Primary Care Joint Committees (PCJC)

28 April 2016

Meeting held at:

The Gallery, The Woolwich Centre, 35 Wellington Street, London SE18 6HQ

Minutes

Meeting Chair Dr Greg Ussher (GU)

Executive Support Tom Bunting (TB)

Bexley Primary Care Joint Committee

Attendees:

Katie Perrior (KP)	Member	Committee Chair (Lay Patient Public Involvement)
Keith Wood (KW)	Member	Committee Vice-Chair (Lay Governance)
Mary Currie (MC) (acting Chair for this meeting)	Member	CCG Governing Body Nurse
Sarah Blow (SB)	Member	CCG Chief Officer
Dr Nikita Kanani (NK)	Member	CCG Chair
Dr Sid Deshmukh (SD)	Member	CCG Governing Body GP
Liz Wise (LW)	Member	NHS England (London) – (Director of Primary Care)
Dr Jane Fryer (JF)	Member	NHS England (Medical Director for South London)
Theresa Osborne (TO)	Observer	CCG Chief Financial Officer
Dr Richard P Money (RM)	Observer	Local Medical Committee (Bexley)
Councillor Teresa O'Neill OBE (TO'N)	Observer	Health and Wellbeing Board (Bexley)
Lotta Hackett (LH)	Observer	Healthwatch (Bexley)

Apologies:

Matthew Trainer	NHS England – London (Director of Commissioning Operations)

Bromley Primary Care Joint Committee

Attendees:

Martin Lee (ML)	Member	Committee Chair (Lay Patient Public Involvement)
Harvey Guntrip (HG)	Member	Committee Vice-Chair (Lay Governance)
Sara Nelson (SN)	Member	CCG Governing Body Nurse
Dr Angela Bhan (ABh)	Member	CCG Chief Officer
Dr Andrew Parson (AP)	Member	CCG Chair
Dr Ruchira Paranjape (RP)	Member	Governing Body GP
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Dr Jane Fryer (JF)	Member	NHS England (Medical Director for South London)
Dr Richi Chelvan (RC)	Observer	Local Medical Committee (Bromley) (representing Dr

Mukesh Sahi

Apologies:

Dr Mukesh Sahi	Local Medical Committee (Bromley)
Linda Gabriel	Healthwatch (Bromley)
Councillor David Jefferys	Health and Wellbeing Board (Bromley)
Matthew Trainer	NHS England – London (Director of Commissioning Operations)

Greenwich Primary Care Joint Committee

Attendees:

Dr Greg Ussher (GU)	Member	Committee Chair (Lay Patient Public Involvement)
Jim Wintour (JWi)	Member	Committee Vice-Chair (Lay Governance)
Dr Iyngaran Vanniasegaram (IV)	Member	CCG Governing Body - Secondary Care Clinician
Annabel Burn (ABu)	Member	CCG Chief Officer
Dr Ellen Wright (EW)	Member	CCG Chair
Dr Nayan Patel (NP)	Member	CCG Governing Body GP
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Dr Jane Fryer (JF)	Member	NHS England (Medical Director for South London)
Jan Matthews (JM)	Observer	CCG Primary Care Transformation Manager

Apologies:

Maggie Buckell	CCG Governing Body Nurse
Simon Hall	CCG Deputy Chief Officer/Director of Strategy & Performance
Dr Tuan Tran	Local Medical Committee (Greenwich)
Leceia Gordon-Mackenzie	Healthwatch (Greenwich)
Councillor David Gardner	Health and Wellbeing Board (Greenwich)
Matthew Trainer	NHS England – London (Director of Commissioning Operations)

Lambeth Primary Care Joint Committee

Attendees:

Professor Ami David (AD) (acting Chair for this meeting)	Member	CCG Governing Body Nurse Member
Andrew Eyres (AE)	Member	CCG Chief Officer
Andrew Parker (AP) (representing Graham Laylee)	Member	CCG Director of Primary Care Development
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Dr Jane Fryer (JF)	Member	NHS England (Medical Director for South London)
Dr Jenny Law (JL)	Observer	Local Medical Committee (Lambeth)

Apologies:

Sue Gallagher	Committee Chair (Lay Patient Public Involvement)
Graham Laylee	Committee Vice-Chair (Lay Governance)
Dr Adrian McLachlan	CCG Chair
Dr Martin Godfrey	CCG Governing Body Clinical Member
Jackie Ballard	Associate Member, CCG Governing Body
Councillor Jim Dixon	Health and Wellbeing Board (Lambeth)
Catherine Pearson	Healthwatch (Lambeth)
Matthew Trainer	NHS England – London (Director of Commissioning Operations)

Lewisham Primary Care Joint Committee

Attendees:

Rosemarie Ramsey MBE (RR)	Member	Committee Chair (Lay Patient Public Involvement)
Ray Warburton OBE (RW)	Member	Committee Vice-Chair (Lay Governance)
Professor Ami David (AD)	Member	CCG Governing Body Nurse Member
Martin Wilkinson (MW)	Member	CCG Chief Officer
Dr Marc Rowland (MR)	Member	CCG Chair
Dr Jacky McLeod (JM)	Member	CCG Clinical Director
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Dr Jane Fryer (JF)	Member	NHS England (Medical Director for South London)
Nigel Bowness (NB)	Observer	Healthwatch (Lewisham)
Dr Simon Parton (SP)	Observer	Local Medical Committee
Peter Ramrayka (PR)	Observer	Health and Wellbeing Board

Apologies:

Diana Braithwaite	CCG Director of Commissioning and Primary Care
Matthew Trainer	NHS England – London (Director of Commissioning Operations)

Southwark Primary Care Joint Committee

Attendees:

Joy Ellery (JE)	Member	Committee Chair (Lay PPI)
Richard Gibbs (RG)	Member	Committee Vice Chair (Lay Governance)
Ami David (AD)	Member	CCG Governing Body Nurse Member
Andrew Bland (ABl)	Member	CCG Chief Officer
Dr Jonty Heaversedge (JH)	Member	CCG Chair
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Dr Jane Fryer (JF)	Member	NHS England (Medical Director for South London)
Malcolm Hines (MH)	Observer	CCG Chief Financial Officer
Caroline Gilmartin (CG)	Observer	CCG Director of Integrated Commissioning
Dr Claire Lloyd (CL)	Observer	Local Medical Committee (Southwark)

Apologies:

Dr Emily Gibbs	CCG Governing Body GP
Aarti Gandesha	Healthwatch (Southwark)
Councillor Barrie Hargrove	Health and Wellbeing Board (Southwark)
Matthew Trainer	NHS England (Director of Commissioning Operations)

Other attendees:

Jill Webb (JWe)	NHS England – London (Head of Primary Care)
Richard Jeffery (RJ)	NHS England – London (Director of Financial Management)

Item		Action
1.	**Introduction and apologies** GU welcomed members, observers and members of the public to the sixth meeting of the Primary Care Joint Committees of: • NHS Bexley CCG and NHS England • NHS Bromley CCG and NHS England • NHS Greenwich CCG and NHS England • NHS Lambeth CCG and NHS England • NHS Lewisham CCG and NHS England • NHS Southwark CCG and NHS England GU informed members, observers and members of the public that the meeting was to be held in two parts, and that part one was a meeting held in public, rather than a public meeting. GU advised that the meeting would be recorded to help to ensure accuracy of the minutes, which would be published in advance of the next meeting, at which point they would be formally approved by the Joint Committees. Apologies received in advance of the meeting:	

Dr Mukesh Sahi	Bromley Primary Care Joint Committee - Observer	Local Medical Committee (Bromley)
Linda Gabriel	Bromley Primary Care Joint Committee - Observer	Healthwatch (Bromley)
Councillor David Jefferys	Bromley Primary Care Joint Committee - Observer	Health and Wellbeing Board (Bromley)
Maggie Buckell	Greenwich Primary Care Joint Committee - Member	CCG Governing Body Nurse
Leceia Gordon-Mackenzie	Greenwich Primary Care Joint Committee - Observer	Healthwatch (Greenwich)
Dr Tuan Tran	Greenwich Primary Care Joint Committee - Observer	Local Medical Committee (Greenwich)
Councillor David Gardner	Greenwich Primary Care Joint Committee - Observer	Health and Wellbeing Board (Greenwich)
Sue Gallagher	Lambeth Primary Care Joint Committee - Member	Committee Chair (lay PPI)
Graham Laylee	Lambeth Primary Care Joint Committee - Member	Committee Vice-Chair (Lay Governance)
Dr Adrian McLachlan	Lambeth Primary Care Joint Committee - Member	CCG Chair
Jackie Ballard	Lambeth Primary Care Joint Committee - Observer	Associate Member, CCG Governing Body

Councillor Jim Dixon	Lambeth Primary Care Joint Committee - Observer	Health and Wellbeing Board (Lambeth)	
Catherine Pearson	Lambeth Primary Care Joint Committee - Observer	Healthwatch (Lambeth)	
Diana Braithwaite	Lewisham Primary Care Joint Committee - Observer	CCG Director of Commissioning and Primary Care	
Dr Emily Gibbs	Southwark Primary Care Joint Committee – Member	CCG Governing Body GP	
Aarti Gandesha	Southwark Primary Care Joint Committee - Observer	Healthwatch (Southwark)	
Councillor Barrie Hargrove	Southwark Primary Care Joint Committee - Observer	Health and Wellbeing Board	
Matthew Trainer	NHS England (London)	Director of Commissioning Operations	

2. Declaration of Interests

The following members and observers reported changes to their declarations. In cases where the attendee was representing a member or observer at the meeting, the declarations were noted as new entries to the declarations of interest register.

Name	Joint Committee	Change
Dr Rishi Chelvan	Bromley	Additions: • GP Partner at Highland Medical Practice • Co-Vice Chair, Bromley LMC • Shareholding – member of BGPA
Sara Nelson	Bromley	Removal of: • Seconded from NHS England to Healthy London Partnership as Assistant Programme Lead for Children & Young People – salaried post (0.8 WTE) • Member of National Atrial Fibrillation Clinical Policy Group of UK Clinical Pharmacy Association • Husband is GP (Charles Gostling) in Lewisham and Diabetes Clinical Director of Health Improvement Network (Academic Health Science

			Network, South London) Additions: • Husband (Charles Gostling) is now Clinical Lead on Lewisham CCG Board Change: • Healthy London Partnership (Programme Lead CYP Transformation) *(Was Assistant Programme Lead)*	
	Dr Jenny Law	Lambeth	Removal of: • Member of GP Federation	
	Dr Simon Parton	Lewisham	Change: • Board Director for Lewisham Healthcare Limited (was previously listed as Member of Lewisham Healthcare Limited).	
	Dr Jonty Heaversedge	Southwark	Addition (to existing registered interest – see bold text): Contribute to campaigns and conferences on an ad hoc basis which may be sponsored by pharmaceutical companies - **currently working on a campaign with ViiV Healthcare.**	
	Dr Claire Lloyd	Southwark	Removal of: • Partner at Evolution Health (is no longer a registered company) Addition: • Partner at Nexus, merged practice in Southwark – to start in July 2016	
3.	**Minutes of the last meeting** GU explained that there were three sets of minutes to approve: those of the last SE London PCJCs meeting (held on 11 February); and those of individual borough Joint Committee meetings for Bexley and Southwark (during March, as the SE London PCJCs meeting scheduled for 17 March had been cancelled due to there being no items of business at the SE London level, and as there had been local items of			

	business required only in the two boroughs noted above. 11 February south east London Primary Care Joint Committees meeting: The minutes were agreed to be a correct record of the meeting. 15 March Bexley Primary Care Joint Committees meeting: The minutes were agreed to be a correct record of the meeting. 17 March Southwark Primary Care Joint Committees meeting: The minutes were agreed to be a correct record of the meeting. **Action log** TB advised that all four of the actions on the log had been set at the previous meetings (listed immediately above). Three of these actions had been closed, and the remaining action (concerning the Southwark Joint Committee) was noted as being in hand.	
4.	**Matters arising** NHS Bexley CCG: Bexley practice reversion to GMS Further to a previous decision by Bexley Medical Group practice to revert from its PMS contract to a GMS contract from 1 April 2016 (as reported at the SE London Primary Care Joint Committees meeting on 11 February), the Joint Committee received a report that the practice had subsequently decided not to revert to a GMS contract. NHS Bromley CCG: Stock Hill / Norheads reversion to GMS Further to previous discussion about the proposed merger of Stock Hill and Norheads Lane practices in Biggin Hill, Bromley (as reported at the SE London Primary Care Joint Committees meeting on 11 February), ML reported that both practices did not wish to pursue the merger at this time, and that this was primarily due to staffing issues. The CCG and NHS England (London region) will be working to support the practices through these difficulties. ML advised that the Joint Committee was satisfied that the quality of care for patients registered at either practice had not suffered as a result. The Joint Committee has noted the potential for a renewed request from the practices toward a merger, depending on the staffing issues (noted above) being resolved during the next few months. General Practice Forward View A brief update was given by ABl and LW. ABl briefly contextualised this by stating that a national announcement on this had been made by NHS England during the last week, and since the issuing of the agenda for this meeting. ABl advised that this would come back to the Joint Committees at a subsequent meeting, as it would shape the future programme of work overseen by the SE London Joint Committees to a significant extent. LW briefly described the General Practice Forward View (previously referred to as the GP Roadmap). This is a five year plan to ensure initially stabilisation and	

	subsequently transformation of general practice in England. It will be aided by increased investment into general practice (via both capital and revenue, and through recurrent and non-recurrent means) with the objectives of enhancing access, workforce, and infrastructure. The aim is to recruit an additional 5,000 GPs and 5,000 other general practice clinical professionals (including Mental Health workers, Physicians Associates, as well as programmes for Nursing development and expansion of the Clinical Pharmacy scheme) in England within the next five years, to address the significant workforce challenges that general practice has and continues to experience. The programme is in line with the "time to care" policy agenda and a follow-up to the "Making Time in General Practice" policy initiative/guidance (announced in the autumn of 2015), which was focused on reducing the level of bureaucracy and administration within GPs' workload in order to increase the amount of time available to them to focus on direct patient care. LW advised that there was a movement toward reviewing the NHS standard contracts held by CCGs with acute providers, to look at the balance of work brought about by the levels of outpatient referrals and re-referrals made to general practice. The General Practice Forward View was also linked to the Primary Care Transformation Fund, a £900m programme of investment to general practice for both estates and technology (as discussed at previous meetings of the Joint Committees and at item 7 of this meeting), with funding specifically earmarked for support for e-consultations, as well as further monies for support for IT in General Practice. LW also briefly described a programme of support to practices as part of this announcement, to develop a new contract which would enable the benefits to local populations of at scale working and practice partnerships/federations, as well as support to the progression toward the move to new models of care, most notably the Multispecialty Community Provider model. LW also referred to the next wave of the Vulnerable Practices programme and the work to review the take-up for it in the second wave in 2016-17, and to increase its scope to cover the wide range of challenges faced by practices. LW recommended that a fuller item for information on this topic be brought to a future meeting – this was agreed. LW also agreed to circulate some introductory summary briefing regarding the General Practice five-year Forward View to the Joint Committees, for their information.	**LW**
5.	**Public Open Space** No written questions from the public had been received in advance of the meeting. There were no questions raised by members of the public present.	
For discussion		
6.	**Quality, Performance and Finance** <u>Month 11 Finance report</u> RJ introduced the Primary Medical Services Financial report for south east London, for the 11 months to 29 February 2016. RJ advised that there was no significant material change to the position as reported in previous month's reports, both in year	

	to date performance and the forecast outturn at month 11. The overall financial position for South East London Primary Medical Services showed an overspend of £1.5 m (0.7%) against issued budgets for the 11 months to 29 February. The forecast outturn was a £1.9m deficit (0.8%) after further mitigation, due to under achievement of planned recurrent QIPP savings. RJ advised that the outturn position at the close of month 12 had shown a slightly reduced deficit (the final position was a £1.7m overspend) on the medical budgets. The position on medical services budgets was in line with the rest of London (including level 1 and 2 CCGs as well as fully delegated CCGs). The overall position at month 12 in London was a £7m overspend, primarily due to under achievement of planned QIPP savings, as well a number of other in-year pressures. For SE London this overspend has been mitigated as NHS England (London region) had met its financial targets for 2015-16 and has ensured that the shortfall has been met by other parts of its Primary Care budget: this included some of the previous years' accruals (which are reflected in individual CCG budgets), slippage elsewhere in the NHS England (London region) budget (ie non-medical contingency streams) as well as partial utilisation of the Primary Care 1% headroom. In addition there was slippage on some central budgets – for example depreciation of property. At month 12 the overall outturn position for primary care in London was an in–year surplus of £10.3m. This was largely brought about by the national requirement for all regions to ring-fence £10m of their 1% risk reserve. In summary this had brought about a stable financial position for south east London's Primary Care medical budget at the end of 2015-16. RJ gave a brief summary of the impact of this year and a look forward to 2016-17 following the publication of Primary Care medical allocations for the next five years to 2020-21 by each CCG, and in light of the recurrent deficits brought about by the QIPP position. It was noted that there was an uneven spread of 2016-17 growth monies across London CCG areas in relation to the position against the capitation target, and that the non-recurrent QIPP coverage in 2015-16 and the demographic and contract inflation costs would create pressures. As a result the majority of SE London CCGs were currently experiencing pressures in their planning for primary care budgets in 2016-17. Discussions on this were ongoing between co-commissioners as to how this will be best managed as level 2 CCGs going into 2016-17. The Joint Committees noted the report and this update. There were no questions raised for this item. <u>Quality and Performance report</u> JWe introduced the Quality and Performance report. The report is presented on a quarterly basis, and this was the second presentation of it at a meeting of the SE London Primary Care Joint Committees. A range of questions and issues had been raised by the Joint Committees in advance of and at its last presentation at this forum (on 10 December). The present version benefitted from improvements made in response to those questions and issues (and a range of comments received from CCGs subsequently) which had been gratefully received. JWe explained that a summary of the responses to the questions and issues raised by the Joint Committees was included as Appendix 1. In general terms, the report had improved in terms of its format, including making it easier to read certain sections of the report.	

	JWe briefly described some recent changes to the content of the report. In addition to Appendix 1 (see above) the report also now included a summary analysis that was appended to the cover paper. This was a high level summary analysis of the reportable quality metrics for primary care services. The actual Quality and Performance Report, which comprises NHS England's reportable quality metrics for primary care services, was at Appendix 2. JWe advised that this iteration of the report contained a new data set that had been omitted in previous versions: the outcomes of CQC practice inspections. As described at the meeting on 10 December, at that time an insufficient number of CQC practice inspections had been carried out across London and nationally (for their findings to be meaningful for the purpose of the report). Since then a greater number of inspections (both in SE London and across London) had been completed (see below). Therefore, data on the findings of these reports (as published) was now included in the Quality and Performance report. The data for *some* elements of the report had been refreshed since its last presentation, but some of the data remained the same as shown in its previous iteration. The Quality Outcomes Framework (QOF) data is only refreshed nationally on a bi-annual basis, so this remained the same as previously reported (this was noted in the report). The data for GP patient survey and Friends and Family test outcomes, and Performer and Contractor information, as well as the GP patient survey metrics had all been refreshed since the start of 2016. JWe said that the remaining key area of development for the Quality and Performance report was the co-commissioner joint approach in response to the data findings within it. This is an ongoing piece of work that was currently being developed between NHS England (London region) and the CCGs. JWe advised that a joint agreed approach to this was in development, that would set out agreed actions in response to the various findings within the report, and that this would be brought back to a future south east London Primary Care Joint Committees meeting. JWe noted that the report did now include an overall Co-Commissioner response to the data included in it, and that this was included in the summary paper. JWe summarised the key findings within the report: • GP survey – overall level of positive experiences for patients in GP practices in south east London is slightly lower than the national average, and patient satisfaction levels for south east London had reduced slightly since the last patient experience survey (July 2015). JWe emphasised the seriousness of the issues behind this data, and advised that NHS England (London region) and CCGs in south east London were working as co-commissioners to seek to address these findings within the ongoing PMS reviews across London, whereby CCGs have each identified two KPIs that they would like practices to work on, toward improving patients' experience (as covered at the last SE London PCJC meeting, on 11 February). • Friends and Family test – overall satisfaction levels are close to London and national averages, with the exception of Southwark, which was reported as being slightly lower. • CQC GP inspection reports - overall the reported findings were good for south east London. At the time of this report, within south east London 76 practices	**JWe**

had had an inspection report published. Of those, 60 had been rated as "Good", 3 had been rated as "Outstanding", 9 had been rated as "Requires Improvement" and 4 practices had been rated as "Inadequate", requiring special measures. Whilst this data was positive overall for south east London, there was some cause for concern also.

- JWe advised the Joint Committees that until there was something close to total coverage of published inspection reports across practices in south east London (and London), that there remained a data warning for this component of the Quality and Performance report. At the time that the report was produced, data was available for reported inspections going up to 8 April. The total number of reported practice inspections as of that date (76) meant that 70% of practices in south east London were still awaiting a CQC inspection, or the report for an inspection that had been carried out.

- JWe also noted that there was an item later on this meeting agenda regarding the development of a Standard Operating Procedure (SOP) for practices rated as "Requiring Improvement" following a CQC practice inspection. The SOP is intended to be the co-commissioner response to a CQC inspection rating (where applied), in order to support the practices concerned to overcome the issues as applied by the CQC inspection report where this rating has been applied. This had not been developed nationally; it was being developed in London only at this time.

Bexley Joint Committee (NK) thanked JWe and colleagues at NHS England (London) for the improvements that had been made to the Quality and Performance report, citing its increased accessibility and the references/caveats to the data sources as notable improvements to it.

Lambeth Joint Committee (AE) asked if the information for Lambeth and Bexley practices (contained in the section "Primary Care Service summary") had been superimposed within the report (including the percentages in the final column). JWe replied by saying that this information had been superimposed and would be addressed.

AE also enquired what the measure was for "single hander" practices (that made up 18% of practices) and wanted to clarify for the benefit of the public the definition of single hander practices. JWe advised that these practices were defined as single contract holders, and that the metric was included in the report merely to indicate the proportionality of practices that were single contract holders (this was 18% of practices in south east London) and that these practices might well have more than one GP working within them.

Lewisham Joint Committee (RW) thanked JWe and colleagues at NHS England (London region) for the improvements in usability and presentation that had been made to the Quality and Performance report. RW referred to the 20 practices that the report showed to be not reporting on the Friends and Family metric, and enquired whether the practices that were reporting on this were doing so with enthusiasm. JWe replied by reminding the Joint Committees of the coverage of this item at the south east London Primary Care Joint Committees meeting (10 December) where it was noted that NHS England (London region) had set a 12 month period for GP practices to settle into this reporting requirement (noting that there was extensive work associated between GPs and Commissioners in doing so). JWe advised that this 12 month period had expired on 31 March, and that there was now a focus on

	supporting those practices (where no evidence of patient satisfaction was routinely being reported) to help enable them to provide this information. JWe also advised that for the 20 practices referred to in the report, that a fuller historical context (on the frequency and quality of previous returns) was currently being gathered, to help identify where recurrent concerns exist. RW also pointed out that for the GP Patient Survey, south east London was in general not far behind the national average, but referenced that for some metrics (for example how accessible it was for patients getting through to their practice on the phone) there was more of a differential, and that learning from other areas (where this was not an issue in terms of reported performance) should be taken where possible.	
7.	**Primary Care Transformation Fund (PCTF)** <u>Update on south east London CCG interim estates strategies</u> MH introduced Enclosure F. MH advised that the PCTF had been re-named as the Estates and Technology Transformation Fund (ETTF), in recognition of the inclusion of IT and digital bids/schemes within this fund, and as noted as part of the GP Forward View. As a reminder, the borough-level strategies are mainly focused on the improvement of primary care and community care premises, as well as being an enabler for the move toward the introduction of Local Care Networks. The South East London Estates Group has a wider membership, consisting of all Trusts and Local Authorities in south east London, and is focused on potentially larger opportunities that are in line with the major service redesign programmes across south east London over the course of the next five years. MH reported that there had been steady progress on the work toward refining Local Estates Strategies at a borough level and at the south east London level. The guidance for the 2016-19 ETTF submissions had not been issued by NHS England, though it was anticipated that this would be issued in the next few weeks, following the publication of the GP Forward View, and informal guidance had been shared with CCGs. It was expected that the deadline for submission would be extended to late June (via online submission). MH advised that the confirmed level of funding for the ETTF was £250m per year, and that this was a mixture of capital and revenue funding. MH reminded the Joint Committees that a range of schemes had been approved for delivery in the first year of the then-titled Primary Care Transformation Fund (in 2015-16) but that a proportion of these had slipped into the second year of the fund programme. A list of these schemes had recently been sent to the south east London CCGs, for consideration of whether these remained valid for roll-out in 2016-17, and whether CCGs would submit them alongside the bids in the new round. Due to the likely revised timing for CCGs to make their ETTF submissions, it was not expected that there would be a suitable south east London Primary Care Joint Committees meeting to receive, consider and endorse CCG bid submission proposals (as the next scheduled meeting was on 29 June 2016). In light of this, and in consideration of the level of detail that will be involved in reviewing CCG's individual submissions, the paper proposed that the Joint Committee each formally delegate to their respective sub committees the review and endorsement of schemes	

	to be submitted to the ETTF, subject to decisions being made by voting members of the relevant Joint Committee, in accordance with their terms of reference. The paper also proposed that a summary report on the process and outcome of the respective subcommittees' considerations should be brought back to the meeting of the south east London Primary Care Joint Committees scheduled for 29 June 2016. The recommendations were approved by all of the Primary care Joint Committees. NHS England gave its approval.	
8.	**PMS update** LW gave a brief update, noting that the position reported for information in Enclosure G was at a fixed point in time (approximately 18 April), and that a number of more recent developments had taken place that had overtaken the position as reported therein. These included (i) the General Practice five year forward view (as briefly described in item 4, above), and (ii) the timescales for the process toward development and agreement of Sustainability and Transformation Plans, both of which had implications on the timescales for the PMS review. LW advised that NHS England was working to align the timescales and processes for the General Practice five year forward view and the Sustainability and Transformation Plans, and to develop guidance on the former that would be shared with the LMCs. Furthermore, the Londonwide LMCs had submitted some further questions on the London PMS offer that were currently being worked through with NHS England (London Region). LW advised that she would amend and update this report in line with the recent updates, as per the above. This would be circulated alongside the summary on the General Practice five year forward view (as noted in item 4, above) for information. GU advised that the Director of Primary Care Strategy of the Londonwide LMCs had submitted an email to him (in his capacity as Chair of the meeting), setting out a number of concerns associated with the position on PMS as set out in Enclosure G, which the Londonwide LMC had requested be acknowledged at the meeting. GU noted these points as follows: 1. Full discussion or action should not take place tonight, with regards to the paper and its recommendations. 2. Because of the timing differences between the writing of the PMS paper, and what is now being termed 'different interpretations' by NHS England (London region) (as opposed to inaccuracies), along with the publication of the General Practice Forward View, the paper should be updated and re-issued after discussion with Londonwide LMCs. 3. No national directive has been issued regarding a revised timeline for the completion of PMS contract reviews. 4. The pause remains in place for local negotiations. 5. Furthermore, we have made it clear to NHS England (London region) that we believe it is wholly appropriate for all SPGs to review their STPs to reflect the messages contained within the General Practice Forward View. We have advised NHS England (London region) that we strongly recommend that caution be taken with reference to STPs as they will also need to review their approach (in particular with the 'London Offer') to ensure it is in line with the General Practice Forward View.	**LW**

	The Joint Committees noted the update and agreed with the proposed approach as set out by LW, as well as the concerns that had been raised by Londonwide LMCs.	
9.	**CQC Requires Improvement Standard Operating Procedure (SOP)** JWe introduced Enclosure H (cover sheet and new draft SOP) and explained that until this point, NHS England (national team) had not issued any guidelines for commissioners on management of and support for GP practices that have been rated as "Requiring Improvement" following a CQC GP Practice inspection. Whilst there is a need to be cautious with this data (ie the limited number of inspections that taken place in south east London, where 70% of practices were still waiting inspection – as referenced in item 6, above), JWe explained that the current outcome of CQC inspections of general practices across England showed London as a significant outlier compared to other regions for practices who had been issued an overall 'Requires Improvement' rating following a CQC practice inspection - this stood at 17.6% as a proportion of inspected practices in London, as at 11 April 2016, compared to the 10% average for England). At a recent meeting between NHS England (London region) and the London Strategic Planning Group (SPG) leads for Primary Care (ABl is the SPG lead for south east London), a proposal recommending the introduction of a SOP for this purpose had been considered. The intention of this was to ensure a consistency of approach across London on the management of this issue. The proposal was agreed in principle at the above meeting, where it was also agreed that the individual CCGs in London should be consulted on the approach and the considerations in the SOP (that were set out in Enclosure H). JWe advised that this process of consultation was underway and that that the SOP was currently a work in progress. All six south east London CCGs had reviewed the draft SOP extensively, (as had the CCGs across London) and all had contributed to its present iteration. The SPG meeting had also recommended that Londonwide LMCs (and two LMCs from outside of London) should also be consulted as part of this process, and JWe advised that this was also in train. JWe stressed the importance of applying a sense of proportionality to the issues that had been identified as part of the development of the considerations, and that this should be taken into account in the further development of the SOP. JWe noted that a final version of the SOP would come back to the Joint Committees for formal approval, and that once approved it would form part of the London Operating model for Primary Care Co Commissioning. The Joint Committees were asked to consider the proposed CQC Requires Improvement SOP and confirm whether they were in agreement, in principle, with the proposed approach and considerations, subject to any material changes that may occur following other CCG or London LMCs inputs. The Joint Committees confirmed their agreement to the proposed approach and considerations.	**JWe**

For Decisions		
10.	NHS Bromley CCG: Medicines Management Bromley Local Incentive Scheme JWe introduced the paper (Enclosure I) that requested that the Joint Committee agree to a recommendation to approve the Local Incentive Scheme (LIS), on the understanding that all practices would be encouraged to participate, with outcomes suitably monitored and reviewed. JWe stated that this LIS was designed to improve current prescribing practice in a number of strategic and local commissioning priority areas. JWe advised that it was not an unusual LIS, and that most CCGs commission similar schemes on a year on year basis. ABh expressed the support of the Joint Committee for the implementation of this LIS, emphasising the anticipated benefits it would bring in terms of improving the quality and cost effectiveness of prescribing in Bromley, for example by supporting good antibiotic stewardship, supporting Bromley CCG's QIPP programme, and developing better links with community pharmacists. ABh advised that the intended success of this LIS would be aided by the appointment of Practice Champions and the development of an antibiotics action plan, as well as the piloting of an electronic prescribing tool. Bromley Joint Committee gave its approval for the recommended approach. NHS England had included some comments in the Assessment template and gave its approval for the recommended approach on the basis that these requirements had been met. NHS Greenwich CCG: Medicine Management Greenwich Local Incentive Scheme JWe introduced the paper (Enclosure J) that requested that the Joint Committee agree to a recommendation to approve the Local Incentive Scheme (LIS). This was on the understanding that all practices would be encouraged to participate, with outcomes suitably monitored and reviewed. JWe advised that further engagement needed to be carried out regarding this LIS with the Greenwich LMC, and noted that a meeting on it was scheduled to take place on 4 May. It was noted by JWe that there had been some informal engagement on this LIS between commissioners and the Greenwich LMC that had already been carried out. NP expressed the support of the Joint Committee for this LIS, emphasising the benefits it would bring in terms of improvements to prescribing, and to the self-care agenda in Greenwich more generally. NP advised that the CCG had already engaged with various members of the LMC regarding this LIS on an informal basis, but were awaiting the conclusion of formal meetings. Greenwich Joint Committee gave its approval for the recommended approach, subject to further engagement with the Greenwich Local Medical Committee. NHS England gave its approval for the recommended approach, subject to further engagement with the Greenwich Local Medical Committee.	

	NHS Greenwich CCG: Plumstead/Tewson Merger JWe introduced the paper (Enclosure K) that requested that the Joint Committee agree to a recommendation to approve the merger of Plumstead Health Centre and Tewson Road Surgery, to take place no earlier than 1 July 2016, by way of a variation to the PHC contract to include the Partners of Tewson Road. If approved, the new partnership would subsequently be offered the new PMS contract at the point the latter is implemented. The merger of Plumstead Health Centre and Tewson Road Surgery was previously approved in principle by the Joint Committee at the south east London Primary Care Joint Committees meeting on 10 December 2015. The merger was agreed at that meeting, subject to further information (regarding the outstanding issues that were listed in Enclosure K), in order to give approval of the Practices' Business Case. JWe advised that NHS England (London region) was now in a position to recommend the approval of the business case for the merger, subject to two remaining associated issues being resolved (see below). JWe reported that the practices had requested that the merger takes place with effect from 1 July 2016. JWe advised that NHS England (London Region) would prefer the merged practice to commence the new PMS contract at the same time, which was now expected to be available later than this. In light of the delay to the PMS contract, should the practices wish to progress their merger from 1 July 2016, NHS England (London Region) would put in place a variation to the Plumstead Health Centre contract to include the Partners of Tewson Road, allowing them to work in partnership. The new partnership would subsequently be offered the new Greenwich PMS contract at the point the latter is implemented. Furthermore, both practices were currently working together to care take a patient list of a neighbouring practice (which has had its CQC registration temporarily suspended for up to six months by the CQC, on 18 March 2016), as noted in item 11, below. The patients were being seen at Garland Road, which is the branch surgery of Plumstead Health Centre. There are 3770 registered patients at the practice in question (Slade Surgery), and caretaking arrangements commenced on 21 March 2016. NHS England (London region) recommended the approval of the merger of Plumstead Health Centre and Tewson Road to take place no earlier than 1 July 2016, in order to afford the required period of time to finalise the remaining issues associated with the merger. NHS England (London region) recommended the approval of financial support for costs associated with writing to the registered patients of both practices (approximately £5-6,000), and costs associated with changes to IT systems (approximately £6,000). In addition to the above, co-commissioners were agreed that approval was conditional upon the agreement of leases for both buildings contemporaneously with the implementation date of the merger, as well as on the completion of the practices' Patient Engagement Plan (to undertake to produce a Q & A for all patients regarding the proposed merger). ABu expressed the support of the Joint Committee for this merger, emphasising that it would bring good outcomes for the local population. Greenwich Joint Committee gave its approval for the recommended approach.	

	NHS England gave its approval for the recommended approach. <u>NHS Lambeth CCG: Business Case re: Merger for Vale Surgery & Dr Gunasuntharam Surgery</u> JWe introduced the paper (Enclosure L) that requested that the Joint Committee agree to a recommendation to the merger between The Vale Surgery and Dr Gunasuntharam & Partner (Dr Guna), based on the analysis of the business case presented by the practices (that was included in Enclosure L). JWe noted that both practices currently held separate PMS Contracts with NHS England, and were located within 1.2 miles of each other, and that the merged practice would have a combined list size of in excess of 8900 patients. Furthermore, the future list size was likely to increase owing to trends in population growth and the fact that the Vale Surgery list had increased by 21% during the past four years. The Joint Committee had considered the proposed merger and the closure of 31 Prentis Road (to take place from 1 July 2016 under a variation of the existing PMS contract, given that the timelines for the outcome of the PMS review were unknown). The Joint Committee was asked to proceed with the recommendation to full approval, provided that the outcome of an agreed and implemented full patient consultation plan would be successfully completed, and which takes in to account the views of identified stakeholders. JWe advised that the practices had developed and submitted a strong business case that set out the benefits of the proposed merger, in terms of improved and wider selection of services, and longer opening hours at the merged practice. The practices had also developed an action plan to address areas of performance that they intend to improve, and this had received the endorsement of co-commissioners. JWe also advised that the practices had identified that the majority of patients at Prentis Road already live within the immediate area of The Vale practice, where services would be run from solely. However, owing to the travel distance between the current sites, it had been recognised that circa 600 patients could potentially de-register and join an alternative local practice, closer to the site of Prentis Road. NHS England (London region) had undertaken some analysis to identify the choices of practices that patients would have if the Prentis road site was closed. This had shown that patients would be able to choose from eight practices in the nearby area between those two sites, and NHS England (London region) were satisfied that all those practices were open and would each represent good choices for patients who would not wish to travel to the Vale Surgery, in this eventuality. Due to the above issue regarding travel distance, it was noted that engagement with local patients registered with the practice was very important. Co-Commissioners were in the process of taking forward engagement on the proposed merger with the Local Medical Committee, and with the Patient Participation Group. So far a number of comments had been received from the Local Medical Committee, and these would be actioned by co-commissioners, and directed to the practices, where appropriate. The most pressing of these concerned what the practices intended to do in support of vulnerable patients (affected by the travel distances imposed by the merger) in the course of the proposed merger. This point would be taken back to the practices, should the recommendation be endorsed. The Joint Committee was asked to give agreement in principle, to the proposed merger and the closure of 31 Prentis Road to take place from 1 July 2016 under a	

variation of the existing PMS contract, given that timelines for the outcome of the PMS review were unknown. Full approval would be contingent on the outcome of an agreed and implemented full patient consultation plan, and which would take in to account the views of identified stakeholders.

JWe said that the local GP Federation had confirmed its support for the proposed merger of the two practices.

Required agreement to contribute financial assistance was noted as follows:

- Actual cost of full usual mail out costs £3740 (confirmed cost)
- It was noted that the actual costs associated with the merge of IT systems had not been fully scoped – this would be added by co-commissioners at a later date
- Financially support the practice by means of an advance payment of £11k through the merger/closure period.

AD expressed the support of the Joint Committee for this approach in principle, and noted the intended benefits as set out in the Enclosure L. AD also advised that the Joint Committee looked forward to working with local stakeholders, including the Patient Participation Groups and the Local Medical Committee to look to gain further necessary support for the recommended approach.

Lambeth Joint Committee gave its approval for the recommended approach.

NHS England gave its approval for the recommended approach.

<u>NHS Lewisham CCG: Supporting Practice Engagement LIS</u>

JWe introduced the cover paper (Enclosure M) that requested that the Joint Committee agree to a recommendation to approve the Lewisham CCG Supporting Practice Engagement in Clinical Commissioning Local Improvement Scheme (LIS), 2016-17.

The scheme was in its third year in Lewisham, and the specification had been developed with the learnings from the first two years of its operation in mind.

It was noted that the specification for the scheme had been unintentionally omitted from Enclosure M in the set of papers that had been issued ahead of this meeting. The specification had been reviewed by the Joint Committee but would be made available more widely on request.

The purpose of the LIS is to support Lewisham GP practices and their neighbourhoods to actively engage in high quality, cost effective clinically-led commissioning and service redesign by financially compensating practices for the input required to achieve measurable, quality and cost effective engagement.

MW expressed the support of the Joint Committee for the LIS. The Local Primary Care Management Board had reviewed the specification and supported the recommendation to approve it, as had the LMC which was also in support of it. MW explained that the specification would (i) enable the participation of practices in the CCG's structures for clinical commissioning and (ii) that it would look to identify and deliver quality outcomes from that engagement.
The CCG has acknowledged that supporting and encouraging practices to continue to

	be involved in this type of engagement is one important part of a wider programme of robust engagement and service development with providers, as part of the CCG's plans to continually improve outcomes and quality of services for patients in Lewisham. Lewisham Joint Committee gave its approval for the recommended approach. NHS England gave its approval for the recommended approach. <u>NHS Southwark CCG: Grange Road CQC Breach & Remedial</u> JWe introduced the paper (Enclosure N) that requested that the Joint Committee agree to a recommendation to approve the issuing of a breach and remedial notice to the Grange Road practice for failure to meet the requirements as noted in the Enclosure N cover paper. This followed a Care Quality Commission (CQC) inspection that took place at the practice on 17 November, which had resulted in an overall rating of "Inadequate" for the quality of care provided by the practice. A link to the published CQC report was included in Enclosure N. It was noted that a joint visit to the practice was undertaken by NHS Southwark CCG and NHS England prior to the practice submitting their improvement plan (following the above inspection) to the CQC. A follow up visit will be arranged to assess the progress against the CQC action plan following submission in April 2016. Advice and support in relation to policy development and the development of practice systems and processes had been offered by NHS Southwark CCG and NHS England, and the practice had been in contact Londonwide LMCs for advice and support. The practice will also be advised of support available from the Royal College of General Practitioners (RCGP), which will be part funded by the practice and NHS England. The practice's action plans to demonstrate how they intend to resolve these breaches are required within 28 days of receiving their letter other than where recommendations relate to Good Practice. The Joint Committee will receive an update on progress following this. Southwark Joint Committee gave its approval for the recommended approach. NHS England gave its approval for the recommended approach. <u>NHS Southwark CCG: Grange Road</u> JWe introduced the paper (Enclosure O) that requested that the Joint Committee agree to a recommendation to endorse an urgent decision made by Joint Committee members (on 12 April 2016) to award a temporary caretaking contract to Bermondsey and Lansdowne Medical Mission in Southwark, in order for this to be in place ahead of 3 May 2016, when the current contract was due to expire, so as to ensure continuity of patient care. This followed a decision made by the Joint Committee at its Part 2 meeting on 17 March, to proceed with the procurement for caretaking arrangements at the Grange Road Surgery, to provide continuity of access for patients registered at Grange Road	

	Surgery, following the retirement of Dr Ezeji and the resignation of Dr Khan (the two contract holders). It was also agreed that the options to either procure a replacement service from the existing site or ask registered patients to register with another practice that covers their home address should be put on hold for at least 12 months. JWe advised that the paper circulated as Enclosure O had been further updated to reflect this latest position (ie that the procurement had been completed), and that the updated version would be circulated to the PCJC members after the meeting. The caretaking arrangements will be in place for 12-15 months via an APMS contract. JWe confirmed that the start date for the new contract will be 3 May 2016. A rapid mobilisation period had commenced as Dr Khan's last working day was due to be 29 April 2016. In the meantime, Dr Khan and the Practice Manager were continuing to develop an action plan following the CQC inspection. They had until Dr Khan's last working day to submit this to the CQC, following the latter agreeing a one month extension period. The practice was working closely with the LMC to produce this. It was noted that a staff and separate patient meeting were held at the practice on 31 March to explain the forthcoming changes. The patient group asked a number of questions relating to continuity of care, access and multi-disciplinary team working, to which NHS England responded. Furthermore, a detailed handover of vulnerable children and adults will take place between the current and new provider. This will include the opportunity for the latter to input into the CQC action plan, for which they will be responsible for taking forward. The Southwark Joint Committee noted the key developments as described, together with the fact that this item should have been included in the section on decisions already taken. A general discussion briefly ensued, regarding concerns raised by the Lewisham Joint Committee (by SP, RW and MR), which centered on the need for co-commissioners to (i) review current systems and metrics that are in place to be more certain of identifying practices that are in danger of facing problems further down the line (for example relating to funding or organisational problems) and (ii) to create a climate in which practices feel more comfortable in approaching co-commissioners to raise concerns regarding challenges that they are facing, in order to try to prevent those challenges from developing into far greater problems (for example where breach and remedial notices are issued, or where CQC apply ratings of "Requires Improvement" following practice inspections), and so that packages of support can be afforded to those practices. It was also noted that by encouraging practices to share issues between themselves and with commissioners that this would enable a greater emphasis on prevention of these types of scenarios. JWe advised that NHS England (London region) recognised the seriousness of this issue, and had initiated the Vulnerable Practices programme during 2015-16, which had been developed with CCGs. JWe advised that this programme had recently completed its first wave and would be reviewed and re-launched ahead of the roll out of its second wave, in order to improve the take up (as noted in item 4, above). It was agreed that an update on this programme would be brought to a future meeting of the south east London Primary Care Joint Committees, so that Joint Committees could	**TB**

	be assured that it would address and support practices in the ways that the Lewisham Joint Committee members had encouraged, as above).	
Report on decisions taken by NHS England on behalf of CCGs		
11.	NHS Bexley CCG: Barnard Medical Group – Thwaites Branch Closure JWe introduced the paper (Enclosure P) that reported that an urgent decision had been taken by the Bexley Joint Committee on 3 March 2016, to approve the closure of the Barnard Medical Group practice (Thwaites premises), with effect from 4 March 2016. JWe reported that the Practice Manager at the Barnard Medical Practice had informed NHS England that the practice had been given 3 months' notice by the landlords that the lease at Thwaites would end on 4 March 2016. This was a 'lease at will' that could be ended at any time. The practice advised that it had not been aware that it was required to inform NHS England of the termination of the lease. The Thwaites premises had historically been used to provide access to a range of services (including primary medical services). Commissioners had been advised that it was now only used for anticoagulation services for patients. Patients using the branch had been informed of the closure and that anticoagulation would be provided at Barnard Medical Practice and Marlborough Park (branch surgery). It was noted that the practice believed that the premises would not have passed a CQC inspection. The decision by the Bexley Joint Committee on this matter was taken on 3 March 2016, in accordance with the Operating Model Co-Commissioning of Primary Care Services 2.1 Decision Making Principles. Bexley Joint Committee and NHS England noted the decision made as reported. NHS Greenwich CCG: Henley Cross Contract End JWe introduced the paper (Enclosure Q) that reported that Dr Nikkhah had left the above practice on 28 August 2014, although the contract variation to remove him from the contract had not been actioned due to the lack of a compelling Business Case submitted by the remaining partner, (it had not detailed a robust plan for the contract going forward). Following a meeting between NHS England (London) and Dr Bassi on 18 February 2016, he submitted notification of his immediate intention to resign from the contract and the medical performers list at 6.30pm on 19 February 2016, following an application for Voluntary Erasure from the GMC register. Upon receipt of the request, NHS England (London) contacted Dr Nikkhah to understand his intentions for the contract on which he was still formally a co-partner. Dr Nikkhah advised that he was not aware that he was in partnership, and confirmed that he wished to relinquish his relationship with the contract with immediate effect. NHS England (London region) immediately agreed and actioned this request. The outcome of the above meant that the Henley Cross PMS contract would be returned to NHS England (London), which assumed statutory responsibility for the registered patients with effect from 8am on 22 February 2016. An urgent unplanned decision was therefore required to consider what arrangements should be put in	

	place to ensure access and continuity of care for the patients. An Urgent Decision was then taken by LW (as Director of Primacy Care Commissioning, NHS England (London Region)), in consultation with ABu (as Chief Officer of NHS Greenwich CCG), to approve the actions as follows: Dr Nikkhah to be removed from the contract with immediate effect. Acceptance of Dr Bassi's resignation from the contract with effect from 6.30pm on 19 February 2016. Immediate temporary caretaking arrangements for the contract (to be provided by Sherard Road Medical Centre) for an initial three-month period from 22 February 2016. To undertake an accelerated close down of Henley Cross Medical Centre and put in place a review of all registered patient care. To secure short term commissioning arrangements beyond the 3 month period for urgent caretaking of the contract (an extension offered to and accepted by Sherard Road Medical Centre to caretake until 1 April 2017). NHS England (London) and NHS Greenwich CCG will complete an options appraisal to consider the future provision of general medical services for the existing registered patients of Henley Cross Medical Centre, as part of the overall review of current and future provision for the Kidbrooke Village redevelopment. Further context was provided in Enclosure Q. The Joint Committee noted the actions taken by NHS England (London region) to secure emergency arrangements for continuation of the provision of services for the registered patients of Henley Cross Medical Centre and was in agreement with the actions taken. The Joint Committee noted the options appraisal that will be developed to enable consideration of the future provision of general medical services for the registered patients of Henley Cross Medical Centre and the residents of Kidbrooke Village as a whole. <u>NHS Greenwich CCG: The Slade Dr Sen CQC Practice Suspension</u> JWe introduced the paper (Enclosure R) that reported that an Urgent Decision had been taken by LW (as Director of Primacy Care Commissioning, NHS England (London Region), in consultation with ABu (as Chief Officer of NHS Greenwich CCG) to put in place short term caretaking arrangements for the provision of primary care medical services at the Slade Surgery (by Plumstead Health Centre, working with the Tewson Road Medical Centre) with effect from 21 March 2016. This course of action followed NHS England (London region) receiving notification from the CQC of its intention to serve the contract holder with Urgent Notice of Decision to temporarily suspend primary care medical services at the Slade Surgery under S31 of the Health & Social Care Act (2008) for a period of up to six months (following a CQC Inspection of Dr Sen's practice at the Slade Surgery). Due to the close proximity of Garland Road Clinic, which is a branch surgery of Plumstead Health Centre, and five minutes' walk from The Slade Surgery, it was	

	considered that the provision of services from this location would offer the least inconvenience to patients registered with the Slade Surgery. NHS England (London region) is pleased to report that there was no interruption of services to patients despite the very short timeframe. NHS England (London region) will work closely with the CQC to understand the progress of the temporary suspension of services and will inform registered patients and local stakeholders of the developments. NHS England (London region), in consultation with NHS Greenwich CCG will advise the Joint Committee when the outcome of the temporary suspension is known. The Joint Committee noted the actions taken by NHS England (London region) to secure emergency arrangements for continuation of the provision of services for the registered patients of The Slade Surgery.	
For information		
12.	<u>Locum Reimbursements under London's Discretionary Funding SOP</u> The Joint Committees noted the content of this paper, which was circulated as Enclosure S. The report gave the end of year expenditure position for 2015-16 against the budget for locum fees for all six south east London CCGs. A notional allocation of £916k for south east London in 2015-16 had been calculated, based on the 2014-15 final outturn of locum reimbursements for London, which had then been allocated at CCG level on a weighted population basis. It was noted that notional allocations for level 3 CCGs had also been calculated and delegated on this basis. JWe advised that there was a total expected overspend of £221,380. This was estimated on the basis that the total expected expenditure for 2015/16 was £1,137,215, against the notional budget of £915,835. It was also noted that the total accruals for 2015/16 amounted to £374,450.This will be reconciled across the overall budget for London. The notional allocation for south east London in 2016/17 will be calculated based on the 2015/16 final outturn of locum reimbursements for London, which will then been allocated at CCG level on a weighted population basis. There were no questions or issues raised following the review of the paper.	
Public		
13.	Public Open Space There were no questions raised by members of the public present.	
Other Business		
14.	There was no other business raised.	
For reference		
	Glossary of Terms	

	The Joint Committees noted the contents of the Glossary of Terms. No updates had been received since the last meeting.	
	Date of Next Meeting 29 June 2016, 6-8.30pm at Bromley Central Library, High St, Bromley.	
Close		

Primary Care Joint Committees

28 April 2016

Signed Attendance Sheet (Public and other observers)

Gary Beard	NHS England
Ravi Birdee	BBG Pharmacist
Hunish Sembhi	Star Medical
Dan Rattigan	Healthwatch (Southwark)
Deborah Haworth	Cancer Research UK
Sue Robinson	London Borough of Bexley and NHS Bexley Clinical Commissioning Group
Stella Babudoh	NHS England (London region)
Sally Edwards	NHS England (London region)
Nick Langford	NHS England (London region)

ENCLOSURE: Q(ii)

Agenda item: 99/16

NHS Bexley Clinical Commissioning Group

BEXLEY PATIENT COUNCIL

Tuesday 22nd March 2016 -
12:00 - 14:30
Marriott Hotel, Bexleyheath

Draft Minutes

Attended:

Sandra Wakeford	(SW)	Chair & CCG PPI Lay member
Lionel Eastmond	(LE)	Vice Chair & Crayford Forum
Tia Giles	(TG)	PPG Chair - Lyndhurst Road surgery
Terry Murphy	(TM)	Bexley Pensioner's Forum
Mei Wells	(MW)	NHS retirement fellowship & Bexley Diabetes Group
Janet Fox	(JF)	Station Road, Sidcup PPG
Sheila Burston	(SB)	Diabetes UK Bexley
Steve Davies	(SD)	Bexley Mencap
Linda Bellingham	(LB)	Crayford Town Surgery - PPG
Hilary Rowley	(HR)	Albion Surgery - PPG
Dennis Roberts	(DR)	Erith Town Forum
Dawn Brooker	(DB)	South London Cancer Network
Joyce Sutherland	(JS)	Bexley Safer Neighbourhood Group
Harbhajan Singh	(HS)	Bexley Multi Faith Forum
Liz Shires	(LS)	Plas Meddyg - PPG
George Heitmann	(GH)	Bellegrove Road PPG Chair
Terry Bamford	(TB)	Healthwatch Bexley

Apologies:

Paul Goulden	(PG)	Age UK Bexley
Ilkay Chirali	(IC)	Turkish Elders
Chris Lee	(CLE)	Bexley Youth Council
Cindy Lowe	(CL)	Bexley Moorings
Sakthi Suriyaprakasam	(SS)	BVSC
Vinod Kumar	(VK)	Inspire Community Trust
Aline McCreedy	(AM)	SNAP

No Apologies:

Dave Baker	(DB)	Carer's Support Bexley

Present:

Annie Gardner	(AG)	Head of Patient Experience, Bexley CCG
Diane Hannaford	(DH)	Stakeholder Insight Officer, Bexley CCG
Dr N Kanani	(NK)	Chair, NHS Bexley CCG
Saby Ghosh	(SG)	PPG Plas Meddyg
John Harris	(JH)	Carer's Support Bexley

ENCLOSURE: Q(ii)

Agenda item: 99/16

NHS Bexley Clinical Commissioning Group

Peter Adams	(PA)	Sooty Box Volunteer, RNIB

Presenters:

Simon Evans-Evans	(SEE)	Director of Governance & Quality
Michael Boyce	(MB)	Deputy Director of Primary Care, PMO & Financial information
Oliver Lake & Fiona Gaylor	(OL)	Our Healthier South east London
Alison Rogers	(AR)	Assistant Director Integrated Care Services

1. Standing Items		
1.1	**Welcome and apologies for absence**	**ACTION**
	All members and guests present were welcomed and apologies noted. An introduction was made to Katie Perrior, newly appointed PPI Lay Member and Chair of Bexley Patient Council. NK acknowledged this would be SW last meeting and made a farewell speech and presentation, NK said SW had been a great support to the CCG through its authorisation and throughout her time in office had always ensured that patients and the public were at the heart of our work – and that decisions reflected the voice of local people. All agreed and again thanked SW for her hard work and support with Patient Council. A small gift of appreciation was presented from all members.	
1.2	**Declarations of interest**	**ACTION**
	None declared	
1.3	**Approval of minutes**	**ACTION**
	Notes of the meeting on 21st January 2016 were received and approved.	
1.4	**Matters Arising**	**ACTION**
	Action Log - • AG introduced the presentation planner and advised members this would be used in future to keep track of presentation requests. • AG confirmed first 2 items on action log to be closed as	

NHS Bexley Clinical Commissioning Group

	actions completed. • SW said she had not been successful in securing representative from NHS E to attend and present to members. SEE said he could talk through process of co-commissioning but SD said this had been an outstanding action now for several months, members had specifically asked for attendance by NHS.E. All members felt that further action should be taken to liaise, specifically as there had been questions raised previously which CCG have been unable to address as not responsible for commissioning of all services. NK agreed and SEE said he would liaise with colleagues at NHS. E to arrange a speaker for future meeting. • **Bexley Health Wellbeing Board –** AG highlighted this as agenda item for SS from BVSC. However, as SS was not present it was agreed to ensure update shared at May meeting.	**SEE to liaise with NHS E & for rep to attend future meeting**
1.5	**Chairman and Members update/feedback**	**ACTION**
	Chairman/ CCG update: The CCG has provided training for all staff in Counter Fraud. SW said she attended Quality and Safety Sub Committee, she also made reference to finance committee and that CCG are working hard to ensure best value for money. SW also attended primary care development group meeting – which had provided a platform to share good practice amongst primary care service providers. Bexley linked care programme up and running, this will allow UCC/OOH provider to access (with patient consent) patient records. Action being taken to make local people aware, practices will have posters/leaflets and information will be available at UCC. SW advised the CCG had offered staff training in Counter Fraud. The Quality & Safety Sub Group had met. Finance continues to be tricky, balancing the books and ensuring that the CCG gets the best value for money. Primary Care Development Group continues to meet, sharing good practice. Bexley Linked Care up and running allowing UCC/OOH access to Patient records. Work continues. **Members update:**	

	TG advised members that the second meeting of the mental health forum takes place at the Job Centre on 23rd March. Providers will be present in the pm. SB asked why blood group information was not available via Linked Care. Asked GP and advised information is not recorded on Patient record. Where is it recorded? NK was able to respond and advised not part of GP records, this information held at hospital. TB shared information about Healthwatch activity and said that a report on dentistry in Bexley was to be presented at H&WB Board in April, TB confirmed he would then share report with PC. TB said that Healthwatch had also onducted 15 enter & view visits in care homes across the borough. A report on findings is expected to be available in April. Work has also taken place around experience of patients transferring from child to adult services. LE highlighted that some patients are still confused about where they can go (or would be the most appropriate place to present) for general health advise and support – particularly if they are unable to access an appointment with a GP. Other members voiced concerns that this could be a reason why people attend UCC's and some agreed that access to GP appointment in some practices was difficult. NK acknowledged comments and agreed to share concerns further with GP members and CCG colleagues. AG shared with members some concerns raised in relation to confidentiality. AG reminded all that when joining PC a code of conduct and confidentiality agreement was signed. However, it had recently come to light that a member of PC, who had been privy to highly confidential information, had shared this with a third party. Consequently, action is being taken to address the issue directly with the member involved. However, AG reminded everyone of their commitment around confidentiality and that if not maintained (or if position abused) members could be removed from the PC. AG added that she will soon be reviewing and updating the PC terms of reference (working alongside new Chair Katie, SEE and a	**TB to share copy of Healthwatch report on dentistry**

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	small group of PC members).	
2	**Presentations / Speakers**	
2.1	**Quality & Safety** Simon Evans-Evans Director of Governance & Quality	**ACTION**
	This is a small team consisting of 1WTE AD (shared post), I manager, I co-ordinator and 2 safeguarding nurses (children and adult). The work of the team helps CCG to hold providers to account for quality of service, triangulating information from patients, GP's and performance data. They look at clinical effectiveness, patient experience, patient safety, provider governance frameworks and performance against the NHS outcomes framework. Linking with Adult safeguarding the team look at the quality of care and nursing homes in Bexley and are involved in a number of contract monitoring boards. **Current issues**: • CDff performance– 72 hospital and community cases recorded against annual target of 56. Patients are picking up CDiff in community and taking it into hospital. • Diagnostics 98.1% on time versus target 99%. • A&E waiting time continues to be a problem. • Cancer – Continues to be a problem however we have made big strides to improve 2ww target. • 62 day referral to treatment, particular problem. Weekly meetings with trust now taking place to ensure patients moved through the system. • Oxleas –have a CQC inspection shortly. • Complaint management at Lewisham and Greenwich NHS Trust poor, particularly delays in response.	

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	• SI's management - Oxleas generally really good demonstrating action and learning. Working closely with DN's and GP's to ensure seamless service. • There has been a cluster of young adult suicides in Bexley recently (3) who hung themselves. (Bromley/Greenwich & Lewisham had 10). CCG working with social care and Headscape to support young people. • Discharge notices – a meeting was convened with clinical staff at Lewisham & Greenwich NHS looking at difficulties with patient discharges. One area of particular focus was poor discharge information to GP to assure management of condition when returned to communitycare. • Norovirus has been found and some wards closed in local hospital. • Junior Drs Strike – this has had an impact on patient care/ access. Paricularly, cancelled appointments had an impact on an already busy system. **Successes** ✓ Improvement in cancer performance – 2ww and 62 day wait improved. ✓ Improvement in Root Cause Analyse (RCA) process at LGT. When something goes wrong, why and what are they going to do about it. We are challenging the quality of the RCA. ✓ Care Plus Partnership – closure of Oakwood House following prescribing and then safeguarding concerns, smooth transfer of all patients, (non-Bexley commissioned) ✓ Quality Alerts – system for GP's now being rolled out to care homes and allowing reverse reporting. Learning across the entire system	

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	✓ Received our first Quality premium ✓ Maples care home – out of special measures ✓ Oxleas & other local Acute Hospitals – decrease in number of avoidable grade 4 pressure ulcers **On-going focus for the team** ➢ Imbedded learning from incidents to stop mistakes repeating. ➢ Improved collaboration between providers ➢ Preventing inequality – LD nurses in place at LGT and DVH. ➢ Dashboards – Improved information flows ➢ Safeguarding children and vulnerable adults – additional nurses safeguarding specialists in place at LGT. MW said that she had been made aware of a local GP who had reviewed a patient presenting with blood in stools. Initially diagnoses as piles and discharged. However, transpired it was due to cancer of the colon. MW then asked what steps are taken to ensure GP's are educated and keep their skills up to date. SEE replied that concerns of that nature should really be raised with NHS.E. NK apologised and advised his should be checked immediately and asked MW to liaise further with AG. HR advised Albion Road Surgery PPG concerned about CDiff and Norovirus and had discussed having more antibacterial hand wash available within the surgery. After speaking to GP's and researching the issue further they decided to put up posters about CDiff and Norovirus and advise patients and staff they are resistant to Antibiotics and that we should all be hand washing more effectively to keep it at bay. SEE suggested this good practice was raised at the next PCDG meeting. DR asked if UCC was easing pressure on A&E? SEE replied that	**Raise good practice at next PCDG meeting**

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	generally people are still choosing to go to A&E. However, Bexley figures are static. It might help that we do not have an A&E in the borough. QEH is the 2nd busiest A&E in London. 400+ a day. They are a small site and will need a big investment if the level goes up. Not huge increase in the entire system, however we are all working together to improve flow around the system. NK added biggest worry is around workforce , gap in people that we need to make systems work. Working closely with trainees and asking them what would keep them in Bexley. They advised they do not want to be full time partners; so we are looking at creating posts in response to this feedback. Oxleas are stopping agency workin and there is a big drive to recruit medical students to work on a voluntary basis in Bexley. SW added also need to educate patients to a different mind-set. Use Dr's resources in a different way. TG asked for clarification regarding items 19 & 20 in Bexley CCG Outcomes data sheet. (IAPT – Patient numbers as % population with depression) & (IAPT – Proportion moving to recovery). Alison Rogers was able to address this point – 19 is how many people identified. Recovery target 50%, hitting 45% on a regular basis. Dependent on who enters the service and their ability to recover and the complexity of the case. How the patient feels on the day when they fill in the form. In Britain 6.1 million suffering from anxiety and depression. National 2.5% accessing IAPT, 1.4	
2.2	**PMS Review** Michael Boyce (MB) Deputy Director of Primary Care, PMO & Financial Information	**ACTION**
	Members were referred to presentation slides. MB explained this is a national programme ensuring that all Bexley residents get equality of access. New contracts will be in place by 30th June 2016. Patients should not see any disruption to services. Our principles are quality & safety. Better outcomes & reduction in health inequalities. Our ambition is to ensure current Primary Care investment remains in Bexley.	

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	Patient council members have previously had opportunity to comment on 5 key performance indicators. The new PMS contract witll include a number of KPI's looking at opening hours, additional technology use, screening (immunisations and vaccinations) and access to services. Patient council and Healthwatch influenced selection of two patient voice KPI's; Overall how would you rate your experience of your GP surgery Overall how would you describe your experience of making apt AG also advised that the KPI's were shared with known PPG chairs for their views.	
2.3	**Non-Emergency Patient Transport Services** Joyce Dukes Commissioner & Contracts Manager	**ACTION**
	This item was withdrawn and will be discussed at future meeting.	
2.4	**Our Healthier South East London Pre-consultation assurance – Planned care** Oliver Lake & Fiona Gaylor	**ACTION**
	Oliver Lake presented. **Key areas discussed & questions raised.** Important for the programme to explain which areas of orthopaedic elective care are included within the pre-consultation and consultation engagement. The case for change and patient benefits needs to be clearly demonstrated. Currently patient experiences vary greatly, dependent on where services are being accessed from. Having one large event in each borough isn't that effective as residents will not travel. It's better to have a range of smaller, local, meetings based on geography, to capture a wider range of views. The focus of pre-consultation and consultation engagement should be on targeting current and recent service users. Most of these patients will be accessing services through the MSK pathway. A questionnaire to those patients would be valuable. Concentrating on the healthy majority might be of less value. By running large scale engagement exercises with the general public might create anxiety and fear that the change is much	

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	bigger than it actually is. This needs to be carefully managed. Residents of Bexley/ Bexleyheath/ Crayford are already travelling to Orpington for services. Travel to this site is problematic and parking limited. Consideration will need to be given to this if plans are to consolidate services onto two sites. It is important to cover all equality groups – with special consideration to different language needs. There needs to be better liaison between CCGs, hospitals and TFL to make sure transport has been properly considered when making changes to services. It's important all providers and commissioners know what is being proposed and have the right information to share with patients. The budget for pre-consultation and consultation is important. We need to always consider if there are better ways reach people more quickly? The Bexley Patient Council felt a number of additional stakeholders should be involved and engaged. Including: • Patient participation groups • Age UK London • South London Faith Forum • Ethnic organisations • Sikh mosques • Hindu temples • University of the third age • Women's Institute • Churches • People with complex caring arrangements • Individuals with additional needs • Current and recent service users – possibly accessed through PPGs and GPs • Hard to reach groups • People for whom English is not a first language. The Patient Council felt a number of methods/ techniques should be used, including: • Asking GPs to speak to patients about the changes, rather than just leaving leaflets in the surgery	

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	• Asking pharmacists to include messages on the bottom of prescriptions • Keep messages succinct and make products eye-catching • As far as possible 1:1 conversations will be the best way of gathering feedback • Consider how to make this prominent and visible on the internet, as this is how a large proportion of people look for information • Use the press to advertise opportunities for involvement • Roadshows in precincts and supermarkets • Smaller public events - "go local" • Social media – target based on location • Use local publications such as the Bexley magazine (potentially with a postcard) – circulated three times a year. **Question and answer session** Q. How will the general public be consulted? They will want to know how they will get to these elective centres. There needs to be community infrastructure to support aftercare, following the surgery. Currently it takes 5 months to get physiotherapy – this seriously impacts rehabilitation. A. These issues are the focus of the discussions today. The patient journey before and after the operation is planned to remain the same – delivered locally. It is only the operation itself that would be centralised. Your local consultant will be operating on their patients at the centralised site. We need to ensure that we explain this carefully to the public. The model in south west London, which is the basis for our thinking, currently provides taxis for patients, to and from their elective centre. Join up with physiotherapy will be considered – these changes should not be seen in isolation. Q. If patients get picked up in a taxi, are able bodied family members/ supporters able to travel too? This is often overlooked. A. We have asked current providers if what we are planning is feasible and if they are capable of delivering this. They are in the process of responding to us, and their responses will cover some of the issues raised here today. Q. Will services at Orpington, around elective orthopaedic care, disappear?	

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	A. Specific sites have not been decided upon; any proposals would be subject to public consultation before being implemented.	
3	**Items for discussion**	
3.1	**Queen Mary's Hospital – site services update** Jon Winter, AD Comms & Corporate Services	**ACTION**
	Briefing circulated	
3.3	**CCG commissioned services updates**	**ACTION**
	Briefing circulated	
3.4	**Bexley Action Plan to reduce Delayed Transfers of Care and Improve Patient Flow** Alison Rogers AD for Integrated Commissioning (CCG/LA)	**ACTION**
	AR works across both organisations. Here to talk about issues within, delayed transfer of care when a patient has stayed in hospital too long, they have been passed fit for discharge but can't access care in the community. Experienced an upward trajectory in delayed transfer of care throughout 15/16 culminating in a 17% increase by year end. A target has been set to reduce delayed transfer of care for Bexley patients in 16/17 by 7%. Actions – Further reduce non-elective admissions, improve patient flow and data cleansing. Current initiatives; review and simplification of processes for notification of discharge at QEH. Winter Patient Flow Manager employed at CCG and Hospital social workers co-located with acute staff at both QEH and LGT to identify patients stuck in the system and ease their journey. Identifying frequent flyers in A&E, holding virtual MDT meetings via OMNIJOIN. Developing frailty pathways and working across acute and community services supported by our community geriatrician. Improving engagement with nursing and residential homes to ensure better connected. Integrated commissioning to join up services for older people, mental health needs and learning	

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	disabilities. End of Life Care proposals using the electronic palliative care register, Coordinate My Care currently has 1363 people registered. Bexley & Greenwich have joined their night nursing service. QEH and DVH are implementing the Safer Patient Flow Bundle to ensure systems flow better. Going to Health and Wellbeing Board in April 2016.	
4	**Items for information & update**	
4.1	**Complaint annual report**	**ACTION**
	Document circulated for information	
4.2	**Equality grading panel**	**ACTION**
	AG currently working with SEE to arrange panel and take forward CCG work around EDS2 and review of equality objectives	
4.3	**Patient Experience & Mystery Shopper Q3**	**ACTION**
	Report circulated for information	
4.4	**Engagement plans & opportunities**	**ACTION**
	AG will contact members with details of engagement opportunities – e.g. when recruiting to programme boards etc and of any opportunities to support CCG community engagement.	
4.5	**Training & Development Opportunities**	**ACTION**
	AG will email separately as opportunities arise/develop.	
5	**AOB & date of next meeting**	**ACTION**
	SG briefly spoke about his experience on Health Champion programme introduced by BVSC. One day training session and a short test at the end. Once completed work with surgery 1 day a week helping to signpost patients. LS said Newshopper reported that cancer centre in Farnborough is closing. LS also said that after new centre opens in Bexley cancer patients will not be able to undertake important blood tests on the QMH site – possibly needing to travel some distance for a blood test to support their on-going chemotherapy treatment. TG shared news that she has been nominated to receive a civic award for her long service in volunteering and is planning a celebration on 20th April - which members were invited to attend.	**SEE advised concerns about blood test support for new cancer centre should be raised at next QMH Site Services meeting**

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	SW congratulated TG on her nomination/achievement. SD advised new accessible information standards with effect from 1st April 2016, CCG contracts should demonstrate compliance for people who require different needs and how capturing different needs. SEE – Take through to ESG (part 2), (part 1) already covered. Also reviewing website, new accessibility on the website. HS advised of "Tidy up day" 4th June, 11am meeting at the Clocktower. Members were encouraged to attend and share this information with communities they represent. LB advised that Bexley Diabetes Group won an award	
	Date of next meeting **Tuesday 19th May 2016 – Bexley CCG Offices (Danson Room)**	

ENCLOSURE: Q(iii)

Agenda Item: 99/16

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 21 July 2016

Audit and Integrated Assurance Committee – Executive Summary
3 December 2015

The AIGC met on 3rd December 2015; present Keith Wood (Chair), Mary Currie, Tina Khanna, Dr Graham Rehling.

Particular attention is drawn to item 9 below which identifies an Internal Audit Report on the administration of Conflicts of Interest with the conclusion that only partial assurance is provided. The AIAC does not dispute the facts of the report but considers that there are other measures in place which provide a higher level of assurance that Conflicts of Interest are managed effectively.

At the meeting the AIAC:

1. **Noted** the interests declared by AIAC members: an interest was declared and managed in respect of item 2 below.
2. **Considered** the aged debt analysis as at 31 October 2015, noted processes to manage outstanding debts and **agreed** that there were no debts which required either provision or write off.
3. **Approved** the Anti–fraud, Bribery and Corruption Policy and noted the intention to work on the consolidation of related policies.
4. **Considered and was assured by** the high level Risk Register and Assurance Framework and suggested issues for further consideration.
5. **Noted** the Local Security Management Specialist's Progress Report.
6. **Noted** the Counter Fraud Progress Report and steps being taken to recover an estimated £170,000 charged to the CCG for the cost of prescriptions issued before the CCG was established.
7. **Noted** the Internal Audit Progress Report.
8. **Noted** with satisfaction the Internal Auditor's Report on the Financial Control Environment Assessment.
9. **Noted** the Internal Auditor's Report on the administration of the Registers of Interests and the recording and provision of conflicts of interest training which provided only partial assurance with improvements required. The recommendations were welcomed but the AIAC considered that there were other measures in place which lead to a greater level of assurance.
10. **Noted** the External Auditor's Report on progress and emerging issues.

11. **Noted** the External Auditor's Report on the achievement of KPIs.
12. **Noted** that a month nine exercise involving the preparation of Accounts, Annual Report and other related documentation would be concluded in January and that Audit Committee sign off would be required; the AIAC **authorised** the Chair to undertake whatever was necessary to achieve this.
13. **Noted** the oral Reports on the management of Acute and Community Contracts.
14. **Received Assurance** that all significant acute contracts had been signed.
15. **Noted** the Report from the Integrated Commissioning Unit.
16. **Noted** the tender waiver since the last meeting.
17. **Noted** the decision log from other fora.
18. **Noted** the register of staff interests.
19. **Noted** the critical dates in the 2015/16 Annual Accounts timetable.
20. **Noted** the arrangements for assurance from the Internal Auditor of SECSU.
21. **Noted** feedback from the Audit Chairs Forum.
22. **Noted** the minutes of recent Finance Sub-Committee and summaries of proceedings at recent Executive Management Committee, Quality and Safety, Medicines Management and Information Governance Sub-Committee meetings and **requested** that draft minutes be provided if final minutes were not available for the most recent meetings.
23. **Noted** the proposed dates for meetings in 2016.
24. **Reflected** on the meeting, noting the need for clearer briefing for the authors of non–routine papers, better discipline in the submission of papers and personal conduct during the meetings as well as the benefits of a pre meeting between the Chair and Internal Audit.
25. **Noted** that Internal Audit did not wish to take up the offer of a meeting in private

Keith Wood
December 2015

ENCLOSURE: Q(iv)

Agenda Item: 99/16

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 21 July 2016

Executive Management Committee – Executive Summaries
Meeting held on 3 March 2016

APOLOGIES FOR ABSENCE
Dr Sid Deshmukh
DECLARATIONS OF INTEREST
Dr Nikita Kanani and Dr Varun Bhalla declared an interest in item 36/16 Finance Recovery Plan. No mitigating action was necessary.
STANDING ITEMS
Risk Management Report
EMC **noted** the risks on the Corporate Risk Register and Simon Evans-Evans to organise risk and risk appetite session with Assistant Directors.
ITEMS FOR DECISION
EPRR & BCP INCORPORATING PANDEMIC FLU PLAN
EMC **approved**, with amendments agreed at meeting:

- The EPRR and Business Continuity Plan.
- The Pandemic Influenza (Flu) Plan.

CCG APPRAISAL PROCESS
EMC **approved** the updated appraisal process – in particular:

- The updated appraisal form – move to twice-yearly reporting.
- The best practice training, achievement and development template.
- The one-to-one best practice checklist.

ITEMS FOR DISCUSSION
INFORMATION GOVERNANCE
All requirements of the IG toolkit were rated at level 3 and the Auditors report for 2015/16 rated the CCG with a 'significant assurance' rating.
FINANCE RECOVERY PLAN 2016
EMC discussed the Financial Recovery Plan 2016 which had been produced as requirement by the CCG as the 1% surplus would not be achieved in 2016/17. EMC discussed mechanisms already in place and considered opportunities/suggestions already in the report and any additional items which could be added to the draft document.
NHS STOCKTAKE UPDATE
A number of stocktakes were taking place e.g. financial, activity, mental health, children, safeguarding, learning disabilities and a financial submission to NHS England which included activity at provider and CCG level. The CCG analysis is regarded as good.
SEL UPDATE
The orthopaedics SEL workstream are currently discussing elective orthopaedics for SEL with two sites being considered and consultation to take place in June 2016. Discussions on Maternity are ongoing. The first meeting of the Committee in Common to take place on 17 March 2016 and the CCG will be represented by Sarah Blow, Dr Nikita Kanani and Mary Currie.

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NOTES OF MEETINGS:

Notes of Meetings:

- Finance Sub-Committee
  12 January 2016
- Medicines Management Sub-Committee
  20 January 2016

ANY OTHER BUSINESS

- Update on the Junior Doctors strike on 9-11 March.
- Healthworks prize money has been donated to Staff Network.

Meeting held on 7 June 2016

APOLOGIES FOR ABSENCE

None.

DECLARATIONS OF INTEREST

None.

STANDING ITEMS

Risk Management Report

EMC **noted** the risks on the Corporate Risk Register and agreed that some risks needed to be updated in line with the changeover of the financial year.

ITEMS FOR DECISION

REVISED EMC TERMS OF REFERENCE

Following discussion EMC agreed that further amendments were needed to include the changes to EMC's remit to reflect the link between the CCG's operational/strategic objectives and an updated version would be considered at future EMC meeting.

ACCOMMODATION OPTIONS APPRAISAL

Bexley CCG had commissioned Sweet's to carry out an accommodation options appraisal to ensure CCG value for money. Option 2 to co-locate with the London Borough of Bexley provided best value for money with a substantial saving on costs the CCG currently paid to rent 221. Initial discussion had been held with the Local Authority and CCG staff.
The CCG would retain its identity with consolidated office space clearly signposted and have use of the meetings rooms. Actions have been agreed to take this programme forward.

EMC **discussed** and **approved** that the CCG should progress with Option 2: co-located with the London Borough of Bexley.

FRAMEWORK FOR JOINT WORKING WITH THE PHARMACEUTICAL INDUSTRY

EMC discussed the Framework for Joint Working with the Pharmaceutical Industry and asked for clarification that the comments received from a Conflict of Interest audit had been incorporated into the document and criteria currently used by CCG staff working with the pharmacy industry.
EMC agreed that following the completion of the above actions a draft Framework for Joint Working with the Pharmaceutical Industry should be presented to a future EMC meeting with track changes to the approved document in 2012.

NOTES OF MEETINGS:

- Notes of Meetings:
  Finance Sub-Committee - 8 March, 12 April 2016

- Medicines Management Sub-Committee – 24 February, 16 March, 20 April 2016
- Quality & Safety Sub-Committee Meeting -10 March 2016
- Information Governance Sub- Committee - 8 March 2016

ANY OTHER BUSINESS

None.

ENCLOSURE: Q(v)

Agenda Item: 99/16

NHS Bexley Clinical Commissioning Group

Governing Body Meeting (held in public)

DATE: 21 July 2016

Financial Recovery Group Executive Summary
Meeting held on 10 May 2016

- This was the first meeting of the Financial Recovery Group.
- Ideas Generation papers for End of Life Care Reduction in Non-Elective Care; Non-Elective GU and Movement Programme were discussed. EoLC Reduction in Non-Elective Care and GU Medicine did not require additional funding and had been discussed with Clinical Leads. They take into account evidence of good practice. Discussion took place regarding the need to link across with integrated care and the Local Authority. It was agreed that the three ideas generation papers should be incorporated into one paper under the banner of frailty which would contribute towards an Older People Strategy linking into integrated commissioning. An enhanced Project Initiation Document would be produced.
- QIPP of £7.4m had been identified for 2015/16 to meet the £6.3m required. The CCG had delivered £4.8m QIPP (76%) during 2015/16, which was a good achievement. Slippage of some schemes had been offset by QIPP reserves. QIPP of £8.5m is required for 2016/17 and £7m had been identified to date. Commissioning for value data packs are being discussed at regular meetings to identify additional QIPP. The Star Chamber continues to meet to discuss QIPP schemes.
- During quarter 3 the practice based pharmacists made actual annualised savings of £243k; the care homes pharmacist had made actual annualised savings of £32k and the prescribing advisors had made annualised cost avoidance savings of £172k – giving a total of £447k. For the nine month period April to December 2015 the medicines management team had made savings of £1,070k which equates to a projected full year saving figure of £1,426k. Frognal and North Bexley localities have signed up to delegated prescribing for 2016/17, but as yet Clocktower had not agreed to participate, but it was hoped that the locality would continue to participate in prescribing work.

ENCLOSURE: Q(vi)

Agenda Item: 99/16

NHS Bexley Clinical Commissioning Group

Governing Body Meeting (held in public)

DATE: 21 July 2016

Finance Sub-Committee Executive Summary
Meeting held on 10 May 2016

- The draft Annual Accounts for 2015/16 was discussed. They had been approved by the Audit and Integrated Assurance Committee and had been submitted in line with the NHS national timetable. The CCG delivered a surplus of £169k. All statutory targets were met for 2015/16; the CCG met the Better Payment Practice Code, remained within its capital allocation, running cost allowance, maximum cash drawdown and was within the allowed tolerance of its year end cash balance. The CCG needed to feedback to Internal Audit regarding two Internal Audit Reports in order that the final Head of Internal Audit Opinion could be produced. The Annual Report and Accounts had been sent to the membership for comments and confirmation that the membership is not aware of any relevant audit information of which the CCG's auditors are unaware.

- The 2016/17 final financial planning template had been submitted in accordance with the timetable, with an option to resubmit on 17 May. As a result of LGT arbitration the CCG would be re-submitting contract values and QIPP would be revised. Bottom line numbers would not change.

- The Consolidated Contracts Report months 11 & 12 2015/16 was discussed. James Olweny advised that Guy's and St Thomas' NHS Foundation Trust had given notice on their role as prime contractor for the cardiology contract, but wish to continue to work collaboratively with the CCG to develop the service. A productive discussion had been held with King's in relation to MSK. Oxleas had received an inspection from the CQC and an update would be provided to the Finance Sub-Committee when available. The DXS e-referral system piloted at Belvedere Surgery is going well and it is anticipated that the system will be rolled out to all practices. This will improve the referral process to the Oxleas District Nursing Service. NHS 111 and Urgent Care procurement across south east London was being discussed, with the possibility of Bexley acting as a pilot for the telephone triage. Some 2016/17 acute contracts were still awaiting agreement. GP referrals were discussed and that results are not received quickly enough from acute trusts.

ENCLOSURE: Q(vii)

Agenda Item: 99/16

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 21 July 2016

Medicines Management Sub-Committee - Executive Summary
Date of meeting: 18 May 2016

- Draft SEL Growth Hormone pathway and a Somatropin Shared Care Agreement were reviewed and commented on.
- Draft SEL documents for Rivaroxaban for ACS were reviewed and commented on.
- Draft SEL documents for DOACs in AF-related stroke were reviewed and commented on
- Draft SEL vitamin D guidelines in adults with deficiency were reviewed and commented on.
- Draft SEL Sacubitril Valsartan guidance for treatment of symptomatic heart failure with reduced ejection fraction were reviewed and commented on.

ENCLOSURE: Q(viii)

Agenda Item: 99/16

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 21 July 2016

Quality and Safety Sub-Committee (QSSC) - Executive Summary
Meeting held on 12 May 2016

Chair: Dr Sonia Khanna-Deshmukh

1. Lotta Hackett declared an interest in respect of item 66/16 IAPT Service Specification in that MIND host office accommodation for Healthwatch. No mitigating action was considered necessary.
2. The minutes of the meeting held on 10th March 2016 were approved, and the status of the action log.
3. QSSC considered, and subject to amendment, confirmed the priorities for the Quality and Safety Strategy 2016. Additional suggestions were: Improvements to CAHMS, frailty and the Older People Strategy, improvement in 2 week cancer waits, Care Homes, Learning & Disability Homes and other Domiciliary Care.
4. The approach to local CQUIN development was discussed.
5. The Quality Premium recommendations for 2016-17 were confirmed. These are Cancer – 62 days to first treatment, and Mental Health - Dementia and Improved Access to Psychological Therapies (IAPT).
6. The service specifications for the procurement of IAPT and procurement of an integrated advocacy service for use during 16/17 were approved.
7. The Q&SSC terms of reference were reviewed with a suggestion of using only jobs titles in future.
8. The AQP Dermatology service specification was approved, with the addition of amendments from the discussion.
9. QSSC noted the Integrated Quality, Safety and Performance Report May 2016.
10. Care Homes Quality monitoring update: The Care Home Forum and LA Infection Control Nurse are now in place. Bexley LA and the CCG have agreed to share intelligence. It is proposed to conduct reactive visits this year and reports will be presented at the QSSC.
11. The risk register was reviewed.
12. The individual funding requests Q4 2015-16 report was noted.
13. The SEL NHS 111 Clinical Governance report for February 2016 was noted.
14. The Cancer waits update report was noted.
15. A Serious Incidents update was given. It was noted that an improvement plan is in place at Darent Valley Hospital in relation to infection control.
16. CQRG minutes, DN Strategy Group and Equality Steering group minutes were noted.
17. Date of next meeting: 14 July 2016, 9.30am-12.30pm, Danson Room.