Primary Care Joint Committees (PCJC)

29 September 2015

Meeting held at:

Bexley Council Chamber, London Borough of Bexley, Civic Offices, 2 Watling Street, Bexleyheath, Kent DA6 7AT

Minutes

Meeting Chair	Martin Lee
Executive Support	Gilbert George (GG) / 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 (MCV)	Member	CCG Governing Body Nurse
Sarah Blow (SBl)	Member	CCG Chief Officer
Dr Howard Stoate (HW)	Member	CCG Chair
Dr Sid Deshmukh (SD)	Member	CCG Governing Body GP
Matthew Trainer (MT)	Member	NHS England (Director of Commissioning Operations)
Dr S Bhadra (SBh)	Observer	Local Medical Committee
Anne Hinds-Murray (AH-M)	Observer	Healthwatch
Sue Robinson (SR)	Observer	Health and Wellbeing Board (Deputising for Teresa O'Neill)

Apologies:

Dr Richard P Money	Local Medical Committee
Teresa O'Neill	Health and Wellbeing Board
David Sturgeon	NHS England - Director of Primary Care
Dr Jane Fryer	NHS England (Medical Director for South London)

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
Matthew Trainer	Member	NHS England (Director of Commissioning Operations)
Dr Mukesh Sahi (MS)	Observer	Local Medical Committee
Linda Gabriel (LG)	Observer	Healthwatch

Apologies:

Dr Ruchira Paranjape	CCG Governing Body GP
Cllr David Jefferys	Health and Wellbeing Board
David Sturgeon	NHS England - Director of Primary Care
Dr Jane Fryer	NHS England (Medical Director for South London)

Greenwich Primary Care Joint Committee

Attendees:

Jim Wintour (JWi)	Member	Committee Vice-Chair (Lay Governance)
Dr Iyngaran Vanniasegaram (IV)	Member	CCG Governing Body - Secondary care clinician
Annabel Burn (ABu)	Member	CCG Chief Officer
Dr Ellen Wright (EW)	Member	CCG Chair
Dr Nayan Patel (NP)	Member	CCG Governing Body GP
Matthew Trainer (MT)	Member	NHS England (Director of Commissioning Operations)
Dr Aseem Kumal (AK)	Observer	Local Medical Committee

Apologies:

Dr Greg Ussher	Committee Chair (Lay Patient Public Involvement)
Cllr David Gardner	Health and Wellbeing Board
Leceia Gordon-Mackenzie	Healthwatch
David Sturgeon	NHS England - Director of Primary Care
Dr Jane Fryer	NHS England (Medical Director for South London)

Lambeth Primary Care Joint Committee

Attendees:

Professor Ami David (AD)	Member	CCG Governing Body Nurse (also representing Lewisham CCG and Southwark CCG)
Andrew Eyres (AE)	Member	CCG Chief Officer
Dr Adrian McLachlan (AM)	Member	CCG Chair
Dr Hasnain Abbasi (HA)	Member	CCG Governing Body GP
Dr Jenny Law (JL)	Observer	Local Medical Committee
Matthew Trainer (MT)	Member	NHS England (Director of Commissioning Operations)

Apologies:

Sue Gallagher	Committee Chair (Lay Patient Public Involvement)
Graham Laylee	Committee Vice-Chair (Lay Governance)
Cllr Jim Dixon	Health and Wellbeing Board
Catherine Pearson	Healthwatch
David Sturgeon	NHS England - Director of Primary Care
Dr Jane Fryer	NHS England (Medical Director for South London)

Lewisham Primary Care Joint Committee

Attendees:

Diana Robbins (DR)	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 (also representing Lambeth CCG and Southwark CCG)
Rosemarie Ramsay (RR)	Member	Lay member (designate)
Martin Wilkinson (MW)	Member	CCG Chief Officer
Dr Marc Rowland (MR)	Member	CCG Chair
Dr Jacky McLeod (JM)	Member	CCG Governing Body GP
Matthew Trainer (MT)	Member	NHS England (Director of Commissioning Operations)
Nigel Bowness (NB)	Observer	Healthwatch
Dr Simon Parton (SP)	Observer	Local Medical Committee
Peter Ramrayka (PR)	Observer	Health and Wellbeing Board

Apologies:

David Sturgeon	NHS England - Director of Primary Care
Dr Jane Fryer	NHS England (Medical Director for South London)

Southwark Primary Care Joint Committee

Attendees:

Robert Park (RP)	Member	Committee Chair (Lay PPI)
Ami David (AD)	Member	CCG Governing Body Nurse (also representing Lambeth CCG and Lewisham CCG)
Andrew Bland (AB)	Member	CCG Chief Officer
Dr Emily Gibbs (EG)	Member	CCG Governing Body GP
Matthew Trainer (MT)	Member	NHS England (Director of Commissioning Operations)
Malcolm Hines (MH)	Observer	CCG Chief Financial Officer
David Cooper (DC)	Observer	Healthwatch
Dr Claire Lloyd (CL)	Observer	Local Medical Committee
Rachel Flagg (RF)	Observer	Health and Wellbeing Board

Apologies:

Richard Gibbs	Committee Vice Chair (Lay Governance)
Dr Jonty Heaversedge	CCG Chair
David Sturgeon	NHS England - Director of Primary Care
Dr Jane Fryer	NHS England (Medical Director for South London)

Other attendees:

Jill Webb (JWe)	NHS England (Head of Primary Care)
Toyin Akinyemi (TA)	NHS England (Head of Finance – Primary Care co-Commissioning)

<table>
<tr><th>Item</th><th></th><th>Action</th></tr>
<tr><td>1</td><td>Introduction and apologies

ML Chaired the meeting in the absence of GU. ML welcomed members, observers and members of the public to the third 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

ML 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.

Apologies received in advance of the meeting:

<table>
<tr><td>Dr Richard P Money</td><td>Bexley Primary Care Joint Committee - Observer</td><td>Local Medical Committee</td></tr>
<tr><td>Teresa O'Neill</td><td>Bexley Primary Care Joint Committee - Observer</td><td>Health and Wellbeing Board</td></tr>
<tr><td>Dr Ruchira Paranjape</td><td>Bromley Primary Care Joint Committee - Member</td><td>CCG Governing Body GP</td></tr>
<tr><td>Cllr David Jefferys</td><td>Bromley Primary Care Joint Committee - Observer</td><td>Health and Wellbeing Board</td></tr>
<tr><td>Dr Greg Ussher</td><td>Greenwich Primary Care Joint Committee - Member</td><td>Committee Chair (Lay Patient Public Involvement)</td></tr>
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	Dr Jonty Heaversedge Southwark Primary Care Joint Committee - Member CCG Chair	
2	The following members and observers reported changes to their declarations: **Name** / **CCG** / **Change** Dr Angela Bhan / NHS Bromley CCG / Remove entry – Secondment to Health Education England – ceased 31 July 2015 Dr Abbasi, Hasnain / NHS Lambeth CCG / Add entry: Appointed as Medical Director for the Prime Minister's Challenge Fund bid Add entry: The practice (Streatham High Practice) is a shareholding member of a GP Federation (South West Lambeth Healthcare Limited) Ray Warburton / NHS Lewisham CCG / Add entry: his membership of the NHS Equality and Diversity Council had been omitted on his declaration and requested that this be reinstated.	
3	**Minutes of the last meeting, held on 6 August 2015** The minutes were agreed to be a correct record subject to the following amendments: Bromley Joint Committee advised that Dr Andrew Parson was not in attendance for the meeting, as stated in the minutes. On page 39 (of the meeting papers pack): Contractual action Month 1-4 2015/16. Relating to request for temporary closure of practice list: **insertion**: "In considering the recommendation CL commented that practices in general should be allowed to make their practice list smaller". On page 43, in section relating to Personal Medical Services (PMS) Review: "The Joint Committees noted and endorsed the proposal that a PMS Working Group be established with CCGs and NHS England representation". JL requested clarification from the six CCGs that the PMS working groups had been established. ABI advised that each of the CCGs had established a PMS Working Group and that an SPG lead had been identified in each borough.	
4	**Action log** Referring to the action tracker for the committees, ML noted that all four of the actions	

	with "open" status were in hand and were due to be covered on the main agenda of the Part 1 meeting and would be closed following the meeting with the committees' agreement.	
Governance		
5	**Governance and Operating Model** ML began by acknowledging the huge amount of work that had gone toward producing and updating the document. ABI introduced the item, noting that the previous iterations of the NHS England Operating Model for Co-commissioning of primary care had been tracked via the first two PCJC meetings, and that the resulting final version (circulated ahead of the meeting as enclosure D), which had been approved internally by the NHS England Primary Care Management Board at its meeting on 24 September. This version had been circulated ahead of the meeting for final sign-off by the Primary Care Joint Committees, who in doing so would mandate their respective CCG Chief Officer to authorise approval of it (and their local Terms of Reference for Primary Care Programme Boards, which had also been circulated within Enclosure D) on their behalf. Since the June and August 2015 meetings of the Primary Care Joint Committees, local Primary Care Programme Boards (or equivalents) in each CCG borough had been established, to operate in line with the Terms of Reference of the Committees to which they report. Terms of Reference for each of the six CCG local Boards were included in Enclosure D (pages 125-168). ABI advised that these Terms of Reference should be considered alongside the Operating Model – in the sense that they are the means by which local Joint Committees for Co-Commissioning will comply with the Operating Model. JWe stated that the Operating Model had been developed by NHS England (London) via extensive consultation with all London CCGs and SPGs via the London Co-Commissioning Next Steps Working Group, and that all CCG Chief Officers in London had given their approval of the version circulated ahead of this meeting, and subsequently signed off by NHS England. JWe noted that NHS England expects this document to evolve further, proposing that any further changes required be developed collaboratively using the existing consultation process, and that this group would be involved only for major changes to its content. A number of changes requested by Joint Committees since the last meeting were reviewed, to ensure that these had been represented in the final version. All of these related to factual points that would not require a further formal review and approvals round by Joint Committee. ML invited each Joint Committee to satisfy themselves that the points they had raised for amendment/ review at and since the last meeting, had been addressed. A summary of these is as follows: p.60 (of the pack): The title of each of the SE London CCGs Co-Commissioning Committees should be referred to as Joint Committees, rather than Delegated Committees Bexley Joint Committee: • Greater clarity is required to be make explicit in the document, the differences between co-commissioning level 2 and level 3, which had been addressed • On Committee Constitution, the model should reference LMC representatives	

on the Joint Committee as non-voting members. JWe advised that it would not be controversial to include this as it is a factual statement, and that she would make the recommendation that this be included.

- SBh asked if the model will reference the inclusion of LMC representatives in discussions with CCGs and NHS England on contractual issues, and what the mechanism will be for involving LMC representatives in these discussions. JWe responded by referencing a number of existing points in the system that facilitate commissioner engagement with LMC. This included the obligations within the regulations for NHS England to consult with the LMC on contractual issues. These will all give LMCs an early opportunity to be involved when issues arise.
- SBl stated that the Bexley Joint Committee had requested that a factual amendment be made in annex 8 – (Safeguarding), which had not been made on the current version of the model: for levels 1-2 on safeguarding responsibilities for Quality Improvement should be stated as Joint Responsibility (the current version stated this is as CCG responsibility). JWe agreed with this amendment as factually accurate.

Greenwich Joint Committee:

- JWe advised that there were no further comments on or changes requested to version 11.

Lambeth Joint Committee:

- JL reiterated the point made by the Bexley Joint Committee, that there was a need to highlight that LMC representatives are invited to attend meetings of the Joint Committee as non-voting members.

Lewisham Joint Committee:

- RW requested clarity on what was meant by the repeated use of the phrase to “reach out”. JWe advised that it means that NHS England will communicate with an organisation or set of organisations. JWe confirmed she would recommend this would be amended in the document.
- RW queried the process as set out regarding urgent unplanned decisions made outside of meetings (page 70 of the pack). In particular that NHS England would proceed with a decision if contact was not returned by the nominated points of contact within a CCG in the stated period of time. RW queried the justification for this under any circumstances. JWe explained that this course of action would only be taken in very unusual circumstances in which a decision had to be taken without delay, where patients’ interests were affected, (for example in arranging for cover for a single handed GP that had passed away, in the event that a CCG committee member was not available to agree), and that there would never be an intention to pursue this course of action on the part of NHS England, who retain the statutory responsibility for Primary Care/ General Practice services. RW requested that the level of circumstances where this course of action might be applied should be explicitly stated in the document.
- SP endorsed the Lambeth statements relating to specific reference being made to LMC representatives as non-voting members, rather than under the umbrella of “other stakeholders,” as this would give greater assurance to GPs that LMC be included in engagement locally, and that other Joint Committees may want to consider this also. SP also echoed the point made by JL around pace of change, as this was causing a degree of concern amongst General Practice in SE London. On this point ABl emphasised that the Operating Model had been intentionally written in conjunction with the Terms of Reference for

- this committee, which referred to LMC representatives as non-voting members in each Joint Committee.

Southwark Joint Committee:

- CL supported the points made previously regarding LMC representation and the need to reference the impacts of the pace of change.

Bromley Joint Committee:

- LG: pointed to factual inaccuracies in section on decision making process (2.2): Table headings on page 76 (of pack) refers to sections 2.5, 2.6 and 2.7, which are not included in this version of the document. JWe advised that this was an administrative error and that these section references reflected an earlier version of the document and would be rectified.

ML summarised by referring to the common theme of the feedback (LMC concern around engagement) but noted that ABI's point regarding the reference of LMC representation within the Terms of Reference of the South East London Primary Care Joint Committees should assuage these concerns and give reassurance to LMCs on this matter.

In terms of sign-off, Joint Committees were asked to either indicate any reason why they might not authorise their Chief Officer to sign off the Operating Model and Local Joint Committee Terms of Reference. In the absence of any further concerns that they should sign it off via email (to Gilbert George/Tom Bunting) following the meeting.

No objections were raised at the meeting and The Joint Committees were content with the final version, pending the factual edits that were identified during the meeting.

Terms of Reference for Local Joint Committees

Voting members were asked to state any issues by exception. The Terms of Reference had been provided by each Local Joint Committee; therefore it was expected that no significant changes would be requested.

Bexley Joint Committee:
SW reported a minor change that would be made to the final version (section on Membership and Attendance (page 127 of the pack) should state "Audit Chair" in the Non-Clinical Members column. Bexley Joint Committee and NHSE were happy to approve the Terms of Reference pending this amendment.

For all other Joint Committees, the Terms of Reference were approved by the borough and NHSE in each case.

For discussion

6 Quality, Performance and Finance

ML reminded the Joint Committees that, following agreement made in advance of the previous meeting, this item had been truncated to focus on matters of Finance only given that Quality and Performance reports would be made available on a quarterly basis.

TA introduced the Primary Medical Services Financial Report (circulated as Enclosure E). The overall financial position for south east London Primary Medical Services was showing an overspend of £1.5m (1.6%) against issued budgets for the year to 5

months ending 31st August. This was largely due to underachievement against planned QIPP savings. The year to date position comprised net overspends after QIPP on PMS (£1.2m), GMS (£177k), and APMS (£150k).

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 had shown a growth of 0.8% from Quarter 1 to Quarter 2. Demographic growth had been funded at 1.3% in the 2015/16 financial plan. Overall, in absolute terms the south east London population had seen an increase of 14,219 year on year and a growth of 13,987 when compared with Quarter 1 in its normalised weighted population.

Based on Month 5 results the Medical Services budget at the south east London level is forecast to be £1.6m (0.7%) overspent. As there are no risk reserves available to NHS England, it would be cautious to note that there is a risk that the overspend on Medical Services may increase. It is envisaged that there will be an improvement on the year to date position as NHS England implement two key mitigating actions. These are access to 1% non-recurrent headroom, and release of Balance sheet accruals (write-backs), which will improve the financial position compared to year to date. Neither of these mitigations were included in the reported figures.

TA advised that the budgets are stated as net of QIPP (i.e. the budgets assume 1.4% savings). At the south east London level this equates to £3.2m. Details at the borough level for expenditure to end of month 5 and forecast were also included in the report.

To date, three schemes had been identified to make inroads against the targeted savings requirements, these were: Routine List maintenance, Clinical Waste, APMS renegotiation and procurement. TA referred to the table (page 173 of the pack) showing London and South East London proportions of the savings required for these schemes.

NHS England (London) will be seeking further mitigations and non-recurrent measures to address the 2015/16 shortfall. These include:

1. A QIPP delivery group will be established to support with identifying further opportunities in other regions
2. An external QIPP review is proposed to be commissioned by NHS England to identify additional opportunities across London

A set of questions in response to the report had been generated by CCG Chief Financial Officers and sent to NHS England members in advance of the meeting.

The questions posed, and the answers provided by NHS England, are shown below:

1. **Southwark Joint Committee (RP): We understand that the contingency (i.e. surplus) held by NHS England from prior year primary care underspends is not available to offset any overspends. Can this be confirmed please? If this is the case, can an explanation be given as to why this is the case?**

   TA confirmed that in accordance with NHS England spending rules any surpluses remaining from the previous year would not be available for the following year, as NHS England's financial planning rules committed all budgets to deliver surpluses against pre-set values. This was the position

across all London CCGs. MT advised that NHS England manages a single budget across all service areas, and that all service areas were under significant financial pressures, particularly the acute sector. To help address these pressures, all budget areas were required to deliver a surplus that would be retained by NHS England centrally. Therefore it was confirmed that any surpluses delivered in previous years would not be available to CCGs.

SP responded to the position put forward by NHS England by emphasising the importance of the role of the Primary Care sector in helping reducing pressures on other parts of the system, and by questioning whether the position on surpluses could be reviewed. SP asserted that the more resource that is invested to support Primary Care, the greater the likelihood of achieving savings and reductions in pressure on other parts of the system. MT replied by agreeing with the notion of primary care as an enabler in this respect, but advised that a financial balance needed to achieved across all service areas, and that the restrictions were in place due to the large deficits being reported elsewhere in the system.

2. **Lewisham Joint Committee (MW): What confidence and assurances can NHS England provide to CCGs on the reported expenditure and year end forecast positions? MW advised that CCGs would like full assurances that the forecast position would hold true, given the variances reported in the year to date position. Although TA had pointed to the write backs and headroom as mitigating actions, no details on the impacts of these had yet been provided.**

   TA replied by stating that all expenditure was captured and reported. NHS England was assured that the year to date position was accurate, and that robust financial governance processes were in place. All payments to contractors were made and captured through the Exeter system, meaning that the reporting was based on actuals. The Exeter payments system interfaces directly with NHS England's ledger, which it mirrors.

   TA advised that by its definition, the forecast was based on assumptions. At present the stated mitigating actions that had been put in place were Work In Progress. The write–backs were more of an unknown quantity in that the savings were based on an assumption of the number of write-backs. The actual number may change during months 6-12. The non-recurrent headroom (figure of £4m set aside from the 1% non-recurrent headroom) is a more certain figure in the view of the NHSE Primary Care Management Board. But TA pointed out that all forecasts were only as good as the assumptions on which they were based.

3. **Lambeth Joint Committee (AE): We have noted the changed position, for material movement in the bottom line. Has the forecast position been established at borough level or at a pro rata south east London or London level?**

   TA replied by confirming that the forecast was established at the London level, and then equitably distributed across London boroughs (by proportion of population), although it was noted by TA that this was not an exact science at this stage.

4. **Greenwich Joint Committee (JWi): Has the QIPP Delivery Group and External QIPP Review identified any additional QIPP savings that south east London CCGs might achieve as yet?**

MT gave a brief update, to the effect that, as an initial step towards this, NHS England had only very recently written to CCG Chief Officers across London to request their involvement in the QIPP Delivery Group, and to share examples of schemes that have worked. The external reviewers would be visiting each CCG and looking for opportunities to make further savings. Any examples of this received would be shared across London with a view to make up as much of the gap as possible. MT advised that a tight timescale had been set for this, so it was anticipated that this would progress further in the short term.

5. **Bromley Joint Committee (ABh): We have noted that the savings for QIPP schemes had been applied “globally” on a pro rata basis (then equitably distributed across London, as per the response to the question raised by Lambeth CCG). We have concerns around the validity of some of the values of savings being put forward for some of the schemes, by NHSE. ABh gave the example that a scheme such as routine list maintenance might yield more savings in areas where there is a greater patient turnover (i.e. inner London boroughs, as compared with outer London boroughs), therefore disadvantaging the outer boroughs by employing a “one size fits all” approach. Furthermore, we noted that clinical waste had been chosen, in spite of the fact that we are all working to develop services outside of the acute sector, in which case the need for clinical waste services is going to increase rather than reduce. In overall terms, we have concern at the selection of some of these QIPP schemes and would query how and where they were signed off, and whether the way they are applied is correct.**

MT advised that the savings had been identified by looking at list sizes and populations proportions, but that CCGs should not see this as an instruction at local level per scheme as identified in the report, but that local variation can and should be included, ie CCGs should amend as they see fit at a local level. MT went on to state that one of the key reasons that NHSE is setting up the QIPP Planning and Delivery Group is to enable an assessment of what has and hasn’t worked for all CCGs to be undertaken, and to understand where the differences are in terms of what will work. MT stated that NHSE expects that there will likely be a gap at year end, but that NHSE expected that it would be less than is currently showing. At that stage there would be a collective effort to identify what remains as residual and what will be required to close it.

6. **Bexley Joint Committee (KW):**

   (i) As SEL are level 2 co-commissioners of Primary Care this year, we understand that the financial risk associated with the achievement of QIPP lies with NHS England and not with the CCGs. Is this correct?

   (ii) Please can you confirm that NHS England will allocate non recurrent resources to meet any shortfall in QIPP, and that therefore CCG's will not have to contribute to any shortfall, if these savings are not

	achieved? (i) TA confirmed that as the budget holder for Primary Care, the financial risk of any level 2 CCGs not achieving QIPP sits with NHS England, who would be liable to make up any financial shortfall. TA also advised that, where appropriate, there have been discussions between NHSE and CCGs, with a view to CCGs making some financial contribution toward ensuring an improved starting position in financial terms at the start of 2016/17. MT followed this by pointing out that should any CCGs move toward level 3 (full delegation), there would be a movement toward a balance of financial risk share on QIPP shortfalls. MT advised that NHS England are working towards closing the gaps, although this was a work in progress. A potential option of using non-recurrent sums of funding to do this was currently being considered by NHS England, but that NHS England was committed to working with CCGs to try to find other means of closing the gap towards year end, via the QIPP Delivery Group and External QIPP Review. MT remarked that, as £54m been moved out of primary care QIPP in the two years preceding 2015/16, the scale of the challenge was well understood by NHS England.	
7	**Update on the London PMS contracts review programme** JWe introduced the item by giving a recap from the last Primary Care Joint Committee meeting, at which NHS England introduced the PMS review, detailing its purpose and principles. CCGs were then given the opportunity to raise issues in a workshop format. JWe advised that the purpose of the item was to update Joint Committees on the progress, identify issues and state the next steps. JWe reported that a good deal of progress had been made since the last meeting (6 August), but that NHS England was not at this point in a position to ask Joint Committees to make decisions with NHS England about commissioning intentions for PMS practises (or for GMS and APMS practices). As a result of that, in line with the revised timelines (as shown in the presentation), JWe advised that there was a strong likelihood that an additional urgent meeting of the Primary Care Joint Committees (ahead of the planned 10th December meeting) would be required for scheduling – to ensure that the reviews can be completed in line with the national timeline as far as is possible, and to fully understand the consequences of not adhering to them. JWe talked through the main thrust of the slide pack (circulated as Enclosure F - Update on the PMS contracts review programme). Through the principles of the PMS review NHS England commissioners are seeking a consistency of approach across London whilst respecting the need for localisation as appropriate, with the overall intention that services are standardised for access and quality to all registered patients across London. This is all driven by Strategic Commissioning Frameworks – set of specifications developed by clinicians, commissioners, patients and other partners across London - to improve access, coordination of care and prevention for all Londoners regardless of where they are registered, as published under the banner of “Transforming Primary Care in London” (published in November 2014). It is also important to understand the necessary differences in commissioning arrangements between PMS practices, for specific populations. This has been the	

purpose of NHS England requesting feedback from all areas where PMS practices that have yet to be reviewed, in order to fully understand the services provided by them. In South East London, where there are clear KPIs and measurements in place, these have been used to support the review.

JWe advised that the minimum price per weighted patient had not yet been finalised but that there was an expectation that it will be in the next week or so.
A key principle of the review is engagement with CCGs – maximising the opportunity of co-commissioning. NHS England (London) has developed a communications and engagement plan for London. This is not yet complete but messages have been developed, and stakeholders identified, and NHS England is working with CCGs to localise this and to identify key stakeholders in each borough area. All of this work was in accordance with Section 13.2 of the NHS Act (to engage and consult taking into account the significance of change), of which NHS England (London) is fully aware.

JWe described the programme phasing, pointing out that the phases as set out in the slide pack were not in order of appearance – but rather they all overlay each other, i.e. not in sequence.

A key element of the PMS review is the development of the case for change. JWe explained that the contributing factors to this were the assessment of KPIs and existing service delivery, plus a collation of financial and outcomes information. There was still an assessment required to understand what this means for each CCG – i.e. the price per weighted patient and the premium in each CCG area.

NHS England has completed some benchmarking on the price per weighted patient, with a view to trying to understand what difference that makes in terms of outcomes, and to assess whether the outcomes were different across APMS/PMS/GMS practices.

JWe advised that NHS England (London) would undertake some further work once the PMS premium had been identified, by meeting with relevant senior CCG commissioners to discuss what all of this information means for their borough, and to identify whether or not individual CCGs have plans to add to the premium from local monies (if possible).

JWe advised that all information would be available two weeks from the time of this meeting. All of this was under senior NHS England internal review at the present time, the purpose of which was to review and challenge the analysis toward the case for change. Following this, later in October, NHS England would undertake engagement with the local LMCs and SPG levels, making the case for change.

Programme timeline

- National deadline for completion of PMS reviews – end of March 2016.
- Most of information described by JWe will be available in early October.
- Financial and affordability assessments and development of contract specifications are scheduled to run in parallel until the end of November, to allow time for meetings between CCGs and NHS England, and whilst the starting point (applied consistently) for NHS England is the contract specifications, this would then need to be localised as appropriate. Furthermore it may be that CCGs have other responses and/or already be commissioning other services and may wish to utilise PMS contracts in a

	different way. • Letter to PMS practices to be issued on 1 October 2015. This to give 6 month notice to the contract variation and setting out the process toward this. • Following meetings between CCGs and NHS England during October, and agreements for each Joint Committee, a further letter to practices will follow – setting out commissioning intentions. • Intention is that decisions will be made by 27 November 2015 in each borough. Then negotiations meetings to run for two/ three months at individual practice and LMC level (as per agreed local approach), concluding 29 January. Following this, the intention is that contract documentation will be reviewed and updated between end of January and of end March. • NHS England is in no doubt as to the scale of challenge associated with this plan. JWe stated that for the assessment of KPI and existing service delivery the starting point would be the same as current, and that in each case this would then be localised for each CCG. In terms of the collation of financial and outcomes information, current figures showed that for PMS practice registered patients there were approximately 4.8m actual registered patients, which works out at 4.5m "weighted" patients according to the Carr Hill formula. JWe stated that PMS total expenditure in 2015/16 was £430m (approximately), and the Global Sum Equivalent was calculated to be £354m (based on April 2015 list size), giving a premium across London of approximately £88m, after adjusting for out of hours services. JWe stressed that this was based on current figures, and that there would be a need to flesh out some areas further. Furthermore that the calculation is very differential depending on the amount of premium in each CCG area, and whether practices therein have been reviewed or not. JWe referred to the care specification (shown on the table on 198-200 of the pack), and advised that the pathways for service specifications are subject to affordability. Specifications are to be agreed by a variety of stakeholders and published. The main area of focus has been on access. NHS England clinical leads have reviewed each standard, to consider whether the requirements for each are already part of the GP contract or not, and whether to propose its addition as a PMS Premium Service Specification (and to offer to GMS practices, and negotiate on it with local holders of APMS contracts). This is the process proposed by NHS England, although it is subject to affordability. Furthermore JWe advised that the table also identified some standards that might be more suitable for GP Federations, or to deliver in collaboration or partnership with other health organisations. JWe referred to the fact that costs were not included on the presentation material, and that these were being finalised. Once finalised these will inform the price per weighted patient. The starting point for this is discussions with individual CCGs. For the development of premium specifications, JWe reported that NHS England clinicians are working on what prioritised areas should be included in the access specification, to be used as the starting point for discussions around what will be included in the renegotiated PMS contract. JWe set out the key CCG input to the process (proposed areas for joint working and engagement) • Decisions needed for next meeting (10 December): agree local commissioning	

intentions for primary care, agree approach to transitional support (if required), content of contract specifications, understand the impact of the affordability modelling, what's available in the premium, understand what investment CCGs are able to make
- Understand the position at CCG level for pooling "premium" funding across CCG boundaries (if there is an appetite for this)

ML noted the complexities associated with the presentation and the PMS review in general. Furthermore that it represented the first national full-scale review, and that it would need to be aligned with local five year strategies that had recently been implemented at a borough level. The level of detail was too great to fully explore in all aspects in the discussions following the presentation. ML invited each CCG table to identify the highest priority question and address this to NHS England.

Lambeth Joint Committee:

1. The pace of change is very fast and poses a genuine risk. Can it be challenged? There is a genuine risk with everything else that is happening at the moment. Furthermore, the pace of change means that the required consultation with patients and public will likely be compromised, and that the timeline is close to being impossible.

2. Is there a mandatory requirement that, in order to have access to the premium, practices must agree to take up Local Incentive Schemes (LIS) and Directed Enhanced Services (DES)? If so, is this enforceable, given that DES is a voluntary option for practices, and there may be challenge if practices were advised that unless they agreed to do it, they would not have access to a PMS premium?

NHSE response:

1. MT addressed the question regarding the risks associated with the pace of change, particularly around technical challenges to the change in contracts, and the challenge to patient safety, as well as the impact on practices. He advised that NHS England is open to receiving any rational arguments from commissioners toward extending the period of the review, provided that these stated clear measurable benefits to practices and to patients, as a result of that additional time. These would be reviewed by the NHS England, London team, to take to the national team. The limit of any extension granted by NHS England would be up to three months (i.e. to the end of June), but this would only be granted if the benefits submitted are in line with the above requirements.

2. In terms of the requirement for DES and LIS and whether it is challengeable; this is a discussion to be had during the negotiations. Some existing contracts in London have DES's embedded in their contracts. JWe recognised that it would not be appropriate for commissioners to use funding available in the premium to pay for DES and LIS. JWe advised that this was why NHS England had proposed (as a starting point) that we must uphold the principle of patients being able to receive the same services regardless of where they are registered (i.e. if there is a service available at a given practice we would like the patients registered in that practice to be able to access those (enhanced) services).

Lewisham Joint Committee:

SP began by stating the importance of this topic, and the difficulties in attempting to coalesce questions on this issue, which did not serve to do the debate justice. SP restated the concerns aired re the timeframes of the PMS review, describing this as a major threat, and one with a potential to destabilise the system.

SP addressed NHS England with the following question: How will local sensitivities be preserved (particularly regarding variations to include specifications)? How will the essence of locally negotiated PMS contracts be preserved to ensure that they are specific to the distinct needs of the local populations in each borough?

JWe replied by stating that the starting point put forward by NHS England would be adapted to the local population via the discussions with commissioners – this would be the minimum required achievement. JWe stated that whilst a commissioning aspiration of NHS England (as joint commissioners) was to achieve some consistency across London, it was also recognised that the localisation aspect is vital to each borough and that this will be embedded into the process.

Southwark Joint Committee:

Will KPIs have a local aspect? And will there be a financial risk for CCG commissioners if KPIs are not met?

JWE advised that there was a lot of work on KPIs. KPIs had been implemented via a number of different models across London. JWe gave four examples (i) a traditional model: value of KPIs = 5% of contract price, and paid based on performance at the end of the year; (ii) KPIs paid at either their price based on performance, (i.e. high, average or poor), and then reconciled at end of the year; (iii) some CCGs have paid KPIs and not taken back any funds; (iv) some practices have lost money.

JWe advised that NHS England will produce a model with proposed KPI methodology. The principle of the PMS contract including KPIs is fixed but the methodology will be discussed with the hope and expectation that practices will be able to achieve highest performance against KPIs that commissioners would wish them to aspire to.

Bexley Joint Committee:

1. We appreciate that LMC will be engaged with as part of this process. What assurances can be given that this will be a genuine engagement and consultation (rather than being informed of a decision having been made)?

2. What engagement mechanisms are in place locally to ensure a positive engagement with LMCs?

NHSE response:

JWe advised that engagement was underway via the Londonwide LMCs and that meetings had taken place over the past two months. The next part of the LMC engagement process was to engage at the borough level.

David Sturgeon will be attending the Londonwide LMCs meeting on 22 October 2015 to set out the principles, processes and all information as presented at the Primary Care Joint Committees. As part of these meetings there will be a clear opportunity for LMCs to state any objections with the process as set out, and to highlight any associated issues and challenges.

Bromley Joint Committee:

In the summary of the programme phasing there is a clear outline for affordability assessment and the development of the case for change. At what point are we starting to assess the impact on the quality and safety for patients? There is potentially a great anxiety of practices reading contractual change, therefore we are keen to understand at what point practices might start to change services, which may have significant impacts on the patient experience. The Bromley Joint Committee was also keen to emphasise that CCGs would be undertaking the PMS review at a time when commissioners are relying on Primary Care services to "step up" in support of the move toward more services being delivered in out of hospital settings - therefore we are creating a lot of change, but are not certain of what will be the impact on practices (as well as patients).

JWe responded by saying that NHS England recognised the challenges of affordability and quality impacts. When discussions commence between CCGs and NHS England, it may well materialise that some of the changes being negotiated will take a longer lead in time (than 1st April). JWe assured the Joint Committees that the nature of discussions between CCGs and NHS England would ensure that realistic timeframes on changes to contracts are built in, and that the level of detail of service changes being enacted would be reviewed sufficiently to ensure that patient safety would not be compromised. Furthermore, JWe explained that there is not an expectation that changes to services as a result of the negotiated contract position will take effect "overnight" from 31 March to 1 April.

In terms of the potential impact of these changes in the context of the transformation agenda (i.e. does this present a risk to moving more services out of the acute setting), ABI pointed out that there was clearly a distraction in going through the PMS review. Considering these premiums and placed-based budgets as a whole, these points should be seen as complimentary (in terms of incentivising different parts of the system). ABI also made a point regarding the differential of premiums across London. In South East London the consistent position amongst commissioners was that PMS is for services genuinely above GMS. ABI put forward the view that this will not necessarily bring instability, but recommended that CCGs in south east London must ensure that this test is passed, and that we can demonstrate this via KPIs and that where KPIs are not achieved, these funds are reinvested back into this part of the system to ensure that primary care thrives.

Greenwich Joint Committee:

One area of concern for commissioners is that (bearing in mind the amount of pressure on primary care services now), this is all about adding to specifications in the PMS contract, and therefore increasing the pressure on services. Thus there is a potential risk in the future for increasing the workload. The Joint Committee suggested (as a strategy in response to this) to pool across London some of the premium and redistribute the funding more equally across London in this review?

JWe responded to the concerns raised regarding additional content to primary care service specifications, by re-emphasising NHS England's starting point for this as being local engagement, using the strategic commissioning framework specifications, and with the notion that PMS contracts are equivalent to GMS contracts – that they include essential and additional services and start with global sum equivalent and build from there.

	JWe advised that any decision on pooling would be made between and across individual CCGs in meetings with NHS England. JWe explained that to date she had not heard from any CCG that had shown willingness to pool its premium nor is this a requirement. Discussions should take place on this across boroughs at the next round of meetings with NHS England. ML summarised the discussions, pointing to some disquiet around the tension that a full opportunity to discuss these issues to the extent that Joint Committee would have wanted to had not been fully afforded at this forum. ML echoed the views expressed that further discussion was required, both locally but at this forum also. ML suggested that CCG Chief Officers would want to gather issues locally and consider whether they would like to request additional time for the PMS review, by devising and submitting a strong case for the rational for this, once NHS England had written to each CCG to request this. Agreement reached that an additional "extraordinary" meeting dedicated to this matter is required to thrash this out in more detail. Details to be confirmed as soon as possible.	**TB**
For Decisions		
8	ML began by referring to a broad consensus in advance of the meeting relating to all the items for decision in this section, and therefore encouraged members to keep the discussions here to a minimum, focusing on aspects that required conjecture or debate. JWe introduced the paper, an options appraisal for request to increase reimbursable premise costs at Slade Green Medical Centre, a PMS practice. NHSE (London) recommends that the Joint Committee approves the additional revenue costs associated with the utilisation of essential and additional space at Slade Green Medical Centre to allow the practice to fully utilise its existing fit for purpose premises to meet the growing needs of its existing and future patients both in terms of access and quality of services provided. JWe explained that the practice had been waiting for approval for funding for the increased utilisation of the existing space, as the associated extension building works had been carried out in 2011, in the hope that the then administration (Bexley Care Trust) would fund the renovations. The Care Trust ruled that there was no case to fund this at that time, as the practice's list size at that time did not require it. The timing of the options appraisal being submitted to the Joint Committee at this point is driven by significant regeneration in the area surrounding the practice, with 2,000 new homes having been built and the list size having increased from 6,500 (April 2013) to 6,900 (April 2015), with further extensive growth to the list anticipated. JWe advised that NHSE (London) has deemed the space fit for purpose and is satisfied that it is compliant with the Disability Discrimination Act. The valuation costs of the essential and additional space has been updated since the premises were assessed in 2011 and this has been updated within the options appraisal to include a recent desktop evaluation of the Commercial Market Rent by the District Valuation Office (on behalf of NHS England), whose conclusion deemed the cost to be value for money in comparison with other prices per patient in the local area. As a condition of agreement to the above, and subject to further strategic work being	

	led by Bexley CCG regarding the premises needs (that NHS England has asked all CCGs to carry out by December 2015), NHS England recommended to the Joint Committee that the practice is required to open between 8am-6.30pm Monday-Friday with extended hours in addition to core opening times in line with the requirements of the Extended Hours Directed Enhanced Services (DES) with immediate effect, and that the practice would be required to finalise negotiations with the landlord and agree to a new lease arrangement contemporaneously with the implementation of the additional rent payment and release of additional space. It was noted that the values in the main body of the paper were outdated, and that the values in the cover paper should be referred to. Bexley Joint Committee supported the recommendation and associated payment. The CCG agreed to the condition for the core opening hours at the practice, but would not include any condition that Slade Green Medical Centre must take up the DES additional opening hours requirement, (although it was noted that the Practice is voluntarily taking up the DES additional opening hours requirement in any case). NHSE gave its approval to this course of action. **NHS Greenwich CCG – Options appraisal following the retirement and contract termination of single handed GP (Dr Guram) (GMS Practice)** JWe introduced the paper, an options appraisal reviewing the options available to NHS England London Region for the continuation of the provision of general medical services for the patients of Dr Guram's practice following his retirement and termination of his GMS contract in March 2016. The Joint Committee was requested to agree to the recommendation to ask the patients currently with Dr Guram's practice to register with an alternative local provider. Greenwich Joint Committee raised no questions in response to the options appraisal and gave its approval for the recommended approach. NHS England gave its approval. **NHS Southwark CCG – Neighbourhood Development Plan 2015-16** ABI introduced the paper, which recommended that the Joint Committee note the Phase 1 principles of the Neighbourhood Development Plan funding arrangements, and approve the 2015/16 Neighbourhood Development Plan funding principles, in accordance with the CCG's Primary Care Programme Board recommendation. ABI confirmed approval on behalf of the Southwark Joint Committee for the 2015/16 funding principle. NHS England gave its approval.	
For information		
9	**NHS Bromley CCG - Winter Resilience Programme for 2015/16 (Enclosure J)** The Joint Committees noted the contents of this overview report. **NHSE London - Contract variations – April – September 2015 (Enclosure K)**	

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The Joint Committees noted the contents of this report.

NHSE London - Locum reimbursements – April – September 2015 (Enclosure L)

JM (Lewisham CCG) raised a number of questions relating to Enclosure L (items for information):

1. **On Page 270 it is apparent that Lewisham has 7 maternity claims, however Lambeth has 6 claims with similar lengths of time but with no attributed costs or spend. Therefore, are we comparing like with like?**

   JWe thanked the Lewisham Joint Committee for submitting the questions in advance, as this helped to ensure that an adequate response could be given at the time of the meeting.

   In response to the initial question, JWe advised that the report contained an error, in that the Lewisham reimbursement claims had been reported in it at full year costs, rather than part-year costs (the latter being the correct method). Therefore the cost reported for Lewisham in this section of the report had been inflated, and the correct costs were in fact £93k (rather than £147k). The report would be amended to ensure we are comparing like with like. Lewisham projected spend is likely to overspend compared to Lewisham allocated locum budget, but all budgets (other than those at level 3) are considered as one for London. JWe asked GG to circulate the correct version of the report with the minutes of the meeting.

   The Lambeth claims (and also several for Bexley and Greenwich) had not been received in time for the production of the report, hence there were no figures included in that part of the report.

2. **For the last 2 periods expenditure is above the planned budget and therefore what assurances can NHS England provide with regard to forecasting the outturn position for this budget? What are NHS England's plans to mitigate this overspend?**

   JWe advised that the overall position (as per the overall finance report position as presented by TA) for level 1 and level 2 CCGs against the overall London budget, and therefore if there are overspends in some areas NHSE would manage these across London at year end. JWe also stated that peaks and troughs were to be expected across the year and across London and that there was a degree of flexibility in this regard to managing overspends.
   In essence, this is not possible to mitigate, other than to smooth across London, in order to balance over and underspends.

3. **Essentially, this is about robust and early workforce planning – has NHS England conducted any reviews or profiling of boroughs with regard to the numbers of GPs, partners, gender, WTEs and Doctor to patient ratios?**

JWe responded by noting that there remained a lot of work that needed to be done on this across London. Recent data had been published on National Clinical Workforce that showed the number of WTE GPs and nurses per thousand patients. This was already being used as benchmarks to show where

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GG/TB

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	each CCG lies, ie applying this information to understand where the pressures are (these are more apparent in some areas than others). JWe advised that the information doesn't split into male-female, so this would need to be locally augmented. Furthermore, NHS England has a new tool which has recently been developed - GP Workforce Census Geographical Comparator Data Tool. This can be discussed with the CCG.	
Public		
10	**Public Open Space** No questions from members of the public had been received in writing in advance of the meeting. A member of the public enquired as to why PMS contracts were the business of this committee. JWe replied, by referring back to the premise and purpose of this group of Joint Committees: the need to make joint decisions that are concerned with commissioning and contracting arrangements for GP practices. As PMS and APMS practices were on local contracts, decisions are made locally (unlike GMS practices which are on national contracts). Therefore there is a fundamental need for Joint Committees to have discussions on what we as commissioners would like PMS GP practices to provide for patients in south east London. MT gave some further context by advising that there was now greater involvement for local CCGs as a result of the recent developments in the co-commissioning of primary care services (as of 2015, CCGs are now jointly commissioning primary care services, in a partnership arrangement with NHS England, who retain the statutory responsibility for the services). There are three levels of co-commissioning arrangements nationally, level 1 being led exclusively by NHSE, level 2 where primary care services are co-commissioned between CCGs and NHSE, and level 3 where full delegation for commissioning has been taken by the local CCG. In south east London, all CCGs are currently at level 2. This is overall part of a journey, moving away from the previous arrangements where NHS England took decisions as commissioners for primary care alone, and toward a more localised open arrangement of commissioning with increasing power to local commissioners. **Frances Hook (Keep Our NHS Public, Greenwich):** 1. Queried further the statement by NHS England that the (£10m) surplus could not be reinvested in General Practice. MT responded by reiterating the points on this from earlier discussions in the meeting, by advising the questioner that the surplus is reinvested into patient care in the NHS (rather than being "held back") – but allocated to patient care in different parts of the system where the need for financial resources is currently greater (i.e. the acute sector). 2. Queried the level of private providers in the local NHS by asking how many more GP practices will be axed, and questioned the level of local control retained by CCGs in light of the new arrangements of this committee (with six joint committees meeting in one session). MT responded to the first part of the question by pointing to areas where the private sector has complimented the provision of NHS services, where we have	

	been able to use it to support overstretched areas of NHS care. **Paul Richardson (Greenwich)** **Given the argument toward patients being at the centre of the process around decision making choice, how does this** *[the PCJC]* **process compliment and help that principle?** ABu replied to the question, referencing MT's response to the first question in the public open session, (where he stated that we are in a process of transition toward more localised control, although we still have some way to go to fully achieve that). Furthermore ABu set out the patient engagement processes that were embedded in the governance process of Greenwich and other CCGs. The CCG has a Healthwatch representative who attends this joint committee and ABu meets with the representative in advance of these and other meetings to ensure their views are fed into the process and that local patient issues are covered. ABu referred to the other south east London CCGs having similar engagement processes. Patient engagement informs and is part of all CCG decision-making, which is a statutory requirement. Other examples of local consultation and engagement are a recent presentation given at the Pensioners Forum in Greenwich where over 100 members of the public engaged in discussions about the SEL and Greenwich commissioning strategies. MT emphasised the importance of patient engagement and involvement in local decision-making around services, and the need to talk to the public in non-technical language, and pointed to a great range of CCG patient-focused local engagements taking place across all six boroughs in south east London where this was continuing to happen.	
Other business		
11	**Any other business** RW raised a concern from the Lewisham Joint Committee, that the amount of time that had been afforded to direct and open questions from the joint committees was insufficient, and that this would seriously detract from the ability of the Lewisham Joint Committee to adequately represent the views of its CCG Governing Body. This issue was raised predominantly as a response to the item on the PMS Review. ABI responded by advising that, as per the governance processes outlined in the Terms of Reference for each Joint Committee (as approved in advance of and at this evening's meeting), local Joint Committees had ample opportunity to discuss details of all agenda items in advance of the meeting and the Joint Committee was not the only forum to engage on these matters. Nonetheless he invited Joint Committee Chairs to discuss ways to improve meetings going forward. ML further reflected that a decision had been taken to hold an additional meeting focused on the PMS review, in order to afford it the time and attention that it required.	
For information		
12	**Glossary of Terms** The Joint Committees noted the contents of the Glossary of Terms, which had been	

	updated since the last meeting following additional entries provided by committee members (and would continue to do so).	
13	**Date of Next Meeting** 10 December 2015	
Close		

Primary Care Joint Committees

29 September 2015

Signed Attendance Sheet (Public and other observers)

Gary Beard	NHS England
Sharon Fernandez	NHS England
Denver Garrison	Member of the public
Eileen M. Smith	Keep Our NHS Public, Greenwich
Abi Begho	Cancer Research UK
Sue McNulty	Cancer Research UK
Tom Barber	Cancer Research UK
Dr Angela Burr	Greenwich resident
Frank King	Patient
Julie Pearson	Greenwich patient
Frances Hook	Keep Our NHS Public, Greenwich
Fiona McKirdy	National Cancer Research Institute
Sarah Birch	NHS Bexley Clinical Commissioning Group
John Harris	Carer
Peter Adams	Crayford Forum and PPG
Paul Richardson	Member of the public
Kerinder Mander	Member of the public
Tom Bunting	South east London Clinical Commissioning Groups

ENCLOSURE: O (ii)

Agenda Item: 18/16

NHS
Bexley
Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 28 January 2016

Audit and Integrated Assurance Committee – Executive Summaries
Meeting held on 28 May 2015

The AIAC met on 28th May 2015; present Keith Wood (Chair), Mary Currie, Tina Khanna, Dr Graham Rehling.

At the meeting the AIAC:
1. **Considered and was assured by** the high level Risk Register and Assurance Framework.
2. **Noted** the Counter Fraud Progress Report and Annual Report.
3. **Noted** the Local Security Management Specialist's Annual Report.
4. **Noted** the results of the Budget Holder Survey, the attendant action plan and arrangements for future surveys.
5. **Noted** the year end Information Governance Report.
6. **Noted** the Head of Internal Audit Opinion and Annual Report.
7. **Considered and approved** the 2014/15 final accounts and Annual Report, including in particular the Annual Governance Statement, noting the minor changes that had been made to the draft considered at the meeting on 21st April, noting also the Chief Officer's Assurance Statement and the External Auditors Findings Report. The AIAC **welcomed** the fact that there were no unadjusted errors which External Audit needed to bring to its attention.
8. **Considered** the Letter of Representation from management to the External Auditor and authorised the AIAC to countersign it on the Committee's behalf.
9. **Approved** the Internal Audit Plan for 2015/16 and **welcomed** the addition of Governing Body governance to the Plan.
10. **Agreed** to defer the report on mental health performance management until the September meeting.
11. **Noted** the five tender waivers since the last meeting.
12. **Noted** the decision log from other fora.
13. **Noted** the Register of Governing Body members' interests and **requested** that the declarations of interests for all members of the CCG be presented to the next meeting.
14. **Noted** the revised Terms of Reference for the AIAC which had been approved by the Governing Body and **requested** that points of clarification be addressed.
15. **Noted** the minutes of recent Finance Sub-Committee and the Primary Care Advisory Group meetings and summaries of proceedings at recent Executive Management, Quality & Safety, Medicines Management & Information Governance Sub-Committee meetings.

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16. **Considered** the aged debt analysis, noted processes to manage outstanding debts and **agreed** that there were no debts which required either provision or write off.
17. **Noted** that Internal and External audit did not wish to take up the offer of a meeting in private.
18. **Reflected** on the meeting and agreed that in future the meeting to sign off the Annual Report and Accounts should be held separately from the regular quarterly meeting.

Meeting held on 15 September 2015

The AIAC met on 15th September 2015; present Keith Wood (Chair), Mary Currie, Dr Graham Rehling.

At the meeting the AIAC:

1. **Congratulated Nikki Kanani** on her election as Chair of the CCG and **noted** that as a consequence she could no longer serve on the AIAC.
2. **Considered** the aged debt analysis as at 31 July 2015, noted processes to manage outstanding debts and **agreed** that there were no debts which required either provision or write off.
3. **Considered and was assured by** the high level Risk Register and Assurance Framework and suggested issues for further consideration.
4. **Noted** the Counter Fraud Progress Report and Annual Report.
5. **Noted** the Local Security Management Specialist's Progress Report and **approved** the annual workplan.
6. **Noted** the Crime Reduction Survey Progress Report.
7. **Noted** the excellent paper on learning from clinical services outcomes.
8. **Reflected** on the recent Finance training session for AIAC members and **welcomed** the proposal for a Governing Body session on the Assurance Framework and Risk Appetite.
9. **Noted** the Internal Audit Progress Report and the report on Safeguarding Children which provided the highest level of "Significant Assurance".
10. **Noted** the External Auditor's Annual Letter and proposed fee for 2015/16 and **thanked** Sue Exton for her work in that role.
11. **Noted** the tender waiver since the last meeting.
12. **Noted** the decision log from other fora.
13. **Noted** the report on mental health performance management.
14. **Noted** the report on the final 2014/15 QIPP performance.
15. **Noted** the 2015/16 Organisational Development Plan and progress made in 2014/5.
16. **Noted and supported** with assurance from internal and external audit, the revised arrangements for processing collaborative claims.
17. **Noted** the remuneration return submitted by the CCG to NHS England as well as the process which the CCG had to now adopt for Consultancy costs.

18. **Approved** the Financial Control Environment Assurance return to NHS England and **noted** the feedback from NHS England and the further work carried out by Internal Audit which confirmed their earlier opinion and would be formally reported to the next meeting of the CGG Governing Body.
19. **Noted and supported** the proposals for Service Auditor reporting in 2015/16 with which Internal and External Audit are each comfortable.
20. **Noted** the items reported since the previous meeting in the Gifts and Hospitality Register.
21. **Noted** the minutes of recent Finance Sub-Committee and summaries of proceedings at recent Executive Management, Quality and Safety, Medicines Management, and Information Governance Committee meetings.
22. **Noted and welcomed** the letter from Paul Baumann commending NHS finance staff and others on their achievements in delivering the 2014/5 Statutory Accounts.
23. **Reflected** on the meeting and agreed the timing and balance of topics was appropriate.
24. **Noted** that Internal and External Audit did not wish to take up the offer of a meeting in private

ENCLOSURE: O (iii)

Agenda Item: 18/16

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 28 January 2016

Executive Management Committee – Executive Summaries
Meeting held on 8 October 2015

APOLOGIES FOR ABSENCE
Dr Peter Fish and Sarah Valentine.
DECLARATIONS OF INTEREST
All GPs present conflicted in respect of Item 128/15 Primary Care Development and Co-Commissioning Update. No mitigating action necessary.
OUSTANDING ITEMS
Risk Management Report
The Executive Management Team **noted** the Risk Register which currently had no high level risks and SE London risks pertinent to NHS Bexley CCG had been added to the register.
ITEMS FOR DECISION
Policy Schedule and Governance Handbook
EMC **approved** the Policy Schedule and Governance Handbook.
ITEMS FOR DISCUSSION
Primary Care Development and Co-commissioning Meeting Update (October)
Additional space for Slade Green Medical Centre approved at PCJC; discussion on finance report and PMS Review.
The CCG would not apply to move from Co-Commissioning level 2 to level 3 at present and would work with NHS England and other CCGs to share good practice to support identification of QIPP savings.
An update paper on Primary Care Development will be presented to the November Governing Body meeting
Frank Cooksey
The EMC **supported** the move of the Frank Cooksey Neuro Rehab unit from Lewisham University Hospital to Orpington to improve outcomes.
London Devolution
EMC discussed the London Devolution documentation and **noted** that Bexley did not intend to apply to be a pilot at present.
Updates from recent NHS meetings
Local Care Networks Workshop had discussed Bexley Neighbourhood Care.
Programme Director for Local Care Networks recruitment in progress.
ITEMS FOR INFORMATION
Notes of Meetings:

- Finance Sub-Committee 11 August 2015
- Medicines Management Sub-Committee 15 July 2015
- Information Governance Sub-Committee 14 July 2015
- Quality & Safety Sub-Committee 23 July 2015

ANY OTHER BUSINESS
Updates Clocktower Locality Representative election and CCG staff recruitment process.

Meeting held on 3 December 2015

APOLOGIES FOR ABSENCE
Dr Peter Fish and Dr Varun Bhalla.
DECLARATIONS OF INTEREST
No conflicts of interest declared.
OUSTANDING ITEMS
Risk Management Report
The Executive Management Team **noted** the Risk Register with risks scored 10+ and agreed that the February GB Seminar meeting would discuss the development of the CCG's strategic needs.
ITEMS FOR DECISION
CSU Lead Provider Framework
The Executive Management Team **noted** the CSU Lead Provider Framework discussions to date.
Annual Reports Briefing
EMC discussed the new format of the document and recommended staff to complete various with detail on the sign-off process to complement the various stages of submission. The CCG now needed to be a full draft Month 9 financial accounts submission which it was agreed that Keith Wood would sign off as Chair of the Audit & Integrated Assurance Committee on 20 January 2016. Sarah Blow would sign off the Annual Report on 23 May 2016.
The EMC Noted and agreed:
1. The change of structure from 2014/15
2. The compilation table
3. The sign-off process

ITEMS FOR DISCUSSION
South East CSU HR Workforce Report for Bexley CCG Quarter 2 (2015/2016)
The Executive Management Committee **Noted:**
1. The CCG's sickness absence rate of 2.48% is within the medium range of that of the latest available national staff sickness absence rates for CCGs which range from 2.22% to 2.97%; against an overall NHS wide sickness absence rate of 4.48%.
2. The CCG's Stability Index (which measures turnover) is 87.88% against that of a national average for CCGs of 86.49% on a rolling year basis.

Role of CCG in Primary Care
Sarah Blow stated that the role of the CCG in primary care needed to be clarified so that the difference between the role of the Delivery Group and the Joint Committee were understood. The role of the CCG as a member of the six SEL Primary Co-commissioning Joint Committees was to progress formal co-commissioning across south east London and separate from the development of primary care.
PMS Contract Presentation
Presentation agreed for GP Engagement Day.
ITEMS FOR INFORMATION
Notes of Meetings:

ANY OTHER BUSINESS

- Finance Sub-Committee 8 September & 13 October 2015,
- Medicines Management Sub-Committee, 16 September & 21 October 2015,
- Information Governance 1 September 2015

ANY OTHER BUSINESS

Vacancies in the Commissioning Directorate were now being recruited to with additional staff starting in January and February 2016.

ENCLOSURE: O (iv)

Agenda Item: 18/16

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 28 January 2016

Finance Sub-Committee Executive Summaries
Meeting held on 8 September 2015

- Responsible Commissioner and other areas where GPs impact on CCG finances to be considered for discussion at December 2015 GP Engagement Event.
- Implementation of the Provider Assurance Management System (PAMS) removed from agenda as more work needed to be done in respect of which providers would use the system, implementation timetable, IT implications and staff resources.
- The Finance Report Month 4 (July) 2015 was discussed. Finances are in line with the plan position both year to date and forecast outturn. The in-month position necessitated the use of currently available reserves. Better practice Payment Code targets were achieved this month. Over performance in the acute sector is being validated.
- Month 4 assessment of QIPP delivery suggests it will be in line with plan at this stage in the year. Slippage in the Children's Services scheme is being mitigated by use of the QIPP reserve. Slippage in End of Life Care savings is mitigated by reduced expenditure in this area. More work is being conducted on GP Referrals and how this can be captured and demonstrated in QIPP.
- The September Consolidated Contracts Report was discussed, including acute over performance. Oxleas will provide a 24 hour District Nursing Service with effect from 16 September 2015. Further to a contract query MSK physiotherapy waiting times are improving, including better patient flows. Discussions are taking place regarding inappropriate attendance at Urgent Care Centres. Lack of a Paediatric Nurse at both UCC sites and the opening hours of the X-Ray Department at Erith continue to be issues. Plans and timescales are being discussed. Vaccinations (flu and shingles) for housebound patients was discussed.
- The Primary Care Activity Reporting Tool (PCART) has been rolled out to all GP Practices for comment and was being demonstrated and discussed at the GP Engagement Event on 10 September 2015. The Finance Sub-Committee members would consider how to use PCART to best advantage and appropriate committees to receive information.
- Discussions took place under any other business in relation to the weight management service and the impact of the Primary Care Improvement Fund, discharge summaries from Queen Elizabeth Hospital and inappropriate outpatient discharges.

Excellent healthcare – locally delivered

Meeting held on 13 October 2015

- A two year extension to the MIND in Bexley contract relating to IAP and Independent Mental Advocacy was supported. A tender waiver would need to be completed.
- An increase in funding for the Greenwich and Bexley Community Hospice (GBCH) was discussed and it was agreed that an additional recurrent contractual payment of £100k for 2015/16 should be made, on condition that GBCH do not close any of the current 17 inpatient beds.
- The Schedule of Matters had been updated, to reflect changes in the internal structure of the organisation. This was discussed and approved.
- A refresh of the Medium Term Financial Strategy (MTFS) 2015/16 to 2019/20 had taken place. This was discussed and noted and recommended for approval by the Governing Body at its next meeting.
- The Finance Report at month 5 showed that finances are in line with the plan position, both year to date and forecast outturn. Risks remain relating to Continuing Healthcare, acute overspend and prescribing budget overspend. Running costs remain within budget. Forecast outturn QIPP delivery has been assessed at 99% of the rag rated QIPP. Better Payment Practice Code continues to perform well.
- The QIPP Report for month 5 was discussed. The main concern related to the Children's and Young People's scheme. Work continues on GP referrals.
- The October Consolidated Contracts Report was discussed. A clinically led deep dive will be taking place to investigate the appropriateness of short stay and CDU admissions. The 24 hour district nursing service will go live on 15 November 2015. UCC overperformance analysis and validation had been undertaken and results will be presented at the next FSC meeting.
- Practice Based Performance Data for July was discussed. Quarterly meetings had been agreed with practices and in future a quarterly briefing would be provided to FSC following these visits.
- A Medicines Management Team update was discussed. The work and savings being achieved were noted. Clare Fernee was asked to write a policy that GPs could use to explain to patients why medication changes are being made.
- An update on King's MSK contract issues was provided. A deep dive is being conducted into physiotherapy appointments as the target had been missed by a small margin.
- Finance training had been held for Audit and Integrated Assurance Committee members, the offer of this training would be further extended to all Governing Body members.

Meeting held on 10 November 2015

- The recruitment of a Dementia Support Worker for post-diagnosis support for patients and their carers was supported, using the budget of £50,000 from the CCG Mental Health Five Year Forward View monies. A tender waiver would need to be completed.
- It was agreed that future 'Tender Waiver' applications should reference, for explanation, 'Exceptions and instances' from the Tender Waiver Form.
- The Finance Report at month 6 showed risks remain relating to Continuing Healthcare, acute overspend and prescribing budget overspend. However, YTD and FOT is still on plan. Running costs remain within budget. Forecast outturn QIPP delivery has been assessed at 93% of the rag rated QIPP. Better Payment Practice Code continues to perform well.
- The QIPP Report for month 5 was discussed. The main concerns related to the Children's and Young People's scheme, Prescribing and minor surgery AQP. Work continues on GP referrals.
- The November Consolidated Contracts Report was discussed. Concerns were raised over the level of over-performance being reported at LGT. A clinical audit will take place. Agreement has been reached with Greenwich CCG regarding the use of available community beds across both boroughs.
- An update on Greenwich & Bexley Community Hospice was provided on the work that is continuing between the organisations looking at funding and different ways of working.

Meeting held on 8 December 2015

- Members approved the proposal to commission a child weight management programme from a consortium of voluntary sector providers. The funding is already in reserves.
- Members approved further development of business cases to assess the feasibility for 3 schemes with Greenwich & Bexley Community Hospice as follows:
    - Scheme 2 – EoLC Facilitator
    - Scheme 3 – Community Support
    - Scheme 4 – Support for Carers – to engage with the Local Authority

  Members also approved Scheme 1 – Training for the 12 month trial to be implemented with immediate effect.
- Members approved Funding of Drugs for the Hospice from 2015/16, in line with national guidance. Reimbursement would be based on bed occupancy. The approval was on the basis that the Medicines Management team can review prescribing if required.

- Members approved the 3 month pilot for the Provider Assurance Management System (PAMS), at a cost of £1,500, with a pilot review at the March FSC.
- Members recommended for approval a tender waiver for GP Support to Care Homes procurement with shortened timescales for re-procurement. Jonathan Manuelpillai to prepare tender waiver for approval.
- Members requested a 6-monthly report on all contracts held by the CCG showing their values, contract length, expiry date and when they will be procured starting from the March FSC.
- Members reviewed the business case and approved additional funding for the Mildmay Mission Hospital HIV Rehabilitation Service. A tender waiver was recommended for approval as Members were advised that there were no other local providers for this specialist service. Jonathan Manuelpillai to prepare tender waiver for approval.
- Members discussed the month 7 Finance report. This showed the main risks as relating to Continuing Healthcare, acute over-performance and the prescribing budget overspend. However, YTD and FOT are still on plan. Running costs remain within budget. Forecast outturn QIPP delivery has been assessed at 92% of the rag rated QIPP.
- The QIPP Report for month 7 was discussed. The month 7 assessment of savings is 92%. However, this fell to 87% in month 8 due to a reduction in the ophthalmology predicted savings. The schemes causing the shortfall have been reviewed and remedial action is being taken where possible.
- The Consolidated Contracts Report for December was discussed. The main concern on Acute is still the over-performance being reported at LGT. It was also noted that 24 hour community nursing (from Oxleas) commenced in November. Consultant led MDT hot clinics will commence on 15th December. MSK has received excellent reviews and wait times have significantly improved.
- Members were advised that interviews took place for the Finance apprentice but were unsuccessful. The CCG is hoping to attend the LBB apprentice open day in March which targets schools in the area and hopes practices will join in the promotion.
- Members were advised that Sue Sitch retires this week after 24 years of service. Members expressed their thanks for all her hard work, a lot of which had passed through the FSC and wished her well in her retirement.

ENCLOSURE: O (v)

Agenda Item: 18/16

NHS
Bexley
Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 28 January 2016

Medicines Management Sub-Committee - Executive Summaries

Meeting held on 16 September 2015

- Bexley wound care dressings pilot evaluation was reviewed and the committee agreed to recommend the change in supply route for dressings from GP prescribing to Oxleas ordering is continued and added to the Oxleas contract with KPIs for on-going monitoring
- The committee agreed the medicine management strategy for 2015-18
- The results of a community pharmacy waste audit were reviewed that highlighted a reduction of £118k waste medicines returned to the pharmacy compared to the previous year
- A patient specific direction for the shingles vaccine was approved to allow Oxleas district nurses to vaccinate patients referred to them
- In-growing toenail pathway approved
- Patient leaflet on omega 3 was approved

Meeting held on 21 October 2015

- The NHS Bexley CCG Shared Diabetes Guideline and Appendix were approved
- Prescribing Guidelines for Stoma and Incontinence Products for Practices approved following a review of continence and stoma prescribing
- NHS Bexley CCG Protocol for switching selected patients with asthma from Seretide Evohaler to Sirdupla Inhaler approved for use by the Bexley CCG Medicines Management Team for suitable patients registered in Bexley GP Practices
- Patient leaflet on omega 3 was approved

Meeting held on 18 November 2015

- NMS Interview Schedules for Asthma, COPD and Type 2 Diabetes for use by community pharmacists in NHS Bexley CCG were reviewed. The decision to approve the documents was to be ratified at December meeting due to lack of quoracy.
- Medicines Management Sub-Committee reviewed the proposed Practice Pharmacist New Costs Saving Areas. The decision to approve the documents was to be ratified at December meeting due to lack of quoracy.

ENCLOSURE: O (vi)

Agenda Item: 18/16

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 28 January 2016

Quality and Safety Sub-Committee (QSSC) - Executive Summary
Meeting held on 3 September 2015

Chair: Dr Sonia Khanna-Deshmukh

1. Conflicts of interest: Mary Currie advised that she is currently working as Interim Director of Governance and Quality at NHS Bromley CCG and Dr Nikita Kanani in respect of the re-procurement of the anticoagulation service as the surgery where she works currently provides this service. No mitigating action necessary.

2. Updated re-procurement of tier 1 anticoagulation service; service specification. The Q&SCC asked for amendments to be made and the paper resubmitted.

3. The health of looked after children annual report 2014/15 was approved. The priorities for 2015/16 as laid out in section 12 of the report were noted.

4. The safeguarding children annual report 2014/15 was approved to go to the Governing Body and noted the priorities for 2015/16 as laid out in section 7 of the report.

5. The safeguarding adults annual report 2014/15 was approved for submission to the Governing Body.

6. Our healthier South East London CCG engagement – local assurance: the Q&SSC approved the CCG engagement plans and noted the presentation, which would be discussed at the Governing Body.

7. Learning disabilities mortality review (leDeR) programme. The Q&SSC noted the contents of the leDeR Programme, associated papers and programme outcomes expected. It was noted that no firm date has yet been issued for the roll out of the programme and the date that this will be effective within Bexley. It was agreed that further discussion would be necessary on who within the CCG would lead on the phased implementation of the programme

8. Provision of maternity services for Bexley women: the system for pregnant Bexley women was fragmented as there is a choice of home birth and three hospitals, Princess Royal University Hospital, Bromley; Lewisham and Greenwich NHS Trust, Lewisham, and Darent Valley Hospital, Dartford. The issues related to PRUH and DVH being unable to offer ante natal and post natal services to all Bexley postcodes due to time constraints on midwives travelling greater distances, even though they deliver babies for any Bexley postcode. An action plan was requested to come to the next meeting that resolves the issue.

9. The integrated quality safety and performance provider report (September 2015) was reviewed and would be discussed at the Governing Body.

10. Care homes quality monitoring update: there had been a decrease in London Ambulance Service call out and hospital admissions from Care Homes and a big decrease in falls.

11. Matters escalated by the safeguarding commissioning standing committee – minutes dated 3rd August 2015. There were no matters to be escalated and the minutes were noted.

12. Individual funding request report Q1 2015-16 report was noted. The report showed an overall reduction in the number of applications, with a slight increase in the number approved.

13. Bexley wound care pilot evaluation April 2014 - March 2015. An evaluation of the pilot had been conducted which had showed that despite an increase in the complexity of wounds, district nurses had been able to increase the cost effectiveness of dressings; formulary compliance had increased; and positive feedback had been received from patients.

14.. Risk register: the current risks were confirmed and it was agreed that CDiff and Maternity should be added.

15. Hurley group urgent care centre prescription audit report: Overall the stock control, distribution, destruction and storage of prescriptions at both sites were found to be of a very high standard. One issue was identified at Erith UCC in that prescriptions were stored in a locked drawer but there was no lock on the office door. This has since been rectified.

16. Patient experience report (annex to Quality report). The administration of Ophthalmology appointments was of concern as the Emergency Eye Referral Unit has limited availability and patients are referred on to UCC, thereby incurring double costs. Optometrists also need to be able to refer direct to Ophthalmology rather than referring patients via their GP. A Clinical Summit is a possible option in respect of Ophthalmology and David Parkins and Dr Nikita Kanani would meet outside the meeting to discuss the Ophthalmology pathways.

17. RCA and action plan management process. It was agreed that action plans to ensure learning was embedded should be reviewed at regular weekly meetings already held. If assurance was not received this should be escalated to CQRG. Themes could be reviewed to inform commissioner led audits.

18. SEL NHS 111 reports. The Q&SSC noted the NHS 111 clinical governance report and the performance report for July.

19. Cancer waits update. The Q&SSC noted the Cancer Waits Update Report, the position regarding Cancer waiting times and the monitoring / actions being taken.

Date of next meeting: Tuesday 19th November 2015 (9.30am – 11.00am), subsequently changed to 14th January 2016.

ENCLOSURE: O (vii)

Agenda Item: 18/16

NHS
Bexley
Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 28 January 2016

Information Governance Sub-Committee (IGSC) - Executive Summary
Meeting held on 17 November 2015

Chair: David Parkins (DP) Caldicott Guardian

1. No conflicts of interest were raised.

2. The IG Framework document was approved in line with the IG toolkit requirements.

3. The Data Loss and Encryption Policy, the E-mail and Internet Policy, the Registration Authority Policy, the ICT Equipment and Disposal Procedure Policy, the ICT Disaster Recovery Plan, the Safe Haven Policy and the Privacy Impact Assessment Policy were all approved.

4. Revised IG Induction programme, a new IG area has been developed on the Bexley CCG intranet which contains key information relating to IG and links to appropriate documents, policies and training information. The revised IG induction programme was approved.

5. IG Training update: current figures for completion of IG mandatory training stands at 65% for IG Refresher/Introduction training and 58% for Records Management NHS Code of Practice. A reminder to be put in the staff bulletin.

6. Communications Plan 2015-16 bi-annual review was approved

7. The Records Management Plan was reviewed. Agreed to have further discussions outside the meeting update the plan prior to the next meeting in January.

8. The NHS Numbers project plan and audit 2015-16 was approved. The CCG now have only two departments that use the NHS number; Continuing Health Care and Adult Commissioning Services. Both these departments completed the audit achieving a coverage level of 100%.

9. IG Risk Register: risks were discussed in relation to Commissioning department, WiFi and paper records in CHC One of the developments in the Continuing Health Care department is the use of digital pens which will allow transcribing notes to be stored electronically. Future discussion regarding options to migrate records to electronic format. Internal and external data flows are continually monitored as part of the IAR and DFM audit and this risk will remain on the register to be monitored.

10. Information Governance Management - IG Development plan update: To date the CCG has obtained four level three requirements on the IG Toolkit and it is estimated that following the numerous policy reviews, reports and documents from the November meeting the level three achievements will increase to approximately 20 by January 2016.

11. The Incident Management and Serious Incident management policy will be presented to the Quality and Safety Sub Committee for approval. Feedback from the IG SC was requested prior to the policy being presented to the Quality and Safety committee in January.

12. IG Incident management report: One incident has been reported; whereby post has been found dropped behind furniture within the reception postal area. This was standard post and did not have any repercussions regarding any patients or service users. To eliminate this incident occurring again furniture has been moved and a tidy up of the area has been completed

13. Bi-annual Security Assurance report: This provided information relating to security access controls audits, anti-virus and internet security incidents, security spot checks and mobile devices.

14. The Data Protection and Caldicott Guardian bi-annual report provided details relating the number of Subject Access Requests (SAR) received over the past six months.

15.. Registration Authority (RA) was approved. There have been no reported RA incidents reported during the time.

16. 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). 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

17. Bexley CCG Privacy Notice review and patient engagement update: In order to gain level 3 on this requirement the privacy notice must be independently reviewed by service users. With the assistance of the Patient Experience Team, members of the Patient Council were engaged in a meeting on 15th September to review the CCGs Privacy Notice. One response was received that suggested the information should be in plain English. Following these comments, discussions have taken place with the Communications Team, who have confirmed that the privacy notice has been written with patients in mind and using the plain English campaign.

18. Freedom of Information report – Quarter 2 July – September 2015. FOIs responded to within 20 days met 100% achievement for this quarter, meeting the 92% target.

13. Information Asset Register and Data Flow Mapping Plan: The CCG complete quarterly reviews of the IAR/DFM, with the most recently being completed in October 2015, which has been signed off by the Senior Information Risk Officer (SIRO).

14. Date of next meeting: Tuesday 12th January 2016 (9.30am – 11.00am).