CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2024
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Primary Care Governance – Focus on Primary Care Contractual Governance Arrangements
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jill Paterson, Director of Primary Care, Community Strategy and Long Term Care
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rhian Bond, Assistant Director of Primary Care

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In response to a request from Board, this report seeks to provide an assurance on the work that has been undertaken to strengthen Primary Care Governance arrangements, particularly in relation to Primary Care contractual decision-making, where improvements have been identified as required.

Cefndir / Background

In terms of current Primary Care governance arrangements, the development of the Primary Care **Strategic Plan** is operationally discharged via the **Primary & Community Services Strategy Sub-Group**, which maintains oversight of the development of the Primary Care Strategic Plan through tasking its reporting groups with specific pieces of work to inform public and staff engagement and to capture responses and feedback.

The work of the Primary & Community Services Strategy Sub-Group feeds into the A Healthier Mid & West Wales Group which, in turn, feeds into the Executive Team, and from here a Chief Executive's Report is constructed to onwardly advise and assure the Board.

In terms of **Quality** within Primary Care, this is currently discharged via the **Primary Care Quality, Safety & Experience Group**. This Group maintains oversight of contractual governance frameworks and mechanisms through its three reporting sub-groups.

The work of the Primary Care Quality, Safety & Experience Group feeds into the Quality, Safety & Experience Sub-Committee, which in turn feeds in to the Quality, Safety & Experience Committee, and from here a Committee Update Report is prepared to onwardly advise and assure the Board.

In terms of an assurance on **Planning** within Primary Care, this is currently discharged through relevant papers and reports submitted to the **Strategic Development & Operational Delivery Committee** where the Director of Primary Care, Community Strategy and Long-Term Care is represented within the membership.

One purpose of the Strategic Development & Operational Delivery Committee is to receive assurance on delivery against the areas of targeted intervention, and the required elements for de-escalation, related to strategy and planning, performance and outcomes, and fragile services. Primary care falls within the category of fragile services and, as such, is also the focus of targeted intervention; the Health Board's Primary and Community Strategic Plan also represents HDdUHB's Planning Objective 7.

The work of the Strategic Development & Operational Delivery Committee is captured within a Committee Update Report to onwardly advise and assure the Board.

In terms of **Professional Performers List** concerns within Primary Care, these are currently managed in a variety of ways depending on the regulatory requirements; it should be noted that these are for individuals who are considered to be Independent Contractors and not employees of the Health Board where Upholding Professional Standards Wales would apply. There are nationally agreed procedures in place for the management of concerns; however, these are currently subject to a national review. Concerns are considered through a Performance Concerns Group which, if appropriate, will formally report concerns to the relevant professional body where there is limited scope for the Health Board to take remedial action.

Previously, reports on Performers concerns have been shared with the **In Committee Board** alongside any suspensions reported within secondary care. Once the national review has reported to address current variances in process, the Health Board will look to establish an appropriate performance management process in response to these and will re-assess the governance in place in terms of how Performers concerns are reported to Board.

In terms of **Contractual (Legal/Regulations)** arrangements within Primary Care, these are currently discharged via the **Primary Care Contract Review Group**, a management group within Primary Care whose role is to consider any contract changes that are undertaken in line with extant Regulations; and to consider any actions arising from GMS contractual changes prior to Board decision making.

Whilst the current Terms of Reference for the Primary Care Contract Review Group (PCCRG) state that it has been constituted to replace the now dis-established Primary Care Applications Committee (PCAC), the PCCRG does not have the same authority as PCAC, which had previously been constituted as a Board level Committee with delegated authority to approve recommendations on Vacant Practice applications and Branch Surgery closures.

It is the absence of delegated authority that has prompted this review of Primary Care Contractual Governance arrangements, to ensure clarity for the Board in its decision-making.

Asesiad / Assessment

In terms of Primary Care **Planning, Quality, Strategy** and **Professional Performance** within Primary Care, the Board should be able to receive assurance on the work undertaken through the Primary Care Directorate's current governance arrangements via the reports it routinely receives: For **Planning** from the Strategic Development and Operational Delivery Committee; for **Quality** from the Quality, Safety and Experience Committee; for **Strategy** though the Chief Executive's Report to Board; and for **Professional Performance** issues, through the revised governance arrangements that will be put in place and onwardly reported to Board following implementation of the new Performers standards in Wales.

It is acknowledged, however, that this is unlikely to be the case in terms of **Contractual (Legal/Regulations)** arrangements within Primary Care, given the dis-establishment of PCAC as a Board level Committee, which previously determined Primary Care contractual matters on behalf of the Health Board, including the approval of vacant practice applications and branch surgery closures, and then onwardly reported the Committee's decision to Board.

It is evident that decisions on these matters are often sensitive, sometimes contentious, and when the Board is asked to approve vacant practice applications or branch surgery closures, Members may feel they are having to make these decisions in isolation, given that they are only presented sporadically to Board.

In addition, since PCAC was dis-established, knowledge of Primary Care contractor profession arrangements by those Board Members who had previously served on the Committee will have diminished over time, and the Board may not have had the opportunity of being kept up to date on contractual issues. It is acknowledged that this might represent a potential gap for the Board and is recognised as an issue which needs to be addressed going forward, via a regular (i.e. annual or bi-annual) Primary Care Contractual Governance report on the Board's workplan, which would help to provide the necessary context to draw upon when vacant practice applications or branch surgery closure decisions need to be made.

To strengthen Primary Care governance arrangements, particularly in relation to Primary Care contractual decision-making, a review of both the **GMS Vacant Practice Panel** Terms of Reference and the **Branch Surgery Panel** Standard Operating Procedure has been undertaken, to identify and then address any shortfalls or deficiencies in the current arrangements, prior to coming to Board for decision-making purposes, as follows:

GMS Vacant Practice Panel

The Vacant Practice Panel meets as and when required on contract termination in line with the extant guidance (Welsh Health Circular (2006) 063 General Medical Services Practice Vacancies – A Guide to Good Practice, attached at Annex 1). Its Terms of Reference state that its purpose is to is to undertake a detailed option appraisal considering a range of criteria in advising on the future provision of services for the Practice population following notice of a GMS Contract resignation or termination, in accordance with WHC (2006) 063. The Vacant Practice Panel will make a recommendation to the Board for approval.

The current Vacant Practice Panel Terms of Reference were most recently approved by the Primary Care Contract Review Group on 13 June 2024. The Terms of Reference state that the Panel will report formally, regularly and on a timely basis to the Board following each Panel meeting. This to include a written update report following each meeting, which will provide a detailed record of the Panel discussion on the option appraisal undertaken, and recommendation for decision/approval.

It is anticipated that the options available to the Health Board in relation to vacant practice applications will be:

- Where the Health Board considers that retaining a small or single handed practice would be appropriate, the Health Board will advertise locally and nationally for expressions of interest to manage the practice under GMS or by another practice/provider under Alternative Provider Medical Services Directions (APMS) arrangements (in line with the APMS Directions 2006), including the private and independent sectors, voluntary sector, not-for-profit organisations, NHS Trusts, other Health Boards, or existing GMS practices.
- Direct management of the practice by the Health Board using salaried GPs i.e. recruiting salaried doctors to run the practice temporarily, working under the direction of the Health

Board to prevent the disruption or collapse of existing services (this option should be viewed as a temporary measure).
- Closure of the practice and dispersal of the patient list to neighbouring practice/s – the Health Board is advised to consult with neighbouring practices and the Local Medical Committee (LMC) in regard to this option. As practice closures can be extremely sensitive issues, the involvement of democratically elected local representatives as early as possible in the process could also be sought (this option is normally an option of last resort).

A combination of these options could also be considered i.e. dispersal of an element of the vacant practice list and then for the Health Board to either seek expressions of interest to manage a smaller practice under GMS or by another practice/provider under APMS arrangements, or to directly manage the smaller practice itself.

A Standard Operating Procedure/Process for Considering Vacant Practice Applications will be developed, to include an algorithm to articulate the process involved, and will be consulted upon with Llais and the LMC.

The Terms of Reference of the Vacant Practice Panel have also been reviewed to ensure the reporting arrangements are clear i.e. that the recommendations of the Vacant Practice Panel will be presented, by the Panel Chair, to Board.

Membership of the Vacant Practice Panel has also been reviewed in line with the membership suggested for inclusion in WHC (2006) 063. However, it should be noted that this represents a Guide to Good Practice only rather than a Directive and is considerably out of date, having been issued in 2006 when the composition of Local Health Boards differed significantly to the arrangements currently in place within Hywel Dda University Health Board.

Given these differences in composition, it is important that the Health Board sets out its own local interpretation of WHC (2006) 063, based on current practice.

Proposed membership of the Vacant Practice Panel is as follows:

- Director of Primary Care, Community Strategy and Long-Term Care (Chair)
- Associate Medical Director for Primary Care (Vice-Chair)
- Assistant Director of Primary Care
- Dyfed Powys Local Medical Committee (LMC) representative
- Head of General Medical Services (GMS) – Sustainability
- Head of General Medical Services (GMS) – Contractual Compliance
- Senior Finance Business Partner
- Llais representative (In Attendance Member)

WHC (2006) 063 states that membership of the Vacant Practice Panel should include as many relevant stakeholders as is practicable, and whilst it will be for the Health Board to determine the membership, it should also consider the inclusion of a Lay/Independent Member. Other suggestions for inclusion within the membership made by WHC (2006) 063 are:

- Local Authority Officer
- Doctors from neighbouring practices
- Practice Nurse
- Local Pharmacy representative
- Local Councillor
- Local Assembly Member and/or Member of Parliament (MS/AS)

Consideration will, therefore, be given to adding these as co-opted members within the revised Terms of Reference.

It will also be made clear amongst the membership who is required to contribute to decision-making, by making a distinction between Core Members and In Attendance Members within the Terms of Reference.

WHC (2006) 063 also states that, while the Health Board will chair and administer the Vacant Practice Panel, any Health Board officers participating in the option appraisal should not normally be involved in the final determination of the matter by the Health Board. Steps will, therefore, be taken to ensure that any Health Board officers, including those chairing the Vacant Practice Panel, are precluded from Board discussion and decision on this item.

Whilst there appears to be no appeal process built into WHC (2006) 063, it is accepted that any appeals against the decision of the Board in relation to Vacant Practices can be resolved through the contractual appeals process 'Contract Dispute Resolution – Part 7 of Schedule 6 to the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004.

The Terms of Reference for the Vacant Practice Panel have been revised in line with the above and are attached at Appendix 1. Whilst the Board is asked to approve these Terms of Reference, it is not intended to identify the Vacant Practice Panel within the Board's formal governance structure, as the Panel is only convened as and when required to consider Vacant Practice applications. This report and the accompanying Terms of Reference are for Board Members to receive an assurance from the newly constituted governance arrangements in place in regard to primary care contractual decision-making.

Branch Surgery Panel
The Branch Surgery Panel meets as and when required to consider applications from GP Practices on proposed branch surgery closures. The Branch Surgery Panel will make a recommendation to the Board for approval.

There are no nationally agreed Terms of Reference for a Branch Surgery Panel; however, a Process for Considering Branch Surgery Closure Applications has been developed within HDdUHB.

The process states that a Panel will be convened to consider the request from a Practice to close a branch surgery and to consider the information provided to support this request, including the outcome of the patient consultation, key stakeholders consultation, the views of Llais and the LMC.

The information it is anticipated the Practice would need to supply to support their request is as follows:

- Reasons for the proposed closure request;
- Opening times and surgery times of the branch and main surgeries;
- The list size of the practice;
- Number of patients accessing the surgery services in the last three years, broken down by month;
- Number of patients that have accessed services at the branch site alone in the last three years, broken down by month;
- Where the Practice is unable to identify patients who use the Branch Surgery, then all patients registered with the practice will need to be consulted with;

- Services that are currently being provided from the branch surgery;
- If appropriate, how the branch surgery site is not fit for purpose as a GP practice;
- Impact the closure will have on patients and services at the main site.

The Health Board, in conjunction with the Practice, will consider the above and also identify the following:

- Any other purpose for which the branch surgery is used;
- Positive and negative impact the closure will have on patients and services at the main site and those who use the branch site;
- Details of public transport links from branch closure site to main practice site;
- Practice proposals for how the information will be communicated to patients if the closure is approved;
- Details of the timing of the closure if approved – whether it will be a staged approach;
- Details of the number of patients reached via each medium used and the numbers of responses received;
- Analysis of the results of the Patient Questionnaire;
- Analysis of the results of the other Key Stakeholders Questionnaire;
- Premises infrastructure concerns, i.e. costs to meet Disability Discrimination Act (DDA) compliance, statutory regulations compliance, assessment against the minimum standards for quality
- Details of the nearest GP practices and pharmacies – to be presented visually on a map;
- Any proposed changes to services at the main practice;
- The outcome of an Equality Impact Assessment on the process undertaken to conduct the patient consultation.

Where the branch surgery closure application is approved by Board, the Practice must write to all registered patients to inform them of the closure and how they will access services from the Practice. Practices should ensure a minimum of 3 months' notice following the Board decision to close, unless agreed otherwise with the Health Board. It is the responsibility of the Practice to meet all associated costs with closing the surgery, including any redundancy and practice information costs.

Where the closure application is not supported by the Board, the Primary Care team will further discuss with the Practice the implications of this decision.

Any appeal against the decision of the Board in relation to Branch Surgery Closure applications will again be resolved through the contractual appeals process 'Contract Dispute Resolution – Part 7 of Schedule 6 to the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004 ("The Regulations")'.

Where there is disagreement, Llais will provide advice and support to enable NHS organisations make necessary changes to services. Whilst the previous role of the Community Health Councils (CHCs) to refer any concerns regarding the outcome of the decision to the Minister to determine no longer applies, Llais can draw to the attention of Welsh Ministers any issues related to health and social services, including changes to services and their management. In such circumstances, Welsh Ministers will expect Llais to explain why it has concerns. Welsh Ministers will seek a view from the relevant NHS organisations including evidence of any engagement / consultation it has undertaken.

Proposed membership of the Branch Surgery Panel as set out within the Process for Considering Branch Surgery Closure Applications is as follows:

- Director of Primary Care, Community Strategy and Long-Term Care (Chair)
- Associate Medical Director for Primary Care (Vice-Chair)
- Assistant Director of Primary Care
- Dyfed Powys LMC representative
- Head of GMS & Community Pharmacy
- Locality Development Manager
- Llais representative (In Attendance Member)

The process currently identifies that the Panel will consider the information provided and agree a recommendation to be submitted to the Primary Care Contract Review Group. The Board will then consider the recommendation from the Primary Care Contract Review Group (including an Equality Impact Assessment on the recommendation), a summary of the request from the Practice, the outcome of the patient consultation and the views of Llais, which are to be presented to the Board independently as part of the decision-making process.

Terms of Reference for the Branch Surgery Panel have been drafted to make the reporting arrangements clear i.e. that the recommendations of the Branch Surgery Panel will be presented, by the Panel Chair, to Board.

The role of members will also be made clearer within the Terms of Reference by making a distinction between Core Members and In Attendance Members within the membership; currently representatives from Llais and the LMC will be in attendance to observe the process.

Similar to the Vacant Practice Panel, steps will be taken to ensure that any Health Board officers participating in the option appraisal process, including those chairing the Branch Surgery Panel, will be precluded from Board discussion and decision on this item.

The Process for Considering Branch Surgery Closure Applications and the accompanying algorithm to explain the process have also been amended to reflect these changes and will be consulted upon with Llais and the LMC prior to finalising.

Terms of Reference for the Branch Surgery Panel have been crafted in line with the above and are attached at Appendix 2. Similar to the Vacant Practice Panel, whilst the Board is asked to approve these Terms of Reference, it is not intended to identify the Branch Surgery Panel within the Board's formal governance structure as the Panel is only convened as and when required to consider Branch Surgery closures. This report and the accompanying Terms of Reference are for Board Members to receive an assurance from the newly constituted governance arrangements in place in regard to primary care contractual decision-making.

For the purposes of further assurance, it is suggested that regular Primary Care Contractual Governance reports are presented to Board and included on the Board's workplan to provide context for Board Members on primary care contractual matters and to aid Board decision-making when determining vacant practice and branch surgery closure applications.

Argymhelliad / Recommendation

The Board is asked to:

- Take **ASSURANCE** from the work that has been undertaken to strengthen Primary Care Governance arrangements, particularly in relation to Primary Care contractual decision-making where improvements have been identified as required;
- **APPROVE** the Terms of Reference for the Vacant Practice Panel and the Branch Surgery Panel.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	7 Primary and community strategic plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Welsh Health Circular (2006) 063 General Medical Services Practice Vacancies – A Guide to Good Practice
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Director of Primary Care, Community Strategy and Long Term Care

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not applicable
Gweithlu: Workforce:	Not applicable
Risg: Risk:	Not applicable

Cyfreithiol: **Legal:**	As above
Enw Da: **Reputational:**	Hywel Dda University Health Board needs to meet the targets set in order to maintain a good reputation with Welsh Government, together with our stakeholders, including our staff
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Consideration of Equality legislation and impact is a fundamental part of the planning of service delivery changes and improvements

WELSH HEALTH CIRCULAR

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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Title: GENERAL MEDICAL SERVICES PRACTICE VACANCIES – A GUIDE TO GOOD PRACTICE

For Action by:
Chief Executives of Local Health Boards

Action required *See paragraph(s)* :

For Information to:
Local Health Boards – Medical Directors

Sender: Mr John Sweeney, Director of Community, Primary Care & Health Services Policy Directorate, National Assembly for Wales

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Enclosure(s): Annex 1

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GENERAL MEDICAL SERVICES
PRACTICE VACANCIES – A GUIDE TO GOOD PRACTICE

Summary

1. The latest statistical data on the General Practitioner workforce in Wales indicates that 25% or more of GPs in eight of our Local Health Boards are aged 55 years or over. In addition three of our LHBs have 10% or more of their GPs working as single handed practitioners. It is clear therefore that some LHBs carry a moderate to significant risk of GPs opting to retire within the next five years or so and some of these may be from small or single handed practices.

2. Local Health Boards have a statutory duty to ensure the sustained delivery of primary medical services to their resident population. When a practice becomes vacant for whatever reasons the LHB must ensure that primary medical services continue to be provided to those patents by the most effective and efficient means possible having regard to local needs and circumstances.

3. The future vision for healthcare services in Wales is spelled out in Designed for Life. This envisages that “the extended primary care team will be central to the delivery of chronic disease management for the overwhelming majority of patients.” The strategy acknowledges that some GPs will develop specialist skills and that increasingly they may work alongside other health professionals undertaking extended roles. These developments are intended to ensure that high quality primary care can develop and expand, and improve recruitment and retention of general practitioners.

4. Local Health Boards have a crucial role in ensuring that their primary care workforce plans address the short, medium and longer term vision for primary care services and reflect the views of GPs, patients, service users and local populations. They should also ensure that capital/estate, financial and workforce planning is done together so that there is a coherent and transparent local plan. They should support local practice development in ways that enhance overall recruitment and retention for example by enabling practitioners to return to work following a career break.

5. Attached at Annex 1 is a guide to good practice in resolving practitioner vacancies. It outlines the steps to be followed by Local Health Boards in anticipating future vacancies, consideration of the best options for future delivery of services and offers advice on consultation and implementation of the preferred option.

ACTION

6. LHB Chief Executives are asked to note the attached guidance and to ensure that this is disseminated widely throughout the LHB. They should also ensure that the guidance is shared with key stakeholders.

John Sweeney Director Community, Primary Care and Health Services Policy

Annex 1

RESOLVING PRACTICE VACANCIES

A GUIDE TO GOOD PRACTICE

Introduction

1. This guidance provides advice to Local Health Boards (LHBs) on the recruitment of General Practitioners and reminds Local Health Boards of the steps they should follow when considering the future of vacant practices. The overriding concern is to ensure that primary medical services are delivered to a consistently high standard across the whole of Wales.

Strategic Considerations

2. Designed for Life – the ten year strategy for healthcare delivery in Wales (building on Improving Health in Wales) outlines a national vision of healthcare services which broadly suggests that delivery of healthcare services will increasingly be determined by:
   - a patient centred or service user focus to health and social care delivery around the patient pathway rather than along functional lines
   - continued technological change that will alter traditional work roles for example through the use of near patient testing
   - a continued shift in the boundary between primary and secondary care with a greater range of chronic conditions being managed in primary care.

3. Every Local Health Board in Wales has translated that national vision into a local vision that addresses local circumstances. LHB primary care estates' strategies should outline how primary care premises development will support the realisation of that vision. It follows therefore that each LHB should have a clear "understanding" of the future shape and configuration of primary medical services. In terms of realising their vision LHBs will need to be clear about their intentions where decisions need to be made about the continued provision of primary medical services when a practice (for whatever reason) becomes vacant.

4. The configuration of primary medical services providers is a matter for LHBs to determine having regard to local healthcare needs and having consulted with all relevant stakeholders including the Local Medical Committee. Practices will vary in size according to local circumstances. Where a small or single handed practice is considered appropriate then the LHB will want to ensure that the following is in place:

- appropriate arrangements for continued professional development of all members of the primary care team
- effective clinical governance arrangements
- reasonable, well equipped premises
- reasonable staffing and infrastructure including IT and manual recording systems

Workforce Planning

5. LHBs should work with contractors locally to ensure that they have a robust primary care workforce plan that takes account of future primary medical services needs. The plan should incorporate realistic projections in terms of future GP numbers; the implications of changing skill mix and where appropriate new roles and new ways of working.

6. LHBs should also have in place a recruitment and retention plan that outlines how the recruitment and retention of GPs and other practice staff complements and supports the future delivery of high quality primary medical services. These plans should outline how Recruitment and Retention monies included in LHB Administered funds might be utilised to support recruitment and retention, e.g. support for retainer, returner schemes.

7. A crucial element of workforce planning is the need for LHBs to maintain an effective dialogue with its independent contractor population. This will mean that age profile is monitored, future retirements are anticipated and a clear strategy exists to maintain, replace or re-provide services in the event of a vacancy. LHBs are strongly urged to maintain an ongoing dialogue with the Local Medical Committee so that any such difficulties are anticipated and managed. It may also be beneficial to seek the advice of the Head of Contractor Services at the NHS Wales Business Services Centre.

Vacant Practices – Consideration of Options

8. Where a practice becomes vacant the LHB will want to determine the best option for sustaining services to the practice population. Every circumstance needs to be considered on its particular individual merits, but in general terms, if the list is less than 1000 patients then the LHB may need to consider whether that list should be dispersed. Where the LHB considers that retaining a small or single handed practice would be appropriate then the vacancy should be advertised.

9. Unless the circumstances are straightforward the LHB should convene a panel to undertake a detailed option appraisal to determine a way forward. The LHB will chair and administer the panel but any LHB officers participating in the option appraisal should not normally be involved in the final determination of the matter by the LHB. The panel will make recommendations to the LHB who will make the final decision.

10. Membership of the panel should include as many relevant stakeholders as is practicable. It will be for the LHB to determine the membership of the option appraisal panel. However it should consider including:
    - GP Board member
    - Board lay member
    - CHC member and/or a patient group representative
    - Local Medical Committee representative
    - local authority officer
    - doctors from neighbouring practices
    - practice nurse
    - local Pharmacy representative
    - Contractor Services Advisor.

    In some circumstances the panel may wish to seek the views of local councillors, the local Assembly Member and/or Member of Parliament.

11. In the majority of cases it is anticipated that the options available to the LHB will be:
    - advertisement of the vacant practice
    - direct management of the practice by the LHB using salaried GPs
    - management by another practice under GMS or by another practice /provider under APMS arrangements
    - closure of the practice and dispersal of the list to neighbouring practice/s

    More detail on these together with other possible solutions appears below from paragraph 13 onwards.

12. The following indicators will be helpful in determining the preferred option:
    - Viability of patient list and potential for growth of the local population
    - Age profile of list and geographical spread
    - Doctor/patient ratio in the area
    - Proximity, capacity, financial consequences upon and willingness of neighbouring practices to absorb extra patients.
    - Particular local needs e.g. ethnic groups, need for women doctors etc.
    - Availability and condition of surgery premises
    - Specific social considerations that may suggest a list should be kept intact e.g. relatively deprived area, rural isolated community, poor public transport infrastructure
    - Preference of local residents

Advertising the vacant practice

13. The LHB should advertise locally and nationally for expressions of interest to run the practice as a GMS practice. The advertisement should provide as much information as possible but in particular should seek to market the local area. Interested applicants should be provided with an information pack that includes:

- A general description of the practice to include premises layout, equipment, staffing, enhanced services, etc
- Full description of services currently provided from the practice and opportunities for further developments
- Financial profile of the practice
- Structure of primary medical services in the area and future plans
- Arrangements for protected learning, continued professional development, and appraisal
- Information on housing, schools and local amenities
- Any financial incentives that may be available to the successful applicant e.g. relocation grant
- Named LHB contact for further discussion

Recruiting Salaried Doctors to run the practice temporarily

14. In order to sustain services while permanent solutions are being pursued the LHB may advertise for salaried doctors to work under the direction of the LHB in running the practice. LHBs are unlikely to view direct management of a practice as part of their core business. However on occasions it may prove necessary to assume management of a practice in order to prevent the disruption or collapse of existing services. This should be viewed as a temporary measure and separate from direct management under LHBMS whereby the LHB takes a strategic decision to provide primary medical services (see 17 below).

15. In seeking to recruit salaried doctors under these temporary arrangements the LHB should consider the possibility that doctors recruited, if they prove effective, could be part of the longer term solution. Therefore their recruitment campaign should be designed with this in mind. Ideally the LHB should supply an information pack that provides the main details of the practice (as indicated above) together with a job description, person specification and an outline of the terms and conditions of employment, including salary range. It should also include information on the LHB's longer term plans for the practice. LHBs should be mindful that to attract high quality candidates they may need to consider offering a range of benefits as part of the employment package e.g. flexible working, childcare support or a voucher scheme, academic/research links, protected learning time, mentorship for professional development.

16. Some LHBs in Wales already run salaried doctor schemes and LHBs will want to consider the benefits of working collaboratively with neighbouring LHBs in this regard.

LHB Medical Services (LHBMS)

17. LHBs have a statutory duty to secure the provision of primary medical services to "the extent that they consider it necessary to meet all reasonable requirements" of their resident populations. Aside from awarding a GMS contract the LHB may decide to provide primary

medical services itself under the Local Health Board Medical Services Directions 2006.

Alternative Provider Medical Services (APMS)

18. The Welsh Assembly Government's preferred policy is to ensure delivery of primary medical services via GMS contracts. However where a LHB is unable to secure a contract with a GMS provider then it may determine that the best option would be to commission the services from an

    alternative provider. Such arrangements must be in line with the Alternative Provider Medical Services Directions 2006. The LHB may enter into an APMS contract with any individual or organisation that meets the provider conditions set out in the Directions. This will include the private and independent sectors, voluntary sector, not-for-profit organisations, NHS Trusts, other LHBs, or existing GMS practices. The LHB must ensure that it has transparent processes in place for securing a contractor in order to encourage competition.

19. Whilst LHBs will need to take account of their Standing Financial Instructions consideration of alternative providers need not automatically involve a formal tender exercise. If LHBs preferred to use another approach (e.g. inviting existing independent contractor providers to put forward proposals in response to a service specification) this would be regarded as acceptable procurement practice within the NHS. LHBs must ensure that they secure a service that delivers clinically safe primary medical care and represents good value for money.

Dispersal or Re-assignment of the Patient List

20. This section should be read in conjunction with Part 2, Schedule 6 of the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004 (as amended) – (*"the regulations"*). These regulations deal with the assignment of patients by LHBs to contractors having "open" or "closed" lists.

21. A decision to disperse or reassign patients is normally an option of last resort. Prior to taking such a decision the LHB is advised to consult with neighbouring practices and the LMC. LHBs will be fully aware that practice closures can be extremely sensitive issues and they would be well advised to seek the involvement of democratically elected local representatives as early as possible in the process.

22. Where a LHB has no alternative other than to disperse or re-assign the patients then the following steps should be followed:
    a. The LHB should discuss with neighbouring practices the feasibility of a measured dispersal of all affected patients to named practices. These discussions should include an accurate assessment of the likely impact on the receiving practice(s). The vacant practice will require interim support to redirect patients to their new practice. The receiving practice(s) will probably need transitional support e.g.

temporary additional staff, registration clinics, transport and storage of patients' notes, help with inputting new patients onto receiving practices' systems etc. The LHB should also ensure that patients notes are transferred with the minimum of delay to minimise inconvenience to patients

b. The LHB should write to every patient (or in the case of those aged under 16 to their parent/guardian) giving full details of the contractor in their area to whom they are being allocated. Details should include names of doctors, details of services provided, opening times and a contact name for any further queries. Consideration should also be given to housebound or disabled patients who may need to be visited at home so that they can have the new arrangements explained to them.

c. Patients should be advised that if they do not wish to be allocated to that particular practice then they should notify the LHB in writing within 14 days. The LHB should ensure it advises that it will provide assistance if requested to any such patients who fail to secure alternative arrangements, so that they may be re-assigned.

d. Where a measured dispersal of patients to named practices cannot be agreed then LHBs have power under *"the regulations"* to assign patients to a new contractor whose list of patients is "open." The use of this power should preferably be avoided but if it has to be used, the LHB should recognise the implications for the receiving practice and provide appropriate support.

e. In certain specified circumstances, a LHB may present a proposal to assign patients to a contractor whose list of patients is "closed" to an assessment panel who may determine that the LHB can assign patients to that contractor as per *"the regulations."* Where an assessment panel makes such a determination the contractor may refer the matter to the Assembly for a review of the determination. Where the LHB assigns patients to a contractor having a closed list then it must enter into discussions with that contractor regarding additional support the LHB can offer the contractor and the LHB will use its best endeavours to provide such support. A practice with a closed list by definition has already signalled that its workload is at the limit. Assessment panels should be mindful therefore of the added pressure an assignment of patients would bring with a risk of destabilising services further.

f. The LHB should seek the advice of the Head of Contractor Services to agree roles and responsibilities for handling the actual dispersal or assignment of patients.

Communication and Consultation

23. The LHB should develop a comprehensive communication plan to support their deliberations around the future of the affected practice.

This should include a clear indication of the timescales involved in agreeing and implementing the new arrangements.

24. The LHB will want to ensure that all affected patients are aware of the departure of their GP(s) at the earliest possible opportunity. They should be advised of the steps the LHB intends to take to determine the future delivery of primary medical services to patients as well as a description of how current services will be maintained in the interim period.

25. As soon as the LHB becomes aware of the vacating of a practice it should contact all neighbouring practices for preliminary discussion about the likely implications. The Local Medical Committee should also be notified as soon as possible of the vacant practice and their views sought about the way forward.

26. Where the LHB decides to undertake an option appraisal it will need to ensure that relevant stakeholders are consulted on the range of options considered together with the rationale for recommending the preferred option. The consultation process should be robust and transparent and follow the guidance contained in WHC (2004) 84 – *"SHAPING HEALTH SERVICES LOCALLY – Guidance for Involving and Consulting on Changes to Health Services."*

27. Unless it is impractical to do so a public meeting should be held so that patients can address any concerns or queries to the LHB and the LHB in turn can enhance public understanding of the preferred option.

28. LHBs should establish a properly staffed telephone helpline so that patients can raise any queries concerning the new arrangements.

29. In addition to letters to affected patients and a public meeting LHBs should consider other appropriate means of communication e.g. posters, leaflets, newspaper articles, briefing for local community leaders.

30. It is important that the LHB maintains effective dialogue with the doctor(s) from the vacating practice.

Review and Reflection

31. Once the decision has been implemented and the "new" services are up and running then the LHB should reflect on the way it managed the changing circumstances to learn lessons for the future. The views of the Local Medical Committee, the CHC and a patient group representative should be sought on the processes adopted by the LHB.

32. The LHB should undertake a further survey of patients a reasonable time after the implementation of the new arrangements to assess the impact on patients and the local community.

Useful References

The National Health Service (General Medical Services Contracts) (Wales) Regulations 2004 – Statutory Instrument 2004 No 478 (W.48)

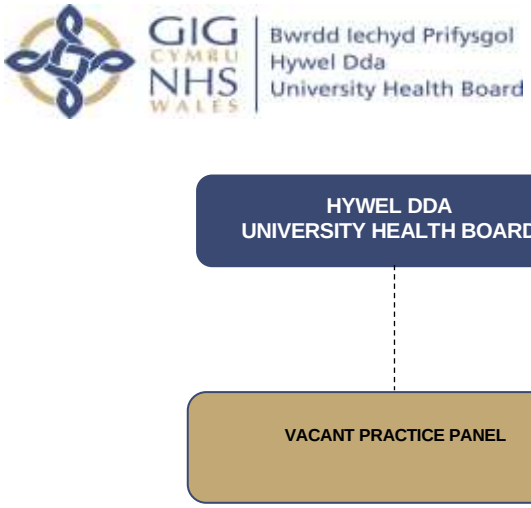
Designed for Life, Creating world class Health and Social Care for Wales in the 21st Century, May 2005

Report on Research into Recruitment and Retention of GPs in Wales, Office of the Chief Medical Officer, March 2005

Primary Care Workforce Development, Dr Jane Harrison, Office of the Chief Medical Officer and Ian Jones, Primary Care Division, June 2005

The Local Health Board Medical Services Directions 2006, National Assembly for Wales (2006/11)

The Alternative Provider Medical Services Directions 2006, National Assembly for Wales (2006/10)



TERMS OF REFERENCE

GENERAL MEDICAL SERVICES (GMS) VACANT PRACTICE PANEL

Version	Issued to:	Date	Comments
V1	Vacant Practice Panel	22.04.2021	Approved
V1	Primary Care Contract Review Sub-Committee	22.04.2021	Approved
V2	Primary Care Contract Review Group	07.07.2021	Approved
V3	Primary Care Contract Review Group	06.09.2021	Approved
V4	Board	05.01.2023	Approved by UHB Chair
V5	Primary Care Contract Review Group	23.05.2023	Approved
V6	Primary Care Contract Review Group	13.06.2024	Approved
V.7	Hywel Dda University Health Board	28.11.2024	For Approval

GENERAL MEDICAL SERVICES (GMS) VACANT PRACTICE PANEL

1. Constitution

1.1 The General Medical Services (GMS) Vacant Practice Panel (the Panel) has been established as a Panel of Hywel Dda University Health Board and constituted from 22 April 2021.

2. Principal Duties

2.1 The purpose of the Vacant Practice Panel is to undertake a detailed option appraisal, considering a range of criteria, in advising on the future provision of services for the Practice population, following notice of a GMS Contract resignation or termination, in accordance with Welsh Health Circular (2006) 063 General Medical Services Practice Vacancies – A Guide to Good Practice (see Annex 1).

2.2 The Panel Chair will present the Panel's recommendation to the Board for approval.

3. Operational Responsibilities

3.1 The Vacant Practice Panel will:

3.1.1 Ensure that full consideration is given to how best to provide services to the Practice population, taking into account local sustainability issues.

3.1.2 Present a recommendation to the Board for the future provision of primary medical services to the Practice population.

3.1.3 The Chair will convene a subsequent Vacant Practice Panel meeting to review the work undertaken or any other developments following the recommendation of the first Panel meeting, and to review feedback from any public engagement activity.

4. Membership

4.1 The membership of the Vacant Practice Panel shall comprise:

Title
Director of Primary Care, Community Strategy & Long-Term Care (Chair)
Associate Medical Director for Primary Care (Vice-Chair)
Assistant Director of Primary Care
Dyfed Powys Local Medical Committee (LMC) representative
Head of General Medical Services (GMS) - Sustainability
Head of General Medical Services (GMS) - Contractual Compliance
Senior Finance Business Partner
In Attendance
Llais representative

4.2 The membership of the Panel will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than a third of the membership and must include as a minimum the Chair and/or Vice-Chair of the Vacant Practice Panel, Llais member and Dyfed Powys LMC representative.

5.2 Any senior officer of Hywel Dda University Health Board or from a partner organisation may, where appropriate, be invited to attend to provide advice and/or clarification to the Panel, subject to the agreement of the Chair.

5.3 The Panel may also co-opt local primary care professionals and additional independent external 'experts' from outside the organisation to provide specialist knowledge, subject to the agreement of the Chair.

5.4 Should any member of the Panel be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.5 The Panel may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. Agenda and Papers

6.1 The Head of GMS (Sustainability) or a designated Deputy (approved by the Chair), supported by the Vacant Practice Panel Secretary (Primary Care Officer), will lead on the co-ordination of the agenda and papers for the meeting.

6.2 All papers shall be signed off by the Chair before being circulated to the Panel.

6.3 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting.

6.4 The draft minutes and table of actions will be circulated to members within **seven** days to check for accuracy.

6.5 Members must forward amendments to the Panel Secretary within the next **seven** days. The Panel Secretary will then forward the final version to the Panel Chair.

7. Frequency of Meetings

7.1 The Vacant Practice Panel will convene within 20 working days of receipt of a GMS Contract resignation or termination. Meetings can be held virtually at the discretion of the Chair.

7.2 A subsequent Panel meeting shall be convened to review the work undertaken, and any other developments, following the recommendation of the first Panel meeting, and to review feedback from any public engagement activity.

7.3 The Chair of the Panel, in discussion with the Panel Secretary, shall determine the time and the place of meetings of the Panel, the procedures of which shall be in accordance with WHC (2006) 063.

8. Accountability, Responsibility and Authority

8.1 The Vacant Practice Panel shall be accountable to the Board for its performance in exercising the functions set out in these terms of reference.

8.2 The Panel shall embed HDdUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

8.3 The requirements for the conduct of business as set out in Board's Standing Orders are equally applicable to the operation of the Panel.

9. Reporting

9.1 The Vacant Practice Panel, through its Chair and members, shall work closely with the Board's other committees, including joint/sub committees and groups to provide advice and assurance to the Board through the:

9.1.1 joint planning and co-ordination of Board and Committee business; and

9.1.2 the sharing of information.

9.2 In doing so, the Panel shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

9.3 The Panel may establish sub-groups or task and finish groups to carry out on its behalf specific aspects of Panel business. The Panel will receive an update following each sub-groups meetings detailing the business undertaken on its behalf.

9.4 The Panel's Chair, supported by the Panel Secretary, shall:

9.4.1 Report formally, regularly and on a timely basis to the Board.

9.4.2 Bring to the Board's specific attention any significant matters under consideration by the Panel.

9.4.3 Ensure a detailed record of the Panel's discussion and recommendations is submitted to Board for approval.

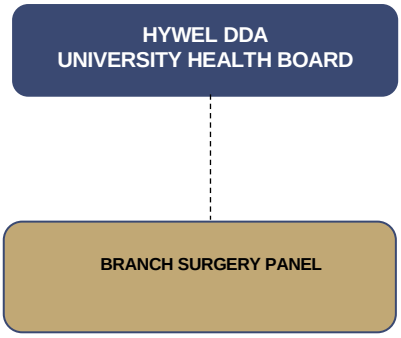
10. Secretarial Support

10.1 The Vacant Practice Panel Secretary shall be determined by the Panel Chair.

11. Review Date

11.1 These terms of reference shall be reviewed on at least an annual basis by the Vacant Practice Panel for approval by the Board.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



TERMS OF REFERENCE

BRANCH SURGERY PANEL

Version	Issued to:	Date	Comments
V1	Hywel Dda University Health Board	28.11.2024	For Approval

BRANCH SURGERY PANEL

1. Constitution

1.1 The Branch Surgery Panel (the Panel) has been established as a Panel of Hywel Dda University Health Board and constituted from 22 April 2021.

2. Principal Duties

2.1 The purpose of the Branch Surgery Panel is to consider requests from GMS practices to close a branch surgery.

2.2 The Panel Chair will present the Panel's recommendation to the Board for approval.

3. Operational Responsibilities

3.1 The Branch Surgery Panel will:

3.1.1 Consider the information provided to support a request from a GMS Practice, including the outcome of the patient consultation, key stakeholders consultation, the views of Llais and the Dyfed Powys Local Medical Committee (LMC).

3.1.2 Present a recommendation to the Board for approval.

4. Membership

4.1 The membership of the Branch Surgery Panel shall comprise:

Title
Director of Primary Care, Community Strategy & Long Term Care (Chair)
Associate Medical Director for Primary Care (Vice-Chair)
Assistant Director of Primary Care
Dyfed Powys Local Medical Committee (LMC) representative
Head of GMS and Community Pharmacy
Locality Development Manager
In Attendance
Llais representative

4.2 The membership of the Panel will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than a third of the membership and must include as a minimum the Chair and/or Vice-Chair of the Branch Surgery Panel. Wherever possible, the Panel will be convened to enable attendance by Dyfed Powys LMC and Llais to observe the proceedings.

5.2 Any senior officer of the Hywel Dda University Health Board or from a partner organisation may, where appropriate, be invited to attend to provide advice and/or clarification to the Panel, subject to the agreement of the Chair.

5.3 The Panel may also co-opt local primary care professionals and additional independent external 'experts' from outside the organisation to provide specialist knowledge, subject to the agreement of the Chair.

5.4 Should any member of the Panel be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.5 The Panel may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. Agenda and Papers

6.1 The Head of GMS (Sustainability) or a designated Deputy (approved by the Chair), supported by the Branch Surgery Panel Secretary (Primary Care Officer), will lead on the co-ordination of the agenda and papers for the meeting.

6.2 All papers shall be signed off by the Chair before being circulated to the Panel.

6.3 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting.

6.4 The draft minutes and table of actions will be circulated to members within **seven** days to check for accuracy.

6.5 Members must forward amendments to the Panel Secretary within the next **seven** days. The Panel Secretary will then forward the final version to the Panel Chair.

7. Frequency of Meetings

7.1 The Branch Surgery Panel will convene within 20 working days of receipt of a GMS Contract resignation or termination. Meetings can be held virtually at the discretion of the Chair.

7.2 The Chair of the Panel, in discussion with the Panel Secretary, shall determine the time and the place of meetings of the Panel, and procedures of such meetings

8. Accountability, Responsibility and Authority

8.1 The Branch Surgery Panel shall be accountable to the Board for its performance in exercising the functions set out in these terms of reference.

8.2 The Panel shall embed the HDdUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

8.3 The requirements for the conduct of business as set out in Board's Standing Orders are equally applicable to the operation of the Panel.

9. Reporting

9.1 The Branch Surgery Panel, through its Chair and members, shall work closely with the Board's other committees, including joint/sub committees and groups to provide advice and assurance to the Board through the:

9.1.1 joint planning and co-ordination of Board and Committee business; and

9.1.2 the sharing of information.

9.2 In doing so, the Panel shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

9.3 The Panel may establish sub-groups or task and finish groups to carry out on its behalf specific aspects of Panel business. The Panel will receive an update following each sub-groups meetings detailing the business undertaken on its behalf.

9.4 The Panel's Chair, supported by the Panel Secretary, shall:

9.4.1 Report formally, regularly and on a timely basis to the Board following each Panel meeting.

9.4.2 Bring to the Board's specific attention any significant matters under consideration by the Panel.

9.4.3 Ensure a detailed record of the Panel's discussion and recommendations is submitted to Board for approval.

10. Secretarial Support

10.1 The Branch Surgery Panel Secretary shall be determined by the Panel Chair.

11. Review Date

11.1 These terms of reference shall be reviewed on at least an annual basis by the Branch Surgery Panel for approval by the Board.