**Doncaster & Bassetlaw Teaching Hospital**
- Pat Johnson
  - Lead Professional for Safeguarding Adults
  - 01302 642437

**Rotherham Doncaster & South Humber**
- Karen Whitby
  - Safeguarding Adult Lead
  - 07770430835
- Kim Goddard
  - Safeguarding Adult Lead
  - 07795223979
- Charlie Cottam
  - Safeguarding Adult Lead
  - 07824343059
- Nicola O’Connor
  - Safeguarding Adult Lead
  - 07901561779
Meeting name: Primary Care Commissioning Committee
Meeting date: 12 December 2019
Title of paper: Primary Care Networks Development

Executive / Clinical Lead(s): Anthony Fitzgerald, Director of Strategy and Delivery
Author(s): Carolyn Ogle, Associate Director of Primary Care & Commissioning

Status of the Report
To approve: √
To consider / discuss: √
To note: 

Purpose of Paper - Executive Summary
The purpose of this report is to outline the principles to be adopted in relation to the use of resources for the development of PCNs and to agree how the funding should be allocated. The evaluation of the primary care event held on 19 November 2019 is included for noting. The event was to support practices to identify the additional partners they are required to include in their Network Agreement from April 2020.

Recommendation(s)
Subject to discussion with the Clinical Directors the principles for use of PCN Development monies are approved.

The deployment of resources to Primary Care Doncaster for this purpose is also approved.

The evaluation of the primary care workshop is noted.

Report Exempt from Public Disclosure
If yes, detail grounds for exemption:
Yes [ ] No [Y]

Impact analysis
Quality impact: Development of primary care networks supports the sustainability of primary care
### Equality impact

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### Sustainability impact

- Development of primary care networks supports the sustainability of primary care as a whole

### Financial implications

- included in report

### Legal implications

- described in the report

### Management of Conflicts of Interest

- None identified but managed within Committee constitution

### Consultation / Engagement (internal departments, clinical, stakeholder and public/patient)

- Practice visits and practice manager discussions

### Report previously presented at

- Regular updates provided to Committee

### Risk analysis

- n/a

### Corporative Objective / Assurance Framework

The report links to the following corporate objectives:

- Commission high quality, continually improving, cost effective healthcare which meets the needs of the Doncaster population
- Work collaboratively with partners to improve health and reduce inequalities in well governed and accountable partnerships.

### Primary Care Statutory Duties (only)

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Primary Care Commissioning Committee

12 December 2019

Primary Care Networks Update

Introduction

At the last meeting of the Primary Care Commissioning Committee it was noted that £1.156m was available to support the development of PCNs across South Yorkshire and Bassetlaw to March 2020.

The proposed plan on a South Yorkshire & Bassetlaw basis meant that £200,000 was to be topsliced to deliver the following:

- Bespoke Clinical Director development
- Social prescribing Link Worker development events
- Management development – Practice manager events and wider leader events
- Development of wider network staff
- Targetted specialist sessions

£956,000 therefore remains to be allocated to CCGs to support local priorities for PCN development. An allocation methodology was agreed which was a combination of the number of PCNs and list size; resulting in £167,892 being available to Doncaster.

The Primary Care Leads have been tasked with agreeing a set of principles for use of the funding to ensure consistency of approach and these are attached for approval by the Committee. Any comments made by the Clinical Directors at their meeting earlier in the week will be shared at the meeting.

Monitoring

The monitoring of PCN development and use of PCN funding in 19/20 has been described by NHS England and NHS Improvement as:

By end December 2019 (Q3)

- ICS/ STP share an interim summary update on how system-level PCN development support is progressing. This is to provide confidence in the development of PCNs but also offer an opportunity to share learning across the Region and potentially to be able to show case.

- ICS/ STP to confirm spend on PCN development, which is already collated, centrally, via the ledger.

By end March 2020 (Q4)

- ICS/ STP to provide information to their system governance on PCN development and CD development covering 19/20 and setting out the top development themes, and the key learning and outputs/impacts, and the extent to which PCNs are set up for success in 20/21 -
in a format that can be aggregated for sharing with Regions, for example themes organised by development support domain.

• ICS/STPs to confirm spend and out-turn on their share of the national PCN transformation funding

The Principles

National Parameters:
Funding should be used for:
- Freeing up clinical time to enable the development of PCNs
- Local transformation resources
- Support from NHS family bodies such as NHS Leadership academy, NHSE Sustainable Improvement Team, CSUs, Federations, at scale providers and Trusts
- Commissioning support from providers through HSSF or other procurement mechanisms

Funding should NOT be used for:
- Anything already covered in the contract including Clinical Director time
- Anything already funded by the CCG or another system partner (see ICS list below)
- Non transformation costs
- Work not related directly to PCNs

ICS plan (topslice)
- Bespoke CD Development £3,200 per CD proposed
- Social Prescribing Link Worker Events £1,000 per post based on 1 post per PCN
- Management development – practice manager events and wider leadership events that are SYB wide
- Development of wider network staff (OD of network)
- Targetted specialist sessions such as legal advice, employment advice, bid writing and negotiation skills.

Doncaster plan (£167,892 available)
- Backfill support should not exceed 20% of the full allocation
- Backfill costs to be provided at local Federation rate
- Support should already have been identified in the submitted development plans
- Priority will be given to those development opportunities that are common across all five PCNs in particular:
  - Creating a shared purpose, common challenge, visions and goals, agreed shared development actions and priorities – support from the Releasing Time for Care leads
  - Integrated working through MDT approach
  - Testing concepts of out of hospital care/new pathways
  - Using population health management techniques and data
Enc G

Should any funding be remaining this will be shared on a pro rata basis by PCN list size to deliver their individual development needs however this will need to be used to demonstrate how progression on the maturity matrix will be assured.

Deployment of Resources
Subject to agreement with the Clinical Directors it is suggested that the funding be devolved to Primary Care Doncaster to work across all five PCNs to deliver the development plans.

Primary Care Network Event – 19 November 2019

The evaluation feedback from the workshop is below for information.

1. On a scale of 1-5 (1 being poor, 5 being excellent), how satisfied were you with the following:

<table>
<thead>
<tr>
<th>Event date</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tr>
<td>Event location</td>
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<td>5</td>
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<td>Catering</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>2</td>
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</table>

2. Do you feel there were any topics missing from the Agenda? YES (1) NO (12)

3. Which topics would you like to see covered at future Events? No Comments

4. Did you find the following topics useful or not useful?

<table>
<thead>
<tr>
<th>Topic</th>
<th>Useful</th>
<th>Not Useful</th>
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<tr>
<td>CCG Update</td>
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<tr>
<td>Population Health Management</td>
<td>11</td>
<td>2</td>
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<tr>
<td>Developing Partnerships</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

5. Do you feel enough time was given to each Agenda item? YES (13) NO (0)

6. Do you feel enough time was given for table top discussions? YES (12) NO (1)

7. As you will be aware, the CCG funds Urgent Medical Cover for Primary Care Events; do you feel the cover is necessary to allow you to attend? YES (12) NO (1)

8. What did you like most about the Event?
   Time to have discussions with wider teams, variety of groups attending, positive mood and discussions, partnership developments, getting up to date,

9. What did you least like about the Event?
   Some GP’s not able to attend without cover, more clarity about what they are supposed to do, limited vegetarian food, feel it would be better to have individual sessions rather than whole group events.
Meeting name: Primary Care Commissioning Committee
Meeting date: 12 December 2019
Title of paper: Coordinated Proactive Primary Care 2020/21

Executive / Clinical Lead(s): Anthony Fitzgerald, Director of Strategy and Delivery
Author(s): Karl Roberts – Primary Care Manager

Status of the Report
To approve: √
To consider / discuss: 
To note: 

Purpose of Paper - Executive Summary
The purpose of this paper is to provide committee with an update and seek approval in relation to Doncaster’s Local Enhanced Service (LES) around Coordinated Proactive Primary Care for 2020/21 and specifically the headline changes in specification relating to move from commissioning at practice level Primary Care Networks/Identified groups of practices.

Recommendation(s)
To approve the headline changes in the specification relating to coordinated proactive primary care in 2020/21

Report Exempt from Public Disclosure
Yes: 
No: √
If yes, detail grounds for exemption:

Impact analysis
Quality impact: Includes quality benchmark measures such as patient experience
Equality impact: Summary of impact, if any, of CCG’s duty to promote equality and diversity based on Equality Impact Analysis (EIA). All reports relating to new services, changes to existing services or CCG strategies / policies must have a valid EIA and will not be received by the Committee if this is
An Equality Impact Analysis/Assessment is not required for this report.

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<tr>
<th>Sustainability impact</th>
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<td></td>
<td>Nil</td>
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<td>Engagement with finance and contracting as well as quality and performance</td>
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<td>CO1 and CO2 report enables CCG to be benchmarked on its governance and effectiveness as well as quality and cost effectiveness</td>
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**Primary Care Statutory Duties (only)**

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**Coordinated Proactive Primary Care (LES) 2020/21**

At the beginning of 2019/20 the CCG committed to the continuation of the Proactive Primary Care funding through to the end of the 2021 financial year. The CCG also committed that the commissioning of this service from the 1st April 2020 would be via Primary Care Networks or identified groups of practices (e.g. as we have established in the south west).

The specification itself was agreed would largely remain the same however because of the move to Primary Care Networks and based upon the feedback from practices there are a number of headline changes that have either had to be made or need to be worked in light of the new operating model/feedback received. The areas have been listed below and represent the changer/variation from the previous specification:

- **No prequalifying qualitative application will be required**
  The vast majority of practices (minus 2) have already provided these and with specification largely remaining the same this would some a fruitless exercise as the responses would remain largely the same.

- **Confirmation of engaging with other services (NRLS, NDPP etc.)**
  PCNs/Groups of practices will have to ensure each of the practices within their identified group confirm that they are working with partners/key services at the beginning of the year via a self-declaration. The CCG will sample the data that they receive in relation to these areas to ensure that that this is still the case throughout the year but PCN’s/Identified groups of practices will not be required to provide quarterly declarations submission around these areas.

- **There will be no quarterly qualitative reports**
  Based upon feedback received and the duplication in the responses received it is felt that this is not the best way to seek assurance of the service being provided. Instead it is put forward that a physical audit is carried out with each of the PCN’s/Group of identified practices at 3 and 9 months. These will be carried out by existing members of the CCG evaluation group but it is intended the audits and content will be quality led. If after the visits the relevant level of assurance in not provided then the CCG withholds the right to ask the PCN/group of practices to complete an actions plan and/or participate in further visits.

  *(It is hoped that we can get LMC and practice input in to how we can make these more meaningful).*

- **Quarterly Quantitative reports**
  PCN’s/Groups of practices will again be required to submit one report for their group each quarter via the Primary Care Matrix. The Data Quality team will
provide coding/templates to facilitate this which should simplify the process. This will require someone to collate and submit the results for each identified group. The indicators for this are likely to change/simplified but have not yet been agreed (it is hoped that we can get LMC and practice input in to how we can make these more meaningful).

- **2% MUST be maintained each quarter for each PCN/Group of practices**
The 2% will be based upon the total PCN/Group of practices list size, this will be down to each PCN group of practices to police and flow funding accordingly. This is a significant change from last year where the 2% was policed as a total at the end of the year.

- **Evaluating the key actions and achievements**
Each PCN/Group of practices will be required to complete an end of year evaluation covering the key areas covered, what has gone well, what not so well, and what has been the learning etc. (It is hoped that we can get LMC and practice input in to how we can make these more meaningful).

Although the final specification for 2021 is not yet complete the changes above represent the most significant changes. The specification will also be clear in the wording relating to non-compliance, assurance and submission timescales; this will provide clear expectations and consequences. This will again be worked up with the CCG and take input from the LMC, PCD and the PCN clinical leads.
Agenda Items | Lead | Paper / Verbal  |
---|---|---
1 | Apologies for absence | Chair | Verbal |
2 | Declarations of Interest | Chair | Verbal |
3 | Notification of Any Other Business | Chair | Verbal |
4 | Minutes of the previous meeting | Chair | Paper |
5 | Matters Arising not on the Agenda, Including Resubmitting the Action Tracker | Chair | Verbal |
6 | Action Tracker | Chair | Paper |
7 | Finance & Contracting: | | |
8 | New Business - Report & Paper | Hayley Tingle | Verbal |
9 | Full Quarterly Report | Hayley Tingle | Paper |
10 | Annual Budget Testing | Hayley Tingle | Paper |
11 | Primary Care Estates Strategy - Implementation Plan | Carolyn Ogle | Paper |
12 | The New Millennium Centre - Boundary Change | Karl Roberts | Paper |
13 | The Harrogate Practice & Dr Sheikh's Surgery - Unguarded | Carolyn Ogle / Karl Roberts | Paper |
14 | Clinical Consultation | Karl Roberts | Verbal |
15 | Minutes | Wendy Lawrence | Paper |
16 | Practice Plan | Karen Lavers | Paper |
17 | Bedside+ Demonstration | Karl Roberts | Presentation |
18 | Practice Registered Patient List Size Issues | Gemma Miller | Paper |
19 | Quality for Care Homes | Karen Tolley | Paper |
20 | The P Bingo Slotman - Contract Extension | Carolyn Ogle | Paper |
21 | Journey - Pathway for | Emma Pray | Paper |
22 | Estates Capital Update | Carolyn Ogle | Paper |
23 | Dynamic Purchasing System | Carolyn Ogle | Paper |
24 | Resilience Funding | Karl Roberts | Paper |
25 | Local Enhanced Services Review | Karl Roberts | Paper |
26 | Standard Access Contract Extension | Carolyn Ogle | Paper |
27 | Quality: | | |
28 | Interim Exception Report | Andrea rison | Verbal |
29 | Full Security Report | Andrea rison | Paper |
30 | Wound Care Service - Support | Andrea rison | Verbal |
31 | Primary Care - Reporting | Chris Empson | Presentation |
32 | GP Patient Survey Results (Access) | Karl Roberts / Healthwatch | Presentation |
33 | Primary Care Survey - Healthwatch (Access) | Jill Telford | Presentation |
34 | Patient Population Issues (Access) | Carolyn Ogle | Paper |
35 | CRAFT Doncaster General Practice Nurse Development Strategy | Zara Head | Paper |
36 | Primary Care Maternity Care Group End of Year Evaluation / Changes to Group | Gemma Munce | Paper |
37 | Strategy & Planning: | | |
38 | Primary Care Delivery Plan 2019/20 | Chris Empson | Paper |
39 | Primary Care Delivery Plan - Reporting Mechanism | Chris Empson | Paper |
40 | DIP Contract Reform | Carolyn Ogle | Paper |
41 | Support Package from Primary Care Commissioning | Karl Roberts | Verbal |
42 | Forward View Update | Carolyn Ogle | Paper |
43 | TARGET Evaluation 2018/19 | Carolyn Ogle | Paper |
44 | Extended Access Report | Laura Sheburn / Jill Telford | Paper |
45 | Tobacco Control Update - HWB | Carolyn Ogle / Victor Joseph | Paper |
46 | Primary Care Enabling Services | Carolyn Ogle | Paper |
47 | Primary Care Commissioning Committee Terms of Reference | Chair | Paper |
48 | Primary Care Delivery Group Terms of Reference | Carolyn Ogle | Paper |
49 | Primary Care Commissioning Committee Annual Report | Carolyn Ogle | Paper |
50 | Primary Care Commissioning Committee Terms of Reference | Chair | Paper |
51 | Primary Care Commissioning Committee Terms of Reference | Carolyn Ogle | Paper |
52 | Primary Care Commissioning Committee Annual Report | Chair | Paper |
53 | Primary Care Provider Engagement Group Notes | Nabeil Atendi | Paper |
54 | Feedback following July's PCCC Development Session | Chair | Verbal |
55 | Primary Care Commissioning Committee Reactions 2018/19 | Karl Roberts | Paper |
56 | Communication & Engagement Strategy | Paul Hemingway | Paper |
57 | Primary Care Networking Update | Carolyn Ogle | Paper |
58 | Primary Care - Next Steps | Nabeil Atendi | Paper |
59 | GP.Y Funding | Karl Roberts | Paper |
60 | Primary Care - Supporting Group Minutes | Carolyn Ogle | Paper |
61 | Performance of Services (as and when) | Member from Primary Care | Verbal / Paper |
62 | Forward Planner | Chair | Paper |
63 | Site visits | Carolyn Ogle | Paper |
64 | Any New Potential Risks | Carolyn Ogle | Verbal |
65 | Other Business | Chair | Verbal |
66 | Date and Time of the next Meeting | Chair | Verbal |

PUBLIC Primary Care Commissioning Committee Forward Planner 2019/20

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<th>Helen Harris</th>
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<td></td>
<td>Head of Corporate Governance</td>
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<tr>
<td>Author(s)</td>
<td>Alison Edwards</td>
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<td>Corporate Governance Manager</td>
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### Status of the Report

To approve [ ]
To consider / discuss [ ]
To note [X]

### Purpose of Paper - Executive Summary

#### 1. Introduction
The primary care related risks on the Corporate Risk Register are presented to the Primary Care Committee to make the members aware of the current risks.

#### 2. Risk Review – Primary Care
The two primary care risks have been reviewed with the Corporate Governance Manager and Head of Service.

- **a)** PCP015: Lack of assurance that proactive care specification is being delivered in Primary Care. A risk review was undertaken on 30 November 2019, with the following updates to the actions being taken:
  - Two practices in East locality confirmed they are not providing a service.
  - A plan to use funding for additional frailty innovation work has not come to fruition.
  - No change anticipated until next contractual year when the service is to be commissioned from Primary Care Networks (PCNs) and not individual practices.

- **b)** PCP014: Lack of workforce sustainability and primary care workforce strategy in Doncaster. A risk review was undertaken on 1 November 2019, with the following update to the actions being taken:
  - Nurse VTS Scheme extended for a further year through resilience and GP retention proposal being worked through.
  - Quarterly workforce strategy update considered at Contracting meeting with PCD.
  - Apex Tool roll out to identify workforce issues by practice continuing with data sharing agreement nearing completion for sign off.

#### 3. Progress Against Target Risk Ratings
PCP014 and PCP015 current risk ratings are nine and 12 respectively. Both risks have a target risk rating of four, to be achieved by 31 March 2020. A review of the risks will be undertaken by the Associate Director of Primary Care & Commissioning and the Corporate Governance Manager to assess the gaps in positive assurance, internal and external assurance, gaps in controls and actions to be taken.
Recommendation(s)

The Primary Care Commissioning Committee is asked to

a) Review the Primary Care risks on the Corporate Risk Register and confirm they are appropriately scored and described.

b) Identify any potential new risks.

Report Exempt from Public Disclosure

If yes, detail grounds for exemption:

Yes □ No X

Impact analysis

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<tr>
<td>An Equality Impact Analysis/Assessment is not required for this report.</td>
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</tr>
<tr>
<td>An Equality Impact Analysis/Assessment has been completed and approved by the lead Head of Corporate Governance / Corporate Governance Manager. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.</td>
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<tr>
<td>An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.</td>
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<td>Risk analysis</td>
<td>The full Corporate Risk Register presents the current risk rating and actions to achieve the target risk rating.</td>
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<td>Assurance Framework</td>
<td>CO2-2.2, CO2-2.3</td>
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<td>[Complete this section if submitting a report to Primary Care Commissioning Committee / Primary Care Delivery Group. For any other committee, delete this row on the report template.]</td>
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<tr>
<td>Duty in relation to quality of primary medical services</td>
<td>14S</td>
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<tr>
<td>Duties as to reducing inequalities</td>
<td>14T</td>
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<tr>
<td>Duty to promote the involvement of each patient</td>
<td>14U</td>
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<tr>
<td>Duty as to patient choice</td>
<td>14V</td>
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<tr>
<td>Duty as to promoting integration</td>
<td>14Z1</td>
</tr>
<tr>
<td>Public involvement and consultation</td>
<td>14Z2</td>
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<tr>
<td>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)</td>
<td>83</td>
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<tr>
<td>Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”)</td>
<td>83</td>
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<tr>
<td>Design of local incentive schemes as an alternative to the Quality Outcomes Framework</td>
<td>83</td>
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<tr>
<td>Decision making on whether to establish new GP practices in an area</td>
<td>83</td>
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<tr>
<td>Approving Practice mergers</td>
<td>83</td>
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<tr>
<td>Making decisions on ‘discretionary’ payment (e.g., returner / retainer schemes)</td>
<td>83</td>
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<tr>
<td>To plan, including needs assessment, primary medical care services in Doncaster</td>
<td>83</td>
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<tr>
<td>To undertake reviews of primary medical care services in Doncaster</td>
<td>83</td>
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<tr>
<td>To co-ordinate a common approach to the commissioning of primary care services generally</td>
<td>83</td>
</tr>
<tr>
<td>To manage the budget for commissioning of primary medical care services in Doncaster</td>
<td>83</td>
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</tbody>
</table>
## Corporate Objectives (COs)

<table>
<thead>
<tr>
<th>CO</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO 1</td>
<td>Ensure an effective, well led, and well governed organisation and its statutory obligations are met.</td>
</tr>
<tr>
<td>CO 2</td>
<td>Commission high quality, continually improving, cost effective healthcare which meets the needs of the Doncaster population.</td>
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<tr>
<td>CO 3</td>
<td>Ensure that the healthcare system in Doncaster is sustainable.</td>
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<tr>
<td>CO 4</td>
<td>Work collaboratively with partners to improve health, care and reduce inequalities in well governed and accountable partnerships.</td>
</tr>
</tbody>
</table>

## Consequences / Severity

<table>
<thead>
<tr>
<th>Likelihood of occurrence</th>
<th>Insignificant</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Unlikely</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Possible</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
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<tr>
<td>Likely</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Almost Certain</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Likelihood of occurrence</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Very High</th>
<th>Extreme</th>
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<tbody>
<tr>
<td>1-3</td>
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<td>4-6</td>
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<td>8-12</td>
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<td>15-20</td>
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- **Low**: The risk appetite under which risks can be tolerated is a score of 12 or below.
- **Medium**: Risks scored at or in excess of a score of 13 must be escalated to the Governing Body.
### NHS Doncaster CCG Corporate Risk Register Summary

#### Risks

<table>
<thead>
<tr>
<th>Reference number</th>
<th>Risks</th>
<th>Date Identified</th>
<th>Initial Risk Rating</th>
<th>Likely Cause</th>
<th>Likely Consequence</th>
<th>Gaps in controls and timescales for remedial action</th>
<th>Gaps in assurance and timescales for remedial action</th>
<th>Actions to be taken</th>
<th>Lead Committee/Board for delegation of actions</th>
<th>Progress Against Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP014</td>
<td>Lack of workforce sustainability and Primary Care Workforce Strategy in Doncaster which clearly highlights current position and future plan.</td>
<td>26.03.18</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>None</td>
<td>None</td>
<td>Implementation of Workforce Strategy - Primary Care, for Doncaster, approved at PCCC on 13 December 2018.</td>
<td>Mar 21</td>
</tr>
<tr>
<td></td>
<td>Risk Cause: Inability to recruit GPs and other clinical staff to work in practices in Doncaster region.</td>
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<td></td>
<td>Is the plan on track?</td>
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<tr>
<td></td>
<td>Risk Consequence: Patient access to care. Sustainability of practices could cause potential Emergencies/issues. Secondary care services could then be affected by not moving them into primary care.</td>
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</tbody>
</table>

#### Lead Objective: Ensure that the healthcare system in Doncaster is sustainable.

- Primary Care Delivery Plan
  - Governing Body
  - Primary Care Commissioning Committee minutes
  - South Yorkshire and Bassetlaw Care Workforce Group
  - Primary Care Network Development
- Primary Care Commissioning Committee
  - Federation Workforce Survey
  - Governing Body Minutes
  - SYBB Care Workforce Group Minutes
  - Integrated Care System Workforce Workshop (27/03/19)
  - NHS England Application for International Recruitment
  - NHS England working with Health Education England
  - NHS England procurement of APEX with CCG leading
  - Network agreement schedule on workforce
- South Yorkshire and Bassetlaw Workforce Hub
  - The strategy and action plan is monitored at meetings.
  - Additional investment from July 2019 for additional roles
  - GPs Development Strategy being drafted
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- Implementation of strategy discussed at quarterly contract meeting with PCD
- Mar 21
- Quality and Patient Safety Committee

#### Risk Review:

- 11.19 - Nurse VTS Scheme extended for a further year through resilience and GP retention proposal being worked through. Quarterly workforce strategy update considered at Contracting meeting with PCD. Apex Tool roll out to identify workforce issues by practice continuing with data sharing agreement nearing completion for sign off.
- 20.08.19 - Additional roles in PCNs being advertised (Clinical Pharmacists and Social Prescribing Link Workers)
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<table>
<thead>
<tr>
<th>Risk</th>
<th>Current Controls</th>
<th>Internal and External Assurances</th>
<th>Positive Assurance</th>
<th>Gaps in controls and timescales for remedial action</th>
<th>Gaps in assurance and timescales for remedial action</th>
<th>Actions to be taken</th>
<th>Action end date (Local)</th>
<th>Lead Committee / Board for delegation of actions</th>
<th>Progress Against Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Description:</strong> Lack of assurance that proactive care specification is being delivered in Primary Care</td>
<td>Where controls are in place that are operating at this level and assist in the delivery of aims and manage/mitigate risks</td>
<td>Where can we gain evidence that the controls/systems are placing reliance on the effective internally externally?</td>
<td>What evidence shows we are reasonably managing our risks and our objectives are being delivered</td>
<td>Areas where we do not have adequate controls/systems in place or existing controls/systems are not effective</td>
<td>Areas where we are not receiving evidence that controls/systems are effective</td>
<td>Detail the Actions to be taken</td>
<td></td>
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<td>Is the plan on track?</td>
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<tr>
<td><strong>Risk Cause:</strong> Practices inability to articulate actual service provision during sign-up process</td>
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<td><strong>Risk Consequence:</strong> Financial and workforce impact</td>
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