Primary Care Joint Committees (PCJC)

11 February 2016

Meeting held at:

John Major Room, Kia Oval, Surrey County Cricket Club, Kennington, SE1 5SS

Minutes

Meeting Chair Dr Greg Ussher (GU)

Executive Support Tom Bunting (TB)

Bexley Primary Care Joint Committee

Attendees:

Sandra Wakeford (SW)	Member	Committee Chair (Lay Patient Public Involvement)
Keith Wood (KW)	Member	Committee Vice-Chair (Lay Governance)
Mary Currie (MC)	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)
Simon Evans-Evans (SE-E)	Observer	CCG Director of Governance & Quality
Dr Richard P Money (RM)	Observer	Local Medical Committee
Lotta Hackett (LH)	Observer	Healthwatch (Bexley)

Apologies:

Theresa Osborne	CCG Chief Financial Officer
Councillor Teresa O'Neill OBE	Health and Wellbeing Board
Dr Jane Fryer	NHS England (Medical Director for South London)
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 Miranda Selby (MSe)	Member	Governing Body GP (representing Dr Ruchira Paranjape)

Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Dr Mukesh Sahi (MSa)	Observer	Local Medical Committee
Councillor David Jefferys (DJ)	Observer	Health and Wellbeing Board

Apologies:

Dr Ruchira Paranjape	CCG Governing Body GP
Linda Gabriel	Healthwatch (Bromley)
Matthew Trainer	NHS England – London (Director of Commissioning Operations)
Dr Jane Fryer	NHS England (Medical Director for South London)

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)
Annabel Burn (ABu)	Member	CCG Chief Officer
Maggie Buckell (MB)	Member	CCG Governing Body Nurse
Dr Ellen Wright (EW)	Member	CCG Chair
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Dr Tuan Tran (TT)	Observer	Local Medical Committee
Dr Sim Kumar (SK)	Observer	Local Medical Committee
Simon Hall (SH)	Observer	CCG Deputy Chief Officer/Director of Strategy & Performance
Councillor David Gardner (DG)	Observer	Health and Wellbeing Board

Apologies:

Dr Iyngaran Vanniasegaram	CCG Governing Body - Secondary Care Clinician
Dr Nayan Patel	CCG Governing Body GP
Leceia Gordon-Mackenzie	Healthwatch (Greenwich)
Matthew Trainer	NHS England – London (Director of Commissioning Operations)
Dr Jane Fryer	NHS England (Medical Director for South London)

Lambeth Primary Care Joint Committee

Attendees:

Graham Laylee (GL)	Member	Committee Vice-Chair (Lay Governance)
Andrew Eyres (AE)	Member	CCG Chief Officer
Dr Adrian McLachlan (AM)	Member	CCG Chair
Dr Martin Godfrey (MG)	Member	CCG Governing Body Clinical Member
Professor Ami David (AD)	Member	CCG Governing Body Nurse Member
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Andrew Parker (AP)	Observer	CCG Director of Primary Care Development
Dr Penelope Jarrett (PJ)	Observer	Local Medical Committee (representing Dr Jenny Law)
Jackie Ballard (JB)	Observer	Associate Member, CCG Governing Body

Apologies:

Sue Gallagher	Committee Chair (Lay Patient Public Involvement)
Dr Jenny Law	Local Medical Committee

Councillor Jim Dixon		Health and Wellbeing Board
Catherine Pearson		Healthwatch (Lambeth)
Matthew Trainer		NHS England – London (Director of Commissioning Operations)
Dr Jane Fryer		NHS England (Medical Director for South London)

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 Faruk Majid (FM)	Member	CCG Senior Clinical Director (representing Dr Jacky McLeod)
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Diana Braithwaite (DB)	Observer	CCG Director of Commissioning and Primary Care
Ashley O'Shaughnessy (AO)	Observer	CCG Associate Director of Commissioning
Dr Simon Parton (SP)	Observer	Local Medical Committee
Peter Ramrayka (PR)	Observer	Health and Wellbeing Board

Apologies:

Dr Jacky McLeod	Governing Body GP and Clinical Director
Nigel Bowness	Healthwatch (Lewisham)
Matthew Trainer	NHS England – London (Director of Commissioning Operations)
Dr Jane Fryer	NHS England (Medical Director for South London)

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
Dr Emily Gibbs (EG)	Member	CCG Governing Body GP
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Malcolm Hines (MH)	Observer	CCG Chief Financial Officer
Caroline Gilmartin (CG)	Observer	CCG Director of Integrated Commissioning
Dr Kathy McAdam Freud (KM-F)	Observer	Local Medical Committee

Apologies:

Aarti Gandesha	Healthwatch (Southwark)
Councillor Barrie Hargrove	Health and Wellbeing Board
Matthew Trainer	NHS England (Director of Commissioning Operations)
Dr Jane Fryer	NHS England (Medical Director for South London)

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 fifth 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 they would be formally approved by the Joint Committees. GU advised that there would be two public open space items during the meeting (one close to the start and the other close to the end) instead of only one, as at previous meetings to date. Apologies received in advance of the meeting:	

Theresa Osborne	Bexley Primary Care Joint Committee - Observer	CCG Chief Financial Officer
Councillor Teresa O'Neill OBE	Bexley Primary Care Joint Committee - Observer	Health and Wellbeing Board
Dr Ruchira Paranjape	Bromley Primary Care Joint Committee - Member	CCG Governing Body GP
Linda Gabriel	Bromley Primary Care Joint Committee - Observer	Healthwatch (Bromley)
Dr Nayan Patel	Greenwich Primary Care Joint Committee - Member	CCG Governing Body GP
Leceia Gordon-Mackenzie	Greenwich Primary Care Joint Committee - Observer	Healthwatch (Greenwich)
Sue Gallagher	Lambeth Primary Care Joint Committee - Member	Committee Chair (lay PPI)
Dr Jenny Law	Lambeth Primary Care Joint Committee - Observer	Local Medical Committee
Dr Jacky McLeod	Lewisham Primary Care Joint Committee - Member	CCG Clinical Director
Nigel Bowness	Lewisham Primary Care Joint Committee - Observer	Healthwatch (Lewisham)
Aarti Gandesha	Southwark Primary Care	Healthwatch (Southwark)

		Joint Committee - Observer		
	Councillor Barrie Hargrove	Southwark Primary Care Joint Committee - Observer	Health and Wellbeing Board	
	Dr Jane Fryer	NHS England (London)	Medical Director - South London	
	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 Richard P Money	Bexley Primary Care Joint Committee – LMC Observer	Amendment: Is now Chair of Bexley Health Limited (was previously listed as Director).
Dr Tuan Tran	Greenwich Primary Care Joint Committee – LMC Observer	Additions: GP Partner. Shareholder of GPCC. Member of Riverview Health LLP. Undertake OOH work for Greenbrook Healthcare. These are Dr Tran's only declared interests (he has not attended this meeting previously).
Dr Penelope Jarrett	Lambeth Primary Care Joint Committee – LMC Observer	Additions: GP Partner, The Corner Surgery. The Corner Surgery is a shareholder in South East Lambeth Health Partnership. Clinical Lead for Dementia, Lambeth CCG Clinical Network. These are Dr Jarrett's only declared interests (she has not attended previously (attended this meeting in place of Dr Jenny Law)).

	Andrew Bland	Southwark Primary Care Joint Committee – Member	Is no longer Stakeholder Governor at South London and Maudsley NHS Foundation Trust.	
	Dr Kathy McAdam-Freud	Southwark Primary Care Joint Committee – LMC Observer	Addition: SELDOC GP member	
3.	**Minutes of the last meeting, held on 10 December 2015** The minutes were agreed to be a correct record of the meeting. **Action log** Referring to the action tracker for the committees, TB noted that the only actions on the log had been set at the previous meeting (each relating to the Quality and Performance report), and that these had all been closed. The ongoing work to further develop the Quality and Performance report will be taken forward by the Transformation team and Primary Care Commissioning team, (both at NHS England (London)).			
4.	**Public Open Space** No written questions from the public had been received in advance of the meeting. Jennifer Quinton-Chelley (member of the Acorn and Gaumont GP Patient Participation Group in Southwark) raised three questions, as follows: i. Jennifer Quinton-Chelley asked if GP practices in Southwark could request/be granted a break for one hour per day (during which time the practice would be closed and the telephone switchboard turned off) to help practices cope with increasing demand and staff overcome fatigue and longer opening hours for practices. JWe advised that there was some flexibility in the existing PMS contracts on this matter, and that there would be in the new PMS contracts, provided that practices maintained core opening hours of 8am-6.30pm, Monday to Friday. To take this forward practices would need to formally communicate with commissioners on this matter, to specify their requirements. JH advised that CCGs in south east London were aware that practice staff are having to cope with an increased patient demand, and that this had been the case for some time and was having an impact on staff in terms of morale and wellbeing. In Southwark, JH advised that the CCG had arranged to meet with practices later this month to discuss the issue of the level to which current demands were affecting staff wellbeing. JH advised that in Southwark there were regular (monthly) Practice Learning Time meetings (full-afternoon sessions) for all practices in the borough that had been established primarily with the purpose of the CCG providing support to the clinical work of the practices. Further to this, the CCG had built into this process additional sessions (on a biannual basis) for staff in each practice to set aside an afternoon session to review how services are being delivered, which would also serve as a break from service delivery. Jacqueline Best-Vassell (Lambeth and Southwark MIND, South London and Maudsley NHS Foundation Trust, Lewisham Patient Participation Group)			

	reiterated the concern raised regarding the need to grant GP practices a break for one hour per day, pointing out that under EU Law all staff were entitled to a complete break for lunch and citing the potential for burnout and high turnover amongst all staff working in GP practices. ii. Jennifer Quinton-Chelley raised a question about the NHS Online Patient Information, Appointments Booking and Cancellation Service, stating that it had not been working adequately during the past 12-18 months. Jennifer had suggested to her PPG that in response to this and to help local patients a smartphone application be made available and promoted for patients to be able to access this service, but had been advised that due to reductions in funding, this would not be possible. JWe responded to this question by stating that she would need to look into this issue further to better understand where the arrangements for updating the NHS Online Patient Information, Appointments Booking and Cancellation service needs to improve, and an assessment of where responsibility lies for it (between NHS England and CCGs). iii. Jennifer Quinton-Chelley asked for confirmation that all patients' responses on patient experience to NHS Patient Survey questionnaires and to the Friends and Family test were anonymous. Jennifer was concerned that the responses held patient details on them and that this might result in a lesser response overall. Jennifer also raised a concern that respondents might receive less favourable treatment by a provider if they had raised a complaint or scored the service as poor within their survey return, and additionally in her own case, that as a member of the Patient Participation Group, if she were to include critical or negative ratings that this would represent a conflict of interests. JWe advised that for both the online National patient survey (conducted by MORI), and the Friends and Family test (by GP practices), personal details provided by patients are anonymised and are not attributable to the respondent in any way by any staff providing NHS services, and that a provider would not be able to access any patient details of any respondent who had provided comments regarding that service.	**JWe**
For discussion		
5.	**Quality, Performance and Finance** This item focused on matters of Finance only, given that Quality and Performance reports were available on a quarterly basis. <u>Month 9 Finance report</u> RJ introduced the Primary Medical Services Financial report for south east London, month 9. 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 9. The overall financial position for South East London Primary Medical Services showed an overspend of £1.4m (0.7%) against issued budgets for the 9 months to 31 December. The forecast outturn was a £1.7m deficit (0.7%) after further mitigation. The reported 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). Overspend was largely due to under achievement of planned QIPP savings. This position comprised small overspends on PMS and GMS budgets with a large shortfall	

on the QIPP delivery target, which was shown separately. The forecast was driven by the QIPP shortfall but included further non-recurrent mitigations to be realised before the end of the financial year. This included the release of £1.8m non-recurrent 2014-15 accruals to date after further reviews.

At present, on a London level, there remained at month 9 a shortfall of circa £3m of the target £20m QIPP, after the application of non-recurrent mitigations. In line with the response from CCGs to the QIPP letter from NHS England in October 2015, the region continued to seek to further mitigate the shortfall on QIPP through non-recurrent measures and other areas within Primary Care. As a result:

A) A QIPP delivery group had been proposed to support with identifying further opportunities and to enable sharing of transformational QIPP schemes across all areas of London.

B) An external QIPP review had been completed which had identified limited further actions for 2015-16, for NHS England or CCGs, but had highlighted areas for joint work in 2016-17.

C) RJ confirmed that NHSE would be able to cover the 2015/16 Medical QIPP shortfall from other non-recurrent mitigations across the whole of Primary Care and that no contribution would be sought from CCGs in 2015-16.

There had been a year on year growth of 0.8% in South East London's weighted population from April 2014 to April 2015. The capitation report showed a growth of 1.3% year to 1 October 2015 (quarter 3). Demographic growth has been funded on an aggregate basis at 1.3% in the 2015-16 financial plan. Benefits from lower than budgeted growth had not been factored in to the YTD or forecast position, due to the unpredictable nature of population changes. Towards the end of the year, the potential benefit or pressure due to demographic growth would be incorporated, however there will be variations for individual CCGs as indicated in the table in the narrative report.

Overall, in absolute terms the South East London population had seen an increase of 14,219 year on year and a growth of 23,866 year to date in its normalised weighted population. There was a notable range of variation in terms of percentage movement year to date across the six south east London CCGs (0.2% to 2.2%, which had increased in the month 10 report, which RJ had seen ahead of the meeting). RJ pointed to the increase in identified risk as the reports have moved to individual (smaller) CCG budgets from the south east London level. The normalised list sizes would include a full year effect in the next iteration of the report.

RJ gave a brief summary of the impact of this year and a look forward to 2016-17 and beyond. RJ reported that Primary Care medical allocations for the next five years to 2020-21 had recently been published by each CCG. The allocations for the next three years were confirmed, and were stated on an indicative basis for the subsequent two years beyond that. NHS England viewed the settlement for 2016-17 as generous, given the state of public finances more generally and of the wider NHS at the current time. The settlement equated to a 4.78% increase in the primary care medical budgets for London in 2016-17 and largely throughout the next five years. For south east London CCGs the increase will be 4%. RJ stated that this would give CCGs in south east London the opportunity to stabilise the financial position for primary medical budgets in the coming year and in the next five years.

There would be an impact of not making 15/16 savings on that growth, but even

	allowing for all of the QIPP shortfall, there would still remain an uplift of approximately £8m (3.5%) for south east London. The Joint Committees noted the report and this update. There were no questions raised for this item.	
6.	**Primary Care Premises Transformation (PCTF)** <u>Update on south east London CCG interim estates strategies</u> MH introduced Enclosure E and gave a brief update on progress on estates strategies at both an individual CCG borough level and the south east London level (via the Our Healthier South East London strategic estates plans), following the update given at the previous meeting on 10 December. MH reported that in each borough there is a broad membership of each borough's estates group, generally including appropriate representation from Local Authorities, Hospital Trusts, CCGs as well as Primary Care providers. The first drafts of the borough estates strategies were submitted to NHS England (London region) ahead of the deadline of 31 December 2015 in conjunction with work carried out with the London-wide Estates Board and Community Health Partnerships, both of whom had been commissioned by NHS England to provide assistance to CCGs in the development of the Estates strategies and bids. These versions were fairly high level and will require further detail and refresh, which the CCGs are working to produce via a series of workshops and meetings ahead of submission in April 2016. MH advised that a south east London group had also been established as part of the Our Healthier South East London strategy, with the same principles of membership as the individual borough estates groups that were working in conjunction with it. MH advised that this group had held two meetings so far, with further meetings scheduled. It was anticipated that there would be wider and more far-reaching opportunities for utilisation at this level, between commissioners/local authorities and providers, as business cases are reviewed in the course of 2016. MH said that some additional monies had been made available from NHS England (London) to support this work across London, which is being used in a range of different ways across the boroughs, including to progress utilisation surveys for a range of GP premises earmarked locally. It was expected that work would be completed around the end of the financial year, and will align with the emerging estates plans at borough and south east London level. MH reminded the Joint Committees of the position regarding capital bids. 2015-16 saw the first round of Primary Care Infrastructure Fund. In 2016-17 this was to be renamed as the Primary Care Transformation Fund (PCTF), moving into the second year for the four year, £250m investment programme, which will be a mixture of capital and revenue funding moving forward. It was noted that the guidance for the PCTF bids had not been issued by NHS England, but it was expected that the deadline for their submission would be extended to April, which was welcomed by the CCGs. It was noted that boroughs were currently working up project proposals and bids. MH also advised that the programme was being widened in scope to cover technology bids as well as estates building infrastructure bids.	

	MH stated that the south east London estates strategy would be a key part of the Our Healthier South east London commissioning strategy across the six CCGs, and that it would in turn be a key part of the south east London Sustainability and Transformation plan, which was due to be submitted to NHS England in June 2016. JWe advised that as CCGs would be making bids to access the Primary Care Transformation Fund, it was expected that there would be a range of business cases for the development and transformation of GP practices in south east London that would be presented to the Primary Care Joint Committees for review and approval in the coming year. Therefore it was noted that this will be a significant standing item at future south east London Primary Care Joint Committee meetings. The overall aim of the PCTF and the bids for its allocation was to improve general practice and ensure that it is fit for purpose for patients and for staff working in primary care in south east London. The Joint Committees noted the report and this update. Several questions were raised by the Joint Committees. Bexley Joint Committee (RM) asked how patients will be involved in this process. JWe explained that this will be specific to each CCG, but that there was a requirement for Strategic Estates plans (although still in their infancy across the south east London boroughs) to be linked to local engagement with patients. JWe noted that PCTF bids would need to be clearly linked to the Strategic Estates Plan for any given borough, thus setting out the link across the breadth of this work with patient engagement and involvement. MH said that the precise mechanisms for patient engagement would vary across the six local CCG Estates Groups, but that as a general rule, patient representatives were involved in each of the local CCG Estates Groups and at the south East London Estates Board. Patient representatives would have an input to the identification of schemes and the review of bids ahead of their submission to NHS England. Lewisham Joint Committee (RW) asked how the allocations for the primary care transformation fund for estates plans would be divided/allocated – would this be on the basis of the highest level of need or on a fair shares basis. JWe replied, stating that the allocations had not been set at this point, but that they would be at a regional (rather than CCG) level. JWe advised that there were clear advantages to taking a regional approach. The nature of premises schemes (these being the vast majority of the schemes to date) had resulted in slippage in the completion of a number of the schemes. A CCG formulaic pro rata allocation was not considered by NHS England to be conducive to effective management and delivery of schemes, some of which would be likely to be delayed for periods of time, and a significant number of which would involve partner organisations from across provider sectors and different boroughs in south east London. Furthermore JWe advised that the programme was necessarily structured around setting and responding to priorities for development of primary care and use of the fund, as the volume of the bids across London will be far greater in excess than the amount of the PCTF. Alongside of the renaming of the Primary Care Infrastructure Fund(PCIF) to the PCTF, the latter is now considered as a three year programme, which will produce a pipeline of schemes in the next three years. RW stressed that there needed to be fairness applied in allocating funds to business cases over the remaining three year period. JWe responded further by stating that fairness was being applied as all CCGs in south east London were being supported on an equal basis in the development of their strategic estates plans by NHS England and the Strategic Planning Group. Therefore this was an opportunity for each CCG to submit the best plan possible in order access funding.	

For Decisions		
7.	<u>NHS Lewisham CCG: Dr Arora single hander request to take on an additional partner (contract variation)</u> JWe introduced the paper (Enclosure F) that requested that the Joint Committee agree to a recommendation that Dr Shashi Arora, currently a single handed GP with a PMS contract (at Baring Road Medical Centre), take on an additional partner. Dr Arora had approached NHS England to request permission to take on an additional partner, in line with NHS England's GP contractual procedure arrangements for PMS contract holders. An assessment report undertaken by NHS England (London) and Lewisham CCG setting out how the application met the criteria for allowing an additional clinical Contract signatory, was included in the paperwork for this Enclosure. Lewisham CCG and NHS England (London) had carefully reviewed the Business Case submitted by Dr Arora, and had found no issue to prevent a recommendation to approve it. JWe stated that the Local Medical Committee had been engaged with in the review of this Business Case and the agreement to the recommended approach. Lewisham Joint Committee gave its approval for the recommended approach, with no conditions. NHS England gave its approval. <u>NHS Lewisham CCG: Revised Terms of Reference for Joint Committee</u> DB introduced the paper (Enclosure G), a revised Terms of Reference (ToR) for the Lewisham Primary Care Joint Committee. The revisions to the ToR had been recommended by the Lewisham CCG Primary Care Programme Board at its meeting on 27 January, to enable improved assurance, scrutiny and governance with regard to the management of conflicts of interest. The core aspects of the recommended revisions to the Joint Committee's ToR were that (i) the CCG's/Joint Committee's Lay member for Governance (who is also the Joint Committee's Vic Chair and the CCG's Conflicts of Interest Champion) be added to the Primary Care Programme Board membership, and (ii) when mitigating any conflicts of interest of GP members by asking those members to leave a discussion at a Joint Committee meeting for the item(s) for which they are conflicted, that the lay member (who is a clinician but not a GP) be included in the Primary Care Management Board membership, to ensure there is quoracy and to maintain sound clinical input to decision-making. Lewisham Joint Committee gave its approval for the recommended approach. NHS England gave its approval. <u>NHS Southwark CCG: Dr Bhatti Bermondsey Spa CQC Breach and Remedial Notice</u> JWe introduced the paper (Enclosure H) that recommended the issuing of a contract remedial notice to Bermondsey Spa Medical Centre. This was following an inspection by the Care Quality Commission (CQC) on 15 October 2015 whereby the above practice received an overall rating of "inadequate" for the quality of services provided by the practice. In addition to the rating applied by the CQC following its inspection, a	

	number of component findings within the CQC's inspection report amounted to contract breaches within NHS England's contractual requirements. In accordance with the Framework for responding to CQC inspections of GP practices, NHS England is recommending a breach and remedial notice be issued to this practice. The detail of this was set out in Enclosure H. In parallel, NHS Southwark CCG and NHS England (London) will meet with the practice to confirm the action plan (agreed following the CQC report) and to offer support and set out the review process against the action plan. LMC support is also being sought by the practice as part of this process. KM-F stated that in her opinion there was not enough evidence and information in the cover paper in support of the recommendation for the Joint Committee to issue the breach and remedial notice. KM-F also advised that the London-wide LMC were working with this practice following the CQC report. Southwark Joint Committee gave its approval for the recommended approach. NHS England gave its approval.	
Report on decisions taken by NHS England on behalf of CCG		
8.	<u>Bexley practice reversion to GMS</u> JWe introduced the paper (Enclosure I) that reported that Bexley Medical Group had approached NHS England to serve notice that it wished to revert its PMS contract to a GMS contract from 1 April 2016 in accordance with the National Health Service (Personal Medical Services Agreement) Regulations 2004. As there is provision within the PMS contract to revert to GMS, approval was not required and the paper (Enclosure I) was presented to the Primary Care Joint Committee for information. JWe advised the Joint Committee that there would be no diminution in services provided to registered patients at this practice as a result of this contractual change, as per the Enclosure I. Bexley Joint Committee and NHS England noted the decision made by the practice for this contractual change.	
For information		
9.	<u>NHS Bromley CCG: Stock Hill / Norheads reversion to GMS</u> JWe advised that this item would not be covered on the agenda as the paper had not been finalised in time. The item related to a proposed merger of two practices (Stock Hill and Norheads Lane). The Joint Committee noted that an urgent planned decision may need to take place on this ahead of the next south east London Primary Care Joint Committees meeting on 17 March. ML said that the practices had produced a draft Business Case for the proposed merger, which would require further review by the Bromley Joint Committee, and that this would take place outside of this forum	**JWe**
Other Business		
10.	GU advised the Joint Committees that the item for any other business would be taken in advance of the further items for discussion, which would be the last substantive item on the agenda.	

	There was no other business raised.	
Further items for decision		
11.	**<u>London PMS Contracts</u>** <u>Managing conflicts of interest</u> GU informed the meeting that the item would be taken in two parts. The first part would focus on the arrangements that had been made for managing conflicts of interest and assurance on clinical engagement. The second part would focus on the consideration of the PMS commissioning intentions, and a summary of those commissioning intentions, by each Joint Committee. ABl reminded the Joint Committees that, as announced at the previous meeting on 10 December, the extension for the completion of the PMS review had been granted by NHS England (on the basis that this would afford CCGs the required time to engage locally with patients, LMCs, member practices and other stakeholders on the PMS commissioning intentions), and that therefore the process would need to be completed by 31 March 2016. ABl explained that for the first part of this item (conflicts of interest and assurance on clinical engagement) all committee members would be present at their respective committee tables, but for the second part (commissioning intentions) the GP voting member of each committee and the LMC representative would be asked to retire to the public audience section of the meeting room. This process had been agreed by the Joint Committees in advance of the meeting in order to ensure that GPs were not involved in the agreement of the financial aspects of the agreement and decision-making regarding the PMS commissioning intentions, in order to best manage conflicts of interest. Following the completion of the item, the GP voting members and LMC representatives would be asked to return to their committee tables ahead of the final item on the agenda, which was the public open space, during which they would be permitted to ask questions (as members of the public) on aspects of the PMS commissioning intentions not relating to finances. RG commented on the importance of managing conflicts of interest whilst retaining vital clinical input to the development of the commissioning intentions appropriately. The process for this item was in line with local CCG policies on management of conflicts of interest and the Terms of Reference of each of the Joint Committees, which stated that decisions could be taken without the presence of GP voting members of each committee, provided that that committee remained quorate in doing so. RG advised that the six committee chairs would each be asked to confirm that they were content that the conflict of interest policy for their CCG had been followed, and that good clinical engagement had been secured in the development of the PMS commissioning intentions for their borough. GU asked each Joint Committee Chair to confirm the two principles above. Each of the Chairs confirmed that both principles had been achieved in their borough in the development of the PMS Commissioning Intentions, on behalf of their Joint Committee. GU asked the GP committee members and the LMC representative for each Joint Committee to leave the table and to be seated within the public audience section of	

	the meeting room. <u>PMS Commissioning Intentions</u> JWe introduced the overarching cover paper to Enclosure J, which summarised the progress on the engagement work that had been carried out by NHS England (London region) on the London review of PMS contracts, and the local engagement work in each CCG borough. JWe reported that the London offer had been concluded following a series of consultation meetings held with the London wide LMC. NHS England (London region) had shared with all London CCGs the final agreed London offer for adoption as part of CCG local commissioning intentions. South east London was the first area in London to consider the PMS Review commissioning intentions at CCG level. The discussions had only concluded late in the week commencing 1 February, and as a result of that the London offer documentation has been amended twice in quick succession ahead of the meeting. The documentation was now publically available (via south east London CCG websites as the papers for this meeting) and was available electronically on request. The PMS review required that investment be retained in general practice, and JWe advised that this was being adopted across south east London CCGs. Furthermore, the PMS review gave NHS England (London region) and south east London CCGs as co-commissioners the platform to now begin to implement the Strategic Commissioning Framework (SCF), which had been consulted on extensively, and had been adopted as the standard for accessible care, coordinated care, and proactive care that commissioners aspired to deliver for their patients. This was demonstrated in the PMS commissioning intentions for each borough. JWe referred to the three documents comprising the London offer that were appended to the overarching cover paper in Enclosure J, which had been consulted on with London-wide LMCs and had been accepted. These were: PMS Core service specification, Premium service specification, and Key Performance Indicators. Some elements within this documentation were mandatory, ie CCGs had agreed that they should be consistently offered, and some areas were for local determination (predominantly in the premium service specification). JWe advised that NHS England required that the PMS review was concluded by the end of March, in accordance with the national timetable. By definition this meant that every PMS contract holder will have been offered the PMS contract by 31 March, followed by local negotiation with practices, to enable all contracts to be signed by 30 June (in line with the three month extension granted by NHS England). It was noted that this was a tight timetable of deliverables (which were listed in Enclosure I) ahead of the contracts being implemented for 1st July. JWe briefly summarised the position in terms of the agreement of the local commissioning intentions (with recommendations) in each CCG borough, stating that each CCG recommendation had a condition attached to it. Five out of six of those conditions were subject to a formal local consultation with the local LMC in each borough. JWe advised that this consultation had not been completed on the CCGs' commissioning intentions at the current time, and was due to be completed by 31 March. GU advised the meeting that each Joint Committee would be asked to present their position regarding acceptance (or otherwise) of the PMS London offer, a summary of	

	the PMS commissioning intentions in their borough and their compliance with the national requirements. In addition each Joint Committee would have the opportunity to ask questions for NHS England (London region) or for the members of their own committee. <u>Bexley Joint Committee:</u> SB confirmed that the recommendation of the Bexley Joint Committee was to accept the London offer, on the condition that Bexley would have first call on 2016-17 primary care growth monies (from NHS England) to enable the CCG to offer the full London PMS offer to all of its practices. This was due to the fact that the London offer was not affordable to the CCG due to the low level of premium that it has. SB stated that if this condition was not met the London offer would not be affordable to the CCG. SB also confirmed that Bexley CCG intends to ensure equalisation across GMS practices from 2016-17 and that it will also equalise for APMS practices along the lines of the PMS contract offer. SB stated that as part of the London offer Bexley CCG had discussed with local Healthwatch and the Patient Council the areas for inclusion for the patient voice for practices in Bexley. The local Healthwatch and Patient Council had recommended (i) overall experience and (ii) experience of getting an appointment as the priorities for the new premium offer. Bexley CCG had accepted these recommendations. There were no questions from the Bexley Joint Committee to NHS England. <u>Bromley Joint Committee:</u> ABh confirmed that the local LMC, Healthwatch and the Health and Wellbeing Board had been engaged in the development of the local commissioning intentions. Bromley CCG is intent on meeting the PMS premium at the level of £12.26 per patient. ABh noted that Bromley is in a different position to the other south east London boroughs in terms of its PMS coverage - 40% of the borough's population are not covered by the PMS contract (as they are registered with GMS practices). ABh confirmed that the Bromley Joint Committee recommended the acceptance of the London offer. The CCG had also agreed to the development of some other indicators for inclusion (subject to further local negotiation between the CCG and LMC), which were in relation to key health priorities in the borough (including breast screening and bowel cancer screening). Bromley CCG is expecting to support practices to be involved in the major transformation programme in the borough including the development of integrated care networks and intends to use a proportion of the PMS premium to support practices to do so. The CCG intends to undergo a programme of equalisation of PMS and GMS practices and anticipates that this will be completed in year, but would require 2016-17 primary care growth monies to support this. There were no questions from the Bromley Joint Committee to NHS England. <u>Greenwich Joint Committee:</u>	

	JWi confirmed that the Greenwich Joint Committee recommended the acceptance of the London offer, and proposed to use the remaining premium to incorporate two cancer screening KPIs, and to make it easier for Greenwich residents to register with GP practices on Saturday mornings, and to introduce a KPI on that. JWi advised that the above had been consulted on with Healthwatch, LMC and the Health and Wellbeing Board. There were no questions from the Greenwich Joint Committee to NHS England. GU noted that Healthwatch Greenwich (who were not able to attend the meeting) had submitted a question to the Joint Committee. The question related to how the CCG intends to further work with Healthwatch Greenwich to deliver patient and public engagement regarding these commissioning intentions). JWi advised that the Greenwich Joint Committee would write to Greenwich Healthwatch after the meeting to follow this up. <u>Lambeth Joint Committee:</u> AP advised that the Lambeth Joint Committee considered sustainable, supported and valued general practice in the borough as a vital part of what the CCG intends to achieve as part of the PMS review process and at a wider strategic level, both at individual practice and federation level. AP reported that the CCG's member practices and other stakeholders had engaged enthusiastically in this process. AP confirmed that the Lambeth Joint Committee recommended the acceptance of the London offer. The CCG was in the process of working through a number of issues regarding weekend access to general practice. AP advised that there was a process under way to finalise the detail of KPIs through which to commission the local CCG premium elements, and that this would be a clinically led process with further meetings due to take place in the next week. There were no questions from the Lambeth Joint Committee to NHS England. <u>Lewisham Joint Committee:</u> MW confirmed that the Lewisham Joint Committee recommended the acceptance of the London offer in terms of the mandatory items for KPIs. MW reported that the CCG had undertaken significant clinical consultation with its membership and informally with the LMC regarding use of the premium locally. Through previous engagement with local patients, the 2 patient voice indicators selected were a) experience of making an appointment and b) support for Long Term Conditions management. In terms of the London service specifications, MW advised that Lewisham CCG had recommended the inclusion of improving access through the use of technology (online). However, MW noted that the CCG had recommended an alternative plan for weekend additional capacity (ie it was not accepting that component of the service specifications) but that the CCG instead recommended implementing arrangements to build on existing primary care services as part of a new model for primary and urgent care to be taken forward in Lewisham in 2016-17. MW said that Lewisham CCG recommended a range of indicators for the local Commissioning intentions in the areas of proactive care and coordinated care. MW confirmed that these were in line with the CCG's local commissioning strategy and	**JWi**

	with the Health and Wellbeing Board. These were listed in more detail in Lewisham CCG section of Enclosure I. There were no questions from the Lewisham Joint Committee to NHS England. <u>Southwark Joint Committee:</u> CG confirmed that the Joint Committee recommended the acceptance of the London offer. The local variations on the offer were as follows: Breast screening KPI was included in use of the local premium (this had been omitted from the overarching London offer). CG advised that the two patient voice KPIs selected were overall experience and experience of making an appointment, and that these were included as a result of engagement with patient groups and GP practices locally. For the access specification CCG said that the CCG has local arrangements in place which enable it to offer 8am-8pm access seven days per week. This meant that the CCG would not include the Saturday mornings opening specification but that the CCG would be including the online access specification. There had been extensive engagement with Council of members, practice locality groups, Patient Participation Groups and via CCG Board seminars, and as a result of this ten KPIs had been agreed that encompassed the accessible care, coordinated care and proactive care areas. On that basis the CCG was confident that it had developed a recommended approach that meets the required standards to demonstrate measurable outcomes, to develop services that go beyond the core, meet the statutory responsibility to reduce health inequalities for the local population. There were no questions from the Southwark Joint Committee to NHS England. GU asked the Joint Committees for any final questions regarding the London offer or the local commissioning intentions. Lewisham Joint Committee (RW) asked how well the equity of access service delivery requirement had been monitored under previous contracts and how had GP practices performed against it in the past and how would it be monitored under the new contract. This would help to indicate trends in performance and ensure consistency of approach. JWe advised that there is a vast multitude of indicators that could potentially be included for monitoring in GP contracts. This service description was slightly different from the national contract in that it better defines what is asked of general practice in terms of treating every patient according to needs. JWe said that there is currently a self-assessment assurance statement which must be completed by all practices – regardless of contract type - on an annual basis to address these types of questions. There was the option for any CCG to develop this specification further (for example to commission a practice to do some specific health promotion work for a particular grouping of patients as part of a commissioning arrangements), which would be costed and monitored separately. DB supported JWe's statement. With regard to requirement 1.3, DB noted that the current contractual requirement was for practices to opportunistically collect the data on ethnic origin, and that the Lewisham Joint Committee welcomed its inclusion in the new PMS contract. Lewisham CCG has an	

	active Primary Care Equalities programme in place to support practices in identifying where there are gaps in ethnic origin of the registered patient population so that this issue can be addressed. SE-E (Bexley Joint Committee) reminded the Joint Committees that there are a total of nine protected characteristics – and that all of them are required to be adhered to, in compliance with the Equalities Act and Disabilities Discrimination Act and other national guidance. Greenwich Joint Committee (ABu) asked if there was a process in place for bidding for additional primary care growth monies for 2016-17. This was in reference to the condition that the Bexley Joint Committee had applied regarding the acceptance of the London PMS offer and to the difference in available PMS premium as experienced across south east London CCGs. LW replied by advising that for 2016-17 primary care uplifts had already been set at individual CCG borough level. For delegated CCGs that would form part of their allocation. For non-delegated CCGs (such as those in south east London), although the growth was held by NHS England, its Primary Care Team was working with SPG leads across London to develop a set of guidance/business rules for use of those growth monies, but it is expected that CCGs would work within the limits of the growth allocations as already published, within national guidelines for planning purposes. RJ further confirmed that that the growth allocations had been published and that the allocations would not be affected by the level of delegation for a CCG. ABl made a comment in his capacity as SPG lead for south east London. ABl reported that there were encouraging and ongoing conversations taking place between CCGs and NHS England (London region). It was anticipated that in the next week a set of draft proposals would go to London CCG Chief Officers for consideration. GU requested that each Joint Committee in turn confirm their acceptance of their recommendation to approve the CCGs' PMS commissioning intentions: SW confirmed the approval of the Bexley PMS Commissioning Intentions (as set out in the Enclosure J) on behalf the Bexley Joint Committee. This was on the condition that Bexley would have first call on growth monies for 2016-17 in order to deliver the premium. ML confirmed the approval of the Bromley PMS Commissioning Intentions (as set out in the Enclosure J) on behalf the Bromley Joint Committee. ABh reminded the Joint Committees of the issue re GMS equalisation in Bromley (as referred to above). JWi confirmed the approval of the Greenwich PMS Commissioning Intentions (as set out in the Enclosure J) on behalf the Greenwich Joint Committee. GL confirmed the approval of the Lambeth PMS Commissioning Intentions (as set out in the Enclosure J) on behalf the Lambeth Joint Committee. RR confirmed the approval of the Lewisham PMS Commissioning Intentions (as set out in the Enclosure J) on behalf the Lewisham Joint Committee. JE confirmed the approval of the Southwark PMS Commissioning Intentions (as set out in the Enclosure J) on behalf the Southwark Joint Committee. NHS England confirmed its agreement with the above. LW indicated that NHS England was supportive of the approach set out by the Bexley Joint Committee with regard to growth monies in 2016-17 (see above), but noted that NHS England would	

	need to work through applications for growth monies before being able to commit to this condition. GU asked the GP committee members and the LMC representative for each Joint Committee to return to their respective Joint Committee tables following the completion of this section of the item.	
Public		
12.	Public Open Space Alison Angus (Lambeth Patient Participation Group Network) commented that the number of members of the public and patient groups present at the meeting was quite low, and that she felt it was difficult for those observers of the meeting to follow all of the items due to some of the terminology used, in spite of the attempts of the Joint Committees to alleviate this by including a glossary at the back of the pack of papers. AE (Lambeth Joint Committee) thanked Alison for her contributions to the meeting and thanked all of the PPG network representatives in Lambeth for their fabulous ongoing contributions. This was highly valued by the CCG who continued to support the Lambeth PPG network via Lambeth Healthwatch. AE said that Lambeth was collectively making good progress on how to engage with public and patients in our local communities, and in working to ensure that general practice is a key focal point for this engagement. Alison Angus asked the Joint Committees about how the CCGs in south east London were responding to the issue of food poverty and what patient-focused innovations they are using to address it. NK (Bexley Joint Committee) noted the seriousness of the issue of food poverty and said that the response to it required clear patient and public leadership to work in partnership with commissioners, providers and local authorities. NK noted that as clinicians she and her counterparts across south east London saw homeless patients at their GP practices and were very mindful of this issue when reviewing services. Alison Angus referred to the item on Primary Care estates strategies, and said that there was a significant issue of underutilisation of buildings in parts of south east London. Alison made reference to the social entrepreneurs and charities with a focus on health and care that were currently desperate to find building space to work from – and who could make a real contribution in partnership with primary care to address health promotion in ways that general practice did not have the capacity to. AE (Lambeth Joint Committee) agreed and advised that there were very many examples of general practice working with the third sector to address and promote healthy lifestyles and wellbeing issues in the borough, and referred to work that general practices had initiated with Age UK that was being taken forward in Lambeth. GU (Greenwich Joint Committee), as someone who works locally in the third sector, noted the amount of pressure on local charities in terms of being at the sharp end in terms of seeing the serious effects (of some of the issues raised) at the heart of communities, and referred to the changes that had taken place in the third sector and the levels of stress that this was imposing on clients for charities' services and the staff in those charities providing them. GU also commended the point made by Alison Angus regarding the need to think and work more creatively in identifying premises opportunities for charities and third sector organisations, both for office space and utilise for clients and said that this was a very pertinent point. Alison Angus described the serious issue of childhood obesity as being prevalent in the boroughs of Lambeth, Southwark and Lewisham, which was well above the	

	national average. Alison asked the CCGs present to facilitate a way for Alison and the network of general practice Patient Participation Groups to contribute to the commissioner response to this problem. NK (Bexley Joint Committee) responded by stating that the issue of a childhood obesity was a major concern to herself and other GPs and commissioners locally. NK advised that this was a subject due to be discussed at her local (Bexley) Health and Wellbeing Board meeting in March, where an item was scheduled to focus on how health commissioners and local authorities could best use the relatively small amounts of public health funding that were now available in order to help families to adopt different habits, in particular where there are cycles of deprivation. NK offered to speak to Alison on this issue following the meeting so that any useful ideas on this could be exchanged. AE (Lambeth Joint Committee) gave the example of Lambeth GP food growing cooperatives that had been implemented locally in Lambeth as just one response to the issue of healthy food and childhood obesity, and supported the importance that Alison had placed on this issue. Helen Chown (DMC Crystal Palace Road Patients and Participation Group and a patient and resident in Southwark) raised a concern that patients were not able to adequately feed in their views on general practice to forums such as this one, and to practices themselves. Helen said that in submitting a concern to a general practice, patients have to do so via the practice administration function. Helen stated that in her experience, the practice administration function was quite selective in what it processed and what it consulted with patients on, in terms of the concerns that were being submitted. Part of this issue was due to the administration functions within practices not being resourced adequately enough to cope with the volume of contact from the public, and Helen also cited the impact of new encoding systems that would place greater strain on them. Helen stressed the importance of this issue in terms of the limit that it set for public views to be heard, and suggested that there should be a PMS KPI on how well practices respond to queries, concerns and complaints raised by patients. SW advised that Bexley CCG had introduced a mystery shopper's scheme to give commissioners and general practices an additional channel through which to hear the views of patients. Under this scheme any member of the public could apply to become a mystery shopper, and the scheme provided commissioners with real, live information on patients' experiences across the full range of health services and that it had was a very useful way of understanding this in detail. JWe responded to the point made on this regarding the lack of confidence that patient's' views could be represented. JWe advised that this was in fact already covered in the KPIs for the PMS contract, via metrics on patient experience covered in the National Patient Survey and the Friends and Family test. Both of these sets of data were covered at the practice level, but were submitted nationally on a contractualised basis, therefore the data collection was complete. JH (Southwark Joint Committee) advised Helen that there were a range of available means to feed in concerns and suggestions regarding general practice that were not limited to doing so via any given practice. JH offered to speak with Helen after the meeting to set out the various channels available to her, which included via the PPGs and via the CCG itself. JH also described how a number of practices in Southwark (and their patients) had benefitted from working together on sharing learning and good practice on how to compile and respond to this type of information, and also by pooling resources in meeting this demand (ie, taking pressure off a single practice where there may be particular issues around resourcing or volume of information coming in).	

	Bob Skelly (South Southwark Patient Participation Group) raised a question regarding the data as shown in the quality and performance report (as covered at the previous PCJC meeting on 10 December), with particular reference to patient satisfaction as the statistics as reported indicated that 24.4% of Southwark registered patients were dissatisfied with general practice access, which showed the borough to be an outlier in south east London. Bob Skelly asked if the figures on this came as a surprise, whether they were felt to be accurate, and if so what the CCG was doing in response to them. JH (Southwark Joint Committee) advised that he did not have the papers from the last meeting to refer to, but said that there were many challenges as well as complexities associated with patient satisfaction levels with general practice (as illustrated by JH specifically at the last meeting). However, JH said that the CCG trusted the validity of the statistics as reported and were continuing to act on them. To give an example JH said that commissioners in Southwark had listened to patients in Southwark regarding their desire for the provision of 8am-8pm access to general practice, seven days per week and that the CCG was continuing to listen to local patient groups to further understand what was creating this level of dissatisfaction. CG advised that she had been in receipt of this question (written) ahead of the recent Southwark Governing Body meeting and advised that a written response to it had been prepared and issued (or that it was in the process of being issued). A number of further points regarding the PMS review were raised by Joint Committee members during this section. SP (Lewisham Joint Committee) stated that the Lewisham LMC had concerns re the timeline for completion of the PMS review (by 31 March) and queried whether there was any flexibility on timescales in the event that further time was required to address all issues that were raised in the local discussions. JWe acknowledged that even with the three-month extension that had been granted by NHS England for London for the completion of the PMS review, the timescales were very tight. JWe noted that a number of CCGs had held preliminary meetings with their GP memberships and with LMCs on this already, which should serve to support the conclusion of reviews within the current timeline, and she encouraged LMC and CCG lead representatives to ensure that dates for further meetings were confirmed in diaries as soon as possible, if they weren't already finalised. SP welcomed the fact that Lewisham CCG had initiated pre-engagement with the LMC on the PMS review and looked forward to the further meetings to come. The deadline of 31 March for completion of the PMS review engagement process had been mandated on CCGs by NHS England in line with the national timetable on this. SP raised several queries regarding the core London contract offer. Firstly, the referral system for urgent suspected cancer – as worded in the contract documentation, the requirement was for referrals to be faxed within 24 hours. SP queried whether this was intended to be 24 working hours. SP cited the example scenario of a referral being made the day prior to a public holiday and urged that this be considered in the interests of patient safety. JWe advised that this aspect had been reviewed with London LMCs in a great level of detail. LW noted that these timings were in accordance with the protocols of the acute Trusts with whom the practices were working with and where these urgent referrals were going to. Bexley Joint Committee (MC) advised that the Bexley Joint Committee strongly encouraged the use of e-referrals and the phasing out of faxed referrals (as had been enacted with providers in secondary care) and that this should be reflected in the core London offer. SP requested clarification on item 4.1 (Enhanced Services). SP's reading of this item within the PMS contract documentation was that practices signing up to the core	

	London aspect of the PMS contract would be contractually required to provide all enhanced services. SP asked if practices had an option to either offer the service directly or to identify another scheme through which to deliver it. JWe advised that the enhanced services would have to be delivered locally and that this could be via practices directly or that practices could make alternative sub-contracting arrangements for how patients could access the enhanced services. The important principle behind this was that, in line with the overall purpose of the PMS review, all registered patients should receive the same breadth and quality of general practice service provision regardless of where they are registered in London. There is a level of flexibility in terms of how that is delivered, as JWe had described. (NK) Bexley Joint Committee applauded the principle of equity of premium and raised a point regarding service provision for patients accessing general practice services across London, pointing out that Bexley was due to receive a disproportionately low amount of funding and held the lowest premium in London. Jennifer Quinton-Chelley (Southwark Patients and Participation Group) raised a concern that, in her view, owing to the large number of residents in Southwark of Latin American and Afro-Caribbean heritage, that the chances of the Zika virus spreading to London might be higher, and that the NHS and the Local Authority should consider reserving contingency funds in order to manage the impact of this scenario. JH replied by stating that there has been no recorded trace of the Zika virus or the mosquito that spreads it in London (or the United Kingdom) but that the borough's Public Health team were keeping a monitor on this.	
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 17 March 2016, 6-8.30pm at Millwall Football Club.	
Close		

Primary Care Joint Committees

11 February 2016

Signed Attendance Sheet (Public and other observers)

Gary Beard	NHS England
Sharon Fernandez	NHS England
Leslie Elliot	Member of the public
Bob Skelly	South Southwark Patients and Participation Group
Bianca Blake	Member of the public
Deborah Haworth	Cancer Research UK (south London)
Chris Beirne	Member of the public
Jacqueline Best-Vassell	Lambeth and Southwark MIND, works for South London and Maudsley NHS Foundation Trust, is on Lewisham Patients and Participation Group.
M. Shepherd	Lambeth and Southwark MIND
Jennifer Quinton-Chelley	Peckham resident, member of the Acorn and Gaumont GP Patients and Participation Group, member of Southwark Pensioners Action Group and Southwark Pensioners Forum
Ali Angus	Lambeth Patients and Participation Group
Rob Danavell	Southwark Carers
Helen Chown	DMC Crystal Palace Road Patients and Participation Group

NHS Bexley Clinical Commissioning Group

BEXLEY PATIENT COUNCIL

Thursday 21st January 2016 -
12:00 - 14:30
Danson Park Boathouse, 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
Cindy Lowe	(CL)	Bexley Moorings
Sakthi Suriyaprakasam	(SS)	BVSC

Apologies:

Liz Shires	(LS)	Plas Meddyg - PPG
Paul Goulden	(PG)	Age UK Bexley
George Heitmann	(GH)	Bellegrove Road PPG Chair
Terry Bamford	(TB)	Healthwatch Bexley
Ilkay Chirali	(IC)	Turkish Elders
Simon Evans-Evans	(SEE)	Director of Governance & Quality
Chris Lee	(CLE)	Bexley Youth Council

No Apologies:

Vinod Kumar	(VK)	Inspire Community Trust
Aline McCreedy	(AM)	SNAP

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		PPG Plas Meddyg
Sylvia Jones		PPG Station Road, Sidcup
Chrissie Lipscombe		PPG Bursted Woods
Carol Sure		PPG Bursted Woods

Presenters:

Colin Cope	(CC)	Head of Estate Development, Oxleas
Nisha Wheeler	(NW)	AD of IT Modernisation & IG

1. Standing Items		
1.1	**Welcome and apologies for absence**	**ACTION**
	SW welcomed all and noted apologies.	
1.2	**Declarations of interest**	**ACTION**
	None declared	
1.3	**Notes of meeting – 4th November 2015**	**ACTION**
	Notes of the meeting on 4th November 2015 were accepted and approved.	
1.4	**Matters Arising**	**ACTION**
	Action Log – • Copy of new presentation planner document shared with all present. • SS gave a brief update on **Bexley Health Partnership**. Explaining Council, CCG and Voluntary sector working together on health issues. Project ended in October 2015 and a report prepared. New Health and Wellbeing Executive board will be chaired by SS, relationships with partners will be broader in future – to include Oxleas and Acute NHS Trusts. SS said terms of reference had not been agreed yet but she would look at these with AG and SW with a view to Patient Council being represented on the Board. SW asked SS to provide feedback to the Quality & Safety Committee and to provide regular updates on progress and outputs via AG to share with Patient Council members. All agreed that the H&WB Executive should be a regular agenda item. • **X-Rays at UCC**– SW advised X-rays services currently provided by Darent Valley Hospital (DVH) on both UCC sites. Hurley Group (UCC provider) has been liaising with DVH to review services on Erith site, which are only available between 8am – 4pm (Monday – Friday). Current negotiations have been unable to extend contract provision at the Erith Site. Consideration given to hire of mobile x-ray unit – but this is not cost effective. All acknowledged this is a challenge and asked for monitoring to continue and updates to be shared. • SW has experienced difficulties in arranging a speaker from NHS England (NHSE) to attend a future meeting to discuss Co Commissioning. SD was concerned and felt that NHSE should be encouraged to attend as this was an important subject • SW explained Healthwatch will in future report to the CQC. • Membership of Patient Council was discussed and a request made to ask that attendance is confirmed or apologies given. Current vacancies (4) were also discussed and need	**H&WB Executive Board to be added to agenda for regular updates**

	for 'right' people/ patient champions to be represented. AG advised that she would be discussing future recruitment with the new PPI Lay Member once in post.	
1.5	**Chairman and Members update/feedback**	**ACTION**
	A briefing/update from TB (Healthwatch Bexley) was shared with all present. TG asked for regular updates on Our Healthier South East London meetings and SEL Stakeholder Reference Group (SRG) meetings. TG also concerned that some action points raised are not fully followed up. AG explained that purpose of action log was to ensure actions identified and addressed. SD shared feedback following the recent Big Health Check Day. Adding that the planning for this year event was excellent and the venue was very good. Members were pleased to learn that a number of presentations on the day had been lead by people with learning disabilities. SS advised that through the work of the Primary Care Development Group GP surgeries were updating their website pages to show what clinic's they operate. HS spoke of successful Diabetes awareness day on 29th November 2015 where they reached 3000 people in 2 churches and 2 Sikh Temples. Also very successful day of prayers in QMH, QEH and Lewisham Hospital. TG advised of a new mental health forum at Job Centre Plus. SS advised of their new Health Champions project that will start in 6 surgeries from Feb onwards. Volunteers will be in surgeries and have been trained to be health messengers re public health. Talking about health issues and signposting.	
2	**Presentations / Speakers**	
2.1	**Bexley Linked Care - Integrated Care Records** **Nisha Wheeler & Sandra Wakeford**	**ACTION**
	Bexley linked care is a data sharing project which can enable clinicians and nurses to view GP records – with consent from the patient. A GP patient record is the most up to date account of patient's health and any treatment they are receiving. Every resident who is registered with a GP has a patient record. More information about the project can be found on the CCG website and within the presentation slides circulated.	AG to email copy of slide presentation

	SW asked members to take this information back to their groups to help make Bexley residents aware of the project. AG added that postcards and posters will be made available in GP surgeries to raise awareness with public/community. SW clarified that patients will be asked for consent before their records are accessed and that all practices within Bexley had signed up to the programme. JF asked about locums at GP practices and if they have signed up to the data sharing agreement, also would they have access to records. NW said locums would have access depending on what level the practice allows them. The UCC or OOH will also have a facility to work with locums to allow them to see records, but if patient does not give consent they cannot access. SB asked what would happen if a patient was unconscious. NW explained access would be allowed but that an alert is sent to the holder of the record to make them aware. AG said all patients will automatically get a Bexley Linked Care record. However you have the right to choose not to have your information available through Bexley Linked Care record. To do so, patients will need to write to their registered GP practice. NW said when a patient goes to UCC it is a read only system. At the moment they send back a summary to the GP advising that they have seen a patient and it is the GP (Practice) that updates the patient's records. TG was concerned regarding IG. NW explained that GP's are connected via a portal. All practices signed up, data is in a secure suppository. IG is in place. Receptionists can only see demographics. GP's/Consultants are given more access	NW to amend background colour of future presentations
2.2	**Queen Mary's Hospital - Site development** **Colin Cope (CC), Head of Estate Development, Oxleas**	**ACTION**
	Maternity block land sold to Anchor and has now been sold on to Sidcup Investments. Oxleas have little contact and influence regarding their plans for the future of the site. . Oxleas holding regular provider meetings and looking to invest £30m in the site/building to make it sustainable for the future A lot of building work has already taken place including new water pipes, cables and wi-fi installed. New wheelchairs have been received and are now being used by visitors/patients. Holbrook Ward on Woodlands unit has improved lighting and reminiscence pods. Front entrance to the unit has been improved.	

	Cancer centre is progressing well although works are slightly behind schedule (4-6 weeks)– expected to open mid-2016. There will be 46 dedicated parking spaces for users of the cancer/renal unit – free of charge. Work progressing well on development of B Block, next phase will see closure of A Block and move of dental, diabetic and outpatient services to B Block. CC was thanked for presentation and agreed to return in May to share update on progress.	
3	**Items for discussion**	
3.1	**OHSEL** **Jon Winter, AD Comms & Corporate Services**	**ACTION**
	AG circulated briefing paper/update	
3.2	**PPI Lay Member & Vice Chair election & Patient Council recruitment**	**ACTION**
	The CCG had appointed a new PPI Lay Member – more details to be announced via Communications Team and will be shared with all members when confirmed. There are currently 4 vacant seats on the patient council. AG will review TOR and membership when new Chair in post. It was acknowledged that LE's term of office would shortly be open for re-election. However, in light of current changes and incoming new PPI lay member LE was asked to extend his role for a further 6 months, which was agreed by all present. SS asked how the CCG recruit to vacant posts. AG explained current membership would be reviewed and consideration given to approach groups/organisations and community groups not currently represented. AG also said some consideration may need to be given to the number of PPG's represented within patient council in the future. JF spoke about linking with other local PPG's and TG said her group had gone through some difficulties and that some investment needed to be made to improve the infrastructure to support PPG's and to help them understand their role. AG is developing training and support programme for Patient Council and PPG's and hopes to share more information about this at the next meeting.	

3.3	**CCG Updates**	**ACTION**
	AG has circulated updates with pre-reading material. In future commissioners will be asked to share updates/briefing papers for members to read outside of the meeting.	
4	**Items for information & update**	
4.1	**Equality annual report**	**ACTION**
	AG shared a copy of the CCG Equality Annual Report. It will be formally presented to the Governing Body at their meeting next Thursday then made available to public on CCG website.	
4.2	**Patient Experience & Mystery Shopper**	**ACTION**
	AG provided an update on output and feedback from the mystery shopper scheme – which still remains very popular. Members were again encouraged to complete feedback forms and share intelligence as this enables CCG to see themes/trends etc.	
4.3	**Engagement**	**ACTION**
	AG shared information about NHS England draft framework for patient and public participation in primary care commissioning. LBB consultation on public health is still open until 12/2 – members were encouraged to view documents and take part. AG advised of an NHS England public event on patient choice taking place in London on 18/2. If interested contact AG and she will share details.	
4.4	**Training & Development Opportunities**	**ACTION**
	AG confirmed she is currently working on a training and development programme for patient council and PPG's. More details will be provided at the next meeting. Members were asked to let AG know if there are any specific areas of training that would be helpful.	
5	**Date of next meeting, AOB & Close**	**ACTION**
	Members were thanked for attending and date of next meeting confirmed.	
	Tuesday 22nd March 2016 – 12 noon at Marriott Hotel	

ENCLOSURE: V(iii)

Agenda Item: 77/16

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 26 May 2016

Audit and Integrated Assurance Committee Executive Summary
Meeting held on 17 March 2016

The AIGC met on 17th March 2016; present Keith Wood (Chair), Tina Khanna, Dr Graham Rehling.

At the meeting the AIAC:

- **Noted** that no interests were declared by AIAC members.
- **Received** an oral update on contractual matters with Lewisham & Greenwich NHS Trust.
- **Considered** the aged debt analysis as at 31 January 2016, noted processes to manage outstanding debts and **agreed** that there were no debts which required either provision or write off.
- **Approved** the 2016/7 Internal Audit Plan.
- **Revisited** the Internal Audit report on Conflicts of Interest administration and **identified** further sources of assurance and controls for implementation.
- **Ratified** the sign off of the accounts for the nine months to 31 December 2015.
- **Agreed** the accounting policies for the 2015/6 accounts having considered the year end timetable and changes in accounting guidance.
- **Considered & was assured by** the high level Risk Register and Assurance Framework and suggested issues for further consideration.
- **Endorsed** the proposals for the membership and Terms of Reference for the Auditor Panel to be submitted to the Governing Body for approval.
- **Noted** the arrangements, timetable and changes in the format for the Annual Report.
- **Noted** the Counter Fraud Progress Report and thanked all involved for the recovery of £170,000 charged to the CCG for the cost of prescriptions issued before the CCG was established.
- **Approved** the Counter Fraud workplan for 2016/7.
- **Noted** the Internal Audit Progress Report and **received** reports on Information Governance & Performance Reporting.
- **Noted** with satisfaction the Internal Auditor's Report on the Financial Control Environment Assessment.
- **Noted** the External Auditor's Report on progress and emerging issues.

- **Considered and approved** the proposed response to Grant Thornton on behalf of the AIAC in its governance role.
- **Noted** the status of External Audit Plan for 2015/6 and a briefing on emerging key issues for CCGs.
- **Received** feedback from the Audit Chairs' Forum.
- **Noted** the SECSU Internal Auditors Report and the process for full year's assurance.
- **Noted** the Bexley CCG Emergency Preparedness and Resilience Response and the positive feedback from NHSE thereon.
- **Received assurance** from reports on the management of Adult Community Service contracts, financial systems and compliance with statutory obligations.
- **Noted** the tenders waived since the last meeting.
- **Noted** the decision log from other fora.
- **Noted** the entries in the register of gifts and hospitality.
- **Noted** that there had not been any use of the seal.
- **Noted** the AIAC Annual Workplan.
- **Noted** the minutes of recent Finance sub Committee and summaries of proceedings at recent Executive Management, Quality & Safety, Medicines Management & Information Governance Committee meetings.
- **Reflected** on the meeting, noting that it was important to allow sufficient time for non - routine presentations.
- **Noted** that neither Internal nor External audit wished to take up the offer of a meeting in private

Keith Wood
March 2016

ENCLOSURE: V(iv)

Agenda Item: 77/16

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 26 May 2016

Finance Sub-Committee Executive Summaries
Meeting held on 8 March 2016

- An update had been made to the Schedule of Matters regarding the cost of continuing healthcare packages. A further amendment may be necessary due to proposed changes in AQP rates. The revised Schedule of Matters would be presented to the Governing Body for approval.

- Local Enhanced Service for Diabetes Care Enforcement of the Terms of the Contract (and payments in 2015/16) Version 2 had been discussed at a Conflicts of Interest Panel as GPs were conflicted. The Finance Sub-Committee approved payment to practices who had not submitted data, provided that the data to the CCG was sent. If any practice fails to provide the data to the CCG within the timescale then the contract criteria (qualifying criteria) should be enforced. Theresa Osborne chaired this item as GPs had a conflict of interest. They were not allowed to participate in the decision.

- Prevention and Early Intervention Schemes Extension of outcomes based grant agreements, due to expire in October 2016, was discussed. Due to positive performance of the schemes and following stakeholder engagement it was proposed to extend the existing arrangements for a further two years to provide a period of stability and maximise outcomes for service users. The Finance Sub-Committee recommended a tender waiver in respect of a two year extension from 1 October 2016 to the Section 256 Agreement covering the Prevention and Early Intervention schemes provided by the voluntary sector. Theresa Osborne chaired this item as Dr Sid Deshmukh had a conflict of interest and was not allowed to participate in the decision.

- A discussion took place regarding the procurement process for Elderly Mental Illness (EMI) Continuing Care Beds. The existing provision is with the Oaks Nursing Home. Various options had been reviewed regarding procurement but no ideal solution had been found and there are few local providers of this service. It was agreed that two papers would be produced for Governing Body members' consideration. One to address the care of existing clients and the need to ensure their care continued until their death or the clients decide to move elsewhere and the second to recognise that the CCG cannot afford double running and therefore the project group will look at options again to test the market.

- The Finance Report for Month 10 was discussed. The surplus and forecast outturn position are in line with plan. Acute contract risk is mitigated by block contracts with King's and GSTT and the cap and collar arrangement with LGT. The DGT PbR contract has deteriorated slightly in month 10. Risks remain in continuing healthcare due to the requirement for expensive care packages to meet client need. Prescribing is expected to be at least c£0.5m overspent at year end. A middle ground

position has been reached with Greenwich CCG relating to Free Nursing Care Contributions for two nursing homes in Greenwich. Running costs are within budget with a small forecast overspend. The Better Practice Payment Code target is still being achieved. There is significant risk to the CCG 2016/17 financial position in relation to the underlying position of acute contracts

- QIPP delivery at month 10 is 89% but month 11 return will show 79.9% due to the deterioration in prescribing. Staff should be congratulated on this achievement. During 16/17 QIPP of £8.6m needs to be identified. This has increased due to the latest guidance regarding the inability to commit the 1% non-recurrent transformation fund. At present £5.8m had been identified, leaving a gap of £2.8m. Weekly meetings are taking place to look at the Commissioning for value packs and identify any further savings to close the QIPP gap.

- The Consolidated Contracts Report for months 9 and 10 was discussed. Dermatology procurement had resulted in one bidder and the "window" has been re-opened; the commissioning team has been asked to energise and stimulate the market.

- The Finance Risk Register was discussed.

- The Financial Planning and Budget Update March 2016 was discussed and recommended to the Governing Body for approval.

- The Contracts Register was discussed and would be further updated.

- An update on the LGT deep dive into non-elective admissions and the latest contract position was given.

- A Conflicts of Interest Panel would be arranged to discuss Diabetes Enhanced Services.

Meeting held on 12 April 2016

- The Finance Sub-Committee Terms of Reference were reviewed and approved.

- The PAMS pilot had been delayed slightly, but this had not incurred any additional costs. A further update would be given in May.

- Discussions took place regarding GPwSI contract extensions for Dermatology, Vasectomy and Erectile Dysfunction. It is intended to request monthly analysis of patients showing number of clinics, number of new patients and number of follow up patients seen in order to enable reporting of activity and the assessment of continued value for money. If contracts can be negotiated to include this regular analysis a tender waiver would be produced in respect of one year extensions to these contracts.

- The Medicines Management Sub-Committee recommended the prescribing budget is set using 100% historical weighting for 2016-17 and that delegated prescribing continued for all three localities. This was approved by the Finance Sub-Committee (Dr Nikita Kanani and Dr Sid Deshmukh did not participate in the decision, due to a conflict of interest).

- The creation of three Whole Health System Fellow roles was discussed. These posts, designed for post VTS trainees, would provide 5 GP sessions per week and placements covering End of Life Care; Community Medicine and Clinical Leadership (within the CCG). The posts would be for two years, starting September 2016. Cost pressures would arise in the clinical leads budget in 2016/17 as a result of these roles and the additional cost pressure could not be absorbed within that budget meaning that the additional funding would need to be found elsewhere. The posts were approved and it was agreed that the scheme should be subject to evaluation.

- The social prescribing pilot, provided by Mind, operating in the Clocktower locality (nine practices) since April 2015, was discussed. The pilot is due to end on 30 June 2016, with a view to extending the service across the borough, if robust evaluations show it is cost effective and the source of future funding is understood. There is a need to extend the pilot for nine months for the findings to be undertaken and understood. This extra time will also allow other models such as health champions to embed and inform the assessment of the best long term social prescribing model for the borough. The extension was agreed and a tender waiver will be prepared for the extension of the pilot for up to nine months.

- The Month 11 Finance Report was discussed. Forecast outturn is in line with the plan submitted to NHS England, with £139k surplus. The month 12 position is being finalised, and will be in line with plan. Final 2015/16 outturn positions have been agreed with the CCG's main providers. Running costs remain within budget and the Better Payment Practice Code has been achieved. Underlying growth in acute contracts for 2015/16 has been included in 2016/17 planning. Significant financial risk in 2016/17 remains.

- Month 11 FOT QIPP delivery was 79.9%. Month 12 outturn is expected to deliver 76% and remains amber rag rated. This is a fantastic achievement. QIPP of £8.6m for 2016/17 is required and task and finish groups are looking at schemes identified from the Commissioning for Value packs.

- The Consolidated Contracts report for Months 10 & 11 were discussed and noted. Issues regarding Ophthalmology have now been resolved. Non-elective performance at LGT remains the subject of an Activity Query Notice between the Trust and Commissioners. UCC attendances are high and are being reviewed. The procurement of Adult Audiology Services and AQP re-procurement for Termination of Pregnancy Services have been completed and contracts awarded.

- The Finance Risk Register was discussed and noted, some risks would carry forward to 2016/17.

- Visits to GP surgeries in May have been arranged to discuss Primary Care Activity Tool Reporting and Practice Based Performance data, which is now available via I Pads.

- The 2015/16 budget holder survey was discussed. This had achieved a 60% completion rate and had shown an improvement on that completed the previous year. The proposed action plan was agreed and members also agreed the use of a generic objective for all budget holders.

Theresa Osborne advised that she was intending to submit the new financial plan as break even on 18 April 2016, unless this changed during the week, primarily due to mediation with LGT. Initial budgets have been signed off by budget holders and the Governing Body.

ENCLOSURE: V(v)

Agenda Item: 77/16

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 26 May 2016

Medicines Management Sub-Committee - Executive Summaries

Date of meetings:

24 February 2016

- The committee agreed the development of directory/care pathways for Bexley care homes encompassing some of the common themes identified (e.g. falls; UTIs; repeat prescribing etc.) and best practice examples.
- The committee agreed appropriate training schedule/plan for care homes (in conjunction with CEPN/HESL), including some of the common themes to be developed.
- A prescribing budget methodology for 2016-17 was agreed to be recommended to Finance Sub-Committee.
- Draft Denosumab shared care documents were reviewed and commented on.

16 March 2016

- PGDs for the Hurley Group to use at their UCC sites in Bexley for Paracetamol, ibuprofen, cetirizine, levonorgestrel and Revaxis vaccination were approved for 2 years while non-medical prescribing staff are being trained.
- Non-medical prescribing policy was approved.

20 April 2016

- Draft Asthma and COPD guidelines were reviewed and commented on.
- Draft BGLO antibiotic guidelines were reviewed and commented on.
- Draft South East London guidance on DOACs for VTE were reviewed and commented on.
- Terms of reference for the group were reviewed and commented on.

ENCLOSURE: V(vi)

Agenda Item: 77/16

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 26 May 2016

Quality and Safety Sub-Committee (QCCS) - Executive Summary
Meeting held on 10 March 2016

Chair: Dr Sonia Khanna-Deshmukh

- Dr Sonia Khanna-Deshmukh and Dr Nikita Kanani both declared a conflict of interest in respect of Item 37/16 Integrated Urgent Care Service Procurement. They had not been sent copies of the paper and this item would be discussed at the end of the meeting. Neither GP would be able to be present during the discussion or decision making.
- The minutes of the meeting held on 14th January 2016 were approved, and the status of the action log.
- The service specification for the Phlebotomy Service (Crayford Town Surgery) was approved.
- Our Healthier South East London pre-consultation plan – planned care was discussed and noted.
- The integrated quality, safety and performance report March 2016 was discussed and noted.
    - C.Diff is significantly high with 72 cases reported from April-December 2015 (annual target 56). The London Borough of Bexley has now appointed an Infection Prevention Nurse to help identify gaps and possible solutions to reduce incidents.
    - A&E targets are not being achieved and all providers have action plans in place to mitigate the risk to patients.
    - Improvement to cancer 62 day waits and other targets had been met in December 2015.
    - The 18 weeks RTT target had not been met and additional funding had been given to LGT by Lewisham CCG.
- The Quality and Safety risks on the Corporate Risk Register were agreed.
- The Annual Complaints Report was noted.
- There was a Quality assurance update on present and future Mental Health Commissioning plans.
- The Screening Quality Assurance Service Report was noted.
- A Suicide Summit Report (due to a cluster of 3 deaths) was noted.
- NHS 111 clinical governance report was discussed and noted.
- The Cancer wait reports was discussed and noted.
- Outcomes of the alerts via QAMS 1 July 2014-15 February 2016 were noted.
- Dr Sonia Khanna-Deshmukh and Dr Nikita Kanani then left the meeting.
- The draft Integrated Urgent Care Service Specification and Key Performance Indicators were approved.
- Date of next meeting: 12 May 2016, 9.30am-12.30pm, Danson Room.

ENCLOSURE: V(vii)

Agenda Item: 77/16

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 26 May 2016

Information Governance Sub-Committee (IGSC) - Executive Summary
Meeting held on 8 March 2016

Chair: Nisha Wheeler (NW) IG Lead and Vice Chair IGSC

1. No conflicts of interest were raised.

2. The Corporate Governance Policy, CCTV Policy, ICT Security Policy and ICT Security Framework were all approved.

3. A Documents Asset Register (DAR) has been developed by the Information Assets Administrators Task Group. The DAR registers details of the organisations corporate records and will be used as part of the organisation annual records management review. The DAR was approved by the IGSC.

4. IG Risk Register: risks were discussed in relation to unprotected flows not being registered on the Data Flow Mapping register and the storage of paper records in the organisation. The risk management plan was presented for review and comments taken forward for update.

5. IG Incident management report Quarter three: Two incidents related to patient identifiable information incorrectly being sent to the CCG. The organisations concerned have been notified and the incidents closed. There were no **serious** IG incidents reported this quarter.

6. IG Contracts monitoring: The contracts register has been updated and circulated to the IG SC detailing the provider organisations IG toolkit scores for 2014-15 (V-12) At this time 87% or organisations had achieved level 2 compliance. The team are continuing to work with the organisations which have not met the attainment level and action plans are being sort to ensure that organisation progress the IG scores for the next submission.

7. Records Management: The Contracts and Commissioning Team are working to streamline and review the departments file structure. Regular updates will be provided to the IG SC on the progress. A draft records management plan for 2016-17 was discussed with recommendations to incorporate further details relating to digitalisation, as some departments are still maintaining and storing paper records. CHC along with some of the CCGs PAs are currently trialling digital pens which capture written word into digital text.

8. Information Governance Management - IG Auditors report: An internal audit of the IG toolkit was completed by KPMG during January and the final report had been circulated to the IG SC. The auditors reviewed 8 requirements acknowledging the level 3 scores achieved. Two recommendations were made relating to PIA retrospective reviews and requirement 352 relating to Pseudonymisation to be registered as Not Relevant (NR).

9. IG Development plan: This showed the CCG being on target to achieve level 3 on all requirements, with the exception of requirement 352, as detailed above.

10. IG Training: The CCG has achieved 100% mandatory IG training compliance for the 2015-16 IG toolkit requirement 134.

11. Bexley Vibe: The IG toolkit auditors requested more information relating to Bexley Vibe document management system. This was detailed in a report to the IGSC and used as evidence for the IG toolkit as recommended.

12. Information Assets Register and Data Flow Mapping: a review of the registers took place during February and was signed off by the Senior Information Risk Officer (SIRO) on 10th March 2016.

13. Privacy Impact Assessments (PIA): During September 2015 – Feb 2016 there were six PIA questionnaires received. A retrospective review will be taking place following the IG toolkit auditors recommendation and the outcomes presented at the May IGSC.

14. An internal and external security penetration test took place at the end of February to test the CCGs new wifi, mobile device management and network security infrastructure. Outcomes of the report will be included in the end of year security assurance report in May 2016.

15. Updates were provided relating the latest IG Alliance bulletins, Data Protection European Union guidance and board pad.

16. Date of next meeting: Tuesday 3rd May 2016 (9.30am – 11.00am).