Primary Care Joint Committees (PCJC)

20 October 2016

Meeting held at:

Main Hall, 1st floor, Deptford Lounge, Deptford Library, 9 Giffin Street SE8 4RJ

6pm to 8:30pm on 20 October 2016

Minutes

Meeting Chair Greg Ussher (GU)

Secretariat Tom Bunting (TB)

Bexley Primary Care Joint Committee

Attendees:

Paul Cutler (PC)	Member	Committee Chair (Lay Patient Public Involvement)
Keith Wood (KW)	Member	Committee Vice Chair (Lay Governance)
Sarah Blow (SB)	Member	CCG Chief Officer
Dr Nikita Kanani (NK)	Member	CCG Chair
Mary Currie (MC)	Member	Governing Body Nurse
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Theresa Osborne (TO)	Member	CCG Chief Financial Officer
Lotta Hackett (LH)	Observer	Bexley Healthwatch

Apologies:

Dr Sid Deshmukh	CCG Governing Body GP
Dr Jane Fryer	NHS England – Medical Director for South London
Councillor Teresa O'Neill OBE	Health and Wellbeing Board
Dr Richard P Money	Bexley LMC

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	Governing Body Nurse
Dr Andrew Parson (AP)	Member	CCG Chair
Dr Angela Bhan (ABu)	Member	CCG Chief Officer
Dr Atul Arora (AA)	Member	CCG Clinical Lead (representing Dr Ruchira Paranjape)
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Dr Rishi Chelvan (RC)	Observer	Joint Vice-Chair Bromley LMC (representing Dr Mukesh Sahi)

Apologies:

Dr Ruchira Paranjape	Governing Body GP
Dr Jane Fryer	NHS England – Medical Director for South London
Linda Gabriel	Bromley Healthwatch
Councillor David Jeffreys	Health and Wellbeing Board
Dr Mukesh Sahi	Observer – LMC

Greenwich Primary Care Joint Committee

Attendees:

Dr Greg Ussher	Member	Committee Chair (Lay Patient Public Involvement)
Jim Wintour (JWi)	Member	Committee V Chair (Lay Governance)
Maggie Buckell (MB)	Member	Registered Nurse GB member
Dr Iyngaran Vanniasegaram (IV)	Member	CCG Governing Body - Secondary Care Clinician
Regina Shakespeare (RS)	Member	Acting CCG Chief Officer
Dr Ellen Wright (EW)	Member	CCG Chair
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Fana Hussain (FH)	Observer	CCG Primary Care Manager
Rikki Garcia (RG)	Observer	Greenwich Healthwatch
Dr Tuan Tuan (TT)	Observer	Greenwich LMC
Councillor David Gardner (DG)	Observer	Health and Wellbeing Board

Apologies:

Dr Jane Fryer	NHS England – Medical Director for South London
Dr Nayan Patel	CCG Governing Body GP

Lambeth Primary Care Joint Committee

Attendees:

Graham Laylee (GL)	Member	Committee Chair (Lay Patient Public Involvement)
Andrew Eyres (AE)	Member	CCG Chief Officer
Andrew Parker (AP)	Member	CCG Director of Primary Care Development
Dr Martin Godfrey (MG)	Member	CCG Governing Body Clinical Member
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Dr Rebecca Farrell (RF)	Observer	LMC Vice Chair

Apologies:

Sue Gallagher	Committee Chair (Lay Patient Public Involvement)
Dr Adrian McLachlan	CCG Chair
Professor Ami David MBE	Governing Body Nurse
Dr Jane Fryer	NHS England - Medical Director for South London
Councillor Jim Dixon	Health and Wellbeing Board (Lambeth)
Catherine Pearson	Healthwatch (Lambeth)

Lewisham Primary Care Joint Committee

Attendees:

Ray Warburton OBE (RW)	Member	Acting Committee Chair (Lay Governance)
Martin Wilkinson (MW)	Member	CCG Chief Officer
Dr Marc Rowland (MR)	Member	CCG Chair
Dr Jacky McLeod (JM)	Member	CCG Clinical Director
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Peter Ramrayka (PR)	Observer	Health and Wellbeing Board
Ashley O'Shaughnessy (AO'S)	Observer	Associate Director, Commissioning

Dr Simon Parton (SP)	Observer	LMC

Apologies:

Rosemarie Ramsey MBE	Committee Chair (Lay PPI)
Professor Ami David	CCG Governing Body Nurse Member
Dr Jane Fryer	NHS England - Medical Director for South London
Nigel Bowness	Healthwatch

Southwark Primary Care Joint Committee

Attendees:

Joy Ellery (JE)	Member	Committee Chair (Lay PPI)
Richard Gibbs (RG)	Member	Committee Vice Chair (Lay Governance)
Dr Emily Gibbs (EG)	Member	CCG Governing Body GP
Dr Jonty Heaversedge (JH)	Member	CCG Chair
Liz Wise (LW)	Member	NHS England – London (Director of Primary Care)
Caroline Gilmartin (CG)	Observer	CCG Director of Integrated Commissioning
Malcolm Hines (MH)	Observer	CCG Chief Financial Officer

Apologies:

Andrew Bland	CCG Chief Officer
Professor Ami David	CCG Governing Body Nurse Member
Dr Jane Fryer	NHS England - Medical Director for South London
Councillor Maisie Anderson	Health and Wellbeing Board (Southwark)
Aarti Gandesha	Healthwatch (Southwark)
Dr Penny Ackland	Southwark LMC

Other attendees:

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

Item		Action
1.	**Introduction and apologies** GU welcomed members, observers and members of the public to the ninth meeting of the Primary Care Joint Committees of: • NHS Bexley CCG and NHS England • NHS Bromley CCG and NHS England • NHS Greenwich CCG and NHS England • NHS Lambeth CCG and NHS England • NHS Lewisham CCG and NHS England • NHS Southwark CCG and NHS England GU informed members, observers and members of the public that the meeting was to be held in two parts, and that part one was a meeting held in public, rather than a public meeting. GU advised that the meeting would be recorded to help to ensure accuracy of the minutes, which would be published in advance of the next meeting, at which point they would be formally approved by the Joint Committees. GU apologised on behalf of the Secretariat to all Joint Committees and to members of the public for the late distribution and publication of the papers for this evening's	

meeting. This was caused primarily by a technical issue, but GU advised that the Secretariat was working with the Joint Committees to review planning processes to ensure that this would be avoided in future.

Apologies received in advance of the meeting:

Dr Sid Deshmukh	Bexley Primary Care Joint Committee - Member	CCG Governing Body GP
Councillor Teresa O'Neill OBE	Bexley Primary Care Joint Committee - Observer	Health and Wellbeing Board
Dr Richard P Money	Bexley Primary Care Joint Committee - Observer	Bexley LMC
Dr Ruchira Paranjape	Bromley Primary Care Joint Committee - Member	Governing Body GP
Councillor David Jeffreys	Bromley Primary Care Joint Committee - Observer	Observer - Health and Wellbeing Board
Linda Gabriel	Bromley Primary Care Joint Committee - Observer	Bromley Healthwatch
Dr Mukesh Sahi	Bromley Primary Care Joint Committee - Observer	LMC
Dr Nayan Patel	Greenwich Primary Care Joint Committee - Member	Governing Body GP
Sue Gallagher	Lambeth Primary Care Joint Committee - Member	Committee Chair (Lay Patient Public Involvement)
Dr Adrian McLachlan	Lambeth Primary Care Joint Committee - Member	CCG Chair
Professor Ami David MBE	Lambeth Primary Care Joint Committee - Member	Governing Body Nurse
Jackie Ballard	Lambeth Primary Care Joint Committee - Member	Associate member, Lambeth CCG Governing Body
Catherine Pearson	Lambeth Primary Care Joint Committee - Observer	Healthwatch
Councillor Jim Dixon	Lambeth Primary Care Joint Committee - Observer	Health and Wellbeing Board
Rosemarie Ramsey MBE	Lewisham Primary Care Joint Committee - Member	Committee Chair (Lay PPI)
Professor Ami David	Lewisham Primary Care Joint	Governing Body Nurse

	MBE	Committee - Member	
	Nigel Bowness	Lewisham Primary Care Joint Committee - Observer	Healthwatch
	Andrew Bland	Southwark Primary Care Joint Committee - Member	CCG Chief Officer
	Professor Ami David MBE	Southwark Primary Care Joint Committee - Member	Governing Body Nurse
	Councillor Maisie Anderson	Southwark Primary Care Joint Committee - Observer	Health and Wellbeing Board
	Aarti Gandesha	Southwark Primary Care Joint Committee - Observer	Healthwatch
	Dr Penny Ackland	Southwark Primary Care Joint Committee - Observer	LMC
	Dr Jane Fryer	Member - NHS England (London region)	Medical Director South London
	Matthew Trainer	Member - NHS England (London region)	Director of Commissioning Operations

2. Declaration of Interests

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

Name	Joint Committee	Change
Dr Arora Atul	Bromley	• Principal GP at Sundridge Medical Practice. • Clinical Advisor for EMDOC, Bromley Healthcare. (sessional remuneration for advisory work) • SSAFA CIC (Charity supporting military families) - Clinical Advisor (Consultancy fees of £500 p.a. received). • Chair/speaker at educational meetings and speaker at meetings operated by pharmaceutical companies for which

			payment at the rate of c £75 per hour is received.	
3.	**Minutes of the last meeting** EW (Greenwich Joint Committee) requested the following correction (from item 10, public open space): *ABu said that following the further engagement and consultation that decisions on whether to open a branch surgery in the Horn Park Estate and whether to close the nurse-led service would be taken at Greenwich CCG's ~~Primary Care Joint Committee~~* **Financial Recovery Board** *meeting on 24 September.* There were a number of errors in the list of attendees from the Bexley Joint Committee as their job titles were incorrectly shown. The minutes were otherwise agreed to be an accurate record of the meeting. **Action log** It was noted that: • Action 1 would be taken offline via the Southwark CCG engagement team, as TB had not received a response from Mr Kapoor (requesting further information on the issues he had raised at the 29 June south east London PCJCs meeting regarding access to sign language interpreters). The CCG confirmed sending multiple emails to Mr Kapoor on this matter. • Action 2 remained open. RG (Southwark Joint Committee) gave a brief update on behalf of Andrew Bland (not present) who chairs a joint working group on the development of co-commissioning Terms of Reference, in the context of (i) their respective twelve-month review points, (ii) the guidance on management conflicts of interest that had recently been published by NHS England, and (iii) the potential for south east London CCGs to make applications to NHS England to become fully delegated (level 3) commissioners of primary care services. The working group comprises governance leads from each of the six south east London CCGs, as well as RG himself (as the representative of the six CCGs' audit committee chairs). • RG reported that the working group had held its initial meeting on 12 October, at which good progress had been made, and from which an overall consensus of approach for south east London CCGs was emerging. A further meeting had been scheduled for 9 November, which was expected to be the final meeting, from which recommendations would be made to each CCG to consider. • ML (Bromley Joint Committee) said more recent guidance on management of conflicts of interest had been released by NHS England, and that this would need to feed into the process and the recommendations being put to the CCGs on this by the working group. SB (Bexley Joint Committee) added to this, advising that the consultation on this matter (being led by NHS England) was still ongoing, which could potentially result in further changes to the guidance, and that therefore the best approach would be to defer final decisions on this by CCGs until all available guidance was finalised and	

	released. • For actions 3 and 4, JWe advised that these points would be addressed at the next meeting when the next iteration of the Quality and Performance report would be presented to the Joint Committees. • Action 5 had been closed, as each Joint Committee had opted to take forward locally the matter of addressing current levels of performance on patient satisfaction with getting through on the telephone to make appointments at their registered practice (as shown in recent quality and performance reports). • RW asked AO'S (both Lewisham Joint Committee) to give a brief update on the response taken by Lewisham CCG in response to this issue. AO'S advised that actions taken by the CCG included contacting practices that had performed well historically (as well as those practices whose performance had recently improved) in this area, to capture best practice and share this with other GP practices in the borough. The CCG had also placed a focus on the use of online services for patients to make appointments in that way rather than via the telephone, and had facilitated a targeted piece of work with Patient Participation Groups (PPGs) for practices across the borough to gather ideas on how they might be able to support improvements for patients in terms of getting through on the phone to their practice, working with their practice to look at how systems might be improved to enable this. • None of the other Joint Committees commented on this matter.	
4.	**Matters arising** <u>Overview from Director of Primary Care, NHS England (London Region)</u> LW gave brief updates on the General Practice Forward View (GPFV) and the PMS review. General Practice Forward View (GPFV) update: LW reminded the Joint Committees of the position as at the previous meeting, at which point NHS England had given notification of the GPFV funding streams that would be allocated to all regions. LW reported that resilience funding for 2016-17 in London was confirmed as £2.6m, which had now been received by NHS England (London region) and which would be allocated notionally on a three way split across London (by Director of Commissioning Operations (DCO) "footprint": north east, north west and south London). NHS England (London region) had worked extensively with the CCGs and Sustainability and Transformation Plan (STP) leads in London to work this down to granular levels of allocations at borough level. LW thanked the south east London CCGs for the huge amount of work that had been put in during the past few weeks toward the development and submission of general practice resilience and development plans. LW advised that in the middle of October NHS England (London region) had received from the national team a list of practices that (on initial review against the criteria set) had been judged to have met the resilience criteria set by NHS England. Plans for communications with these practices were being finalised at the time of the meeting. These plans also set out the priority areas for the resilience programme and the	

	provider development programme (the latter of which is being led by the Healthy London Partnerships under its primary care programme). Furthermore, these plans would be reviewed via the newly-established London Provider Development Working Group, which incorporated all Sustainability and Transformation Plan (STP) area leads for primary care, and LMC leads. The level of resources to support local provision of additional extended access to general practice was being negotiated by NHS England's national team with each of the regional teams. For London, agreement had been reached for the process to apply this, and the NHS England London region team had also gained agreement with the NHS England national team for this to be applied for in hours as well as out of hours GP services, as per discussions with the CCGs with whom NHS England (London region) was working to roll out these plans. The amount of resource was yet to be confirmed at the time of the meeting, but it was expected that this would be confirmed soon. Discussions were ongoing between co-commissioners around which additional local extended access programmes would commence in 2016-17 and in 2017-18, including the agreement of plans for boroughs where this was not already commissioned. LW reminded Joint Committees that there will also be resource allocated for training for clerical and reception staff in general practice, which would come directly to CCGs. The NHS England national team had also identified that resources would be allocated to each of the regions to support the delivery of the GPFV for 2016-17 and for the subsequent two years. LW said that her team in London had already been working with STP leads from across London to agree the best way to utilise these resources, to ensure that there is clinical and non-clinical leadership to support this work across London, and most importantly to ensure that resources would be in place to provide the additional staffing in general practice to help to deliver the priority areas of the GPFV, in particular provider development and provider transformation. LW reported NHS England (London region) had secured approval at the national level for a proposal on applying these resources across London. LW said that the London team was currently working through the detail of the plan to mobilise the proposal, and that there was a hope and expectation that NHS England (London region) would be in a position to give the go-ahead to CCGs to commence appointing additional staff resource to support this, during the next few weeks. LW advised that the governance of NHS England (London region)'s Transforming Primary Care Implementation Board (PCIB) had been reviewed to incorporate representation from Health Education England (HEE) in its membership, as it was agreed that the expertise of HEE was required to help the PCIB to deliver the GPFV in London (in accordance with its extended remit to do so). LW said that the initial meeting of the General Practice Forward View Oversight Group (GPFVOG, the new name for the PCIB in light of the extension of its remit and membership) was scheduled to take place on 25 October. NHS England (London region) were in the process of engaging with the Londonwide LMC to establish what its role will be in this governance framework to support GPFV delivery. NHS England (London region) had also proposed that delivery groups would be established that would report to the GPFVOG, to deliver against the priority areas of the GPFV, in (i) extended access, (ii) workforce, (iii) provider development, (iv) the technology/virtual general practice/GP online agenda.	

	Personal Medical Services (PMS) update: LW gave a brief update. She advised that in formal terms, the pause on negotiations between NHS England (London region) and the Londonwide LMC on the London offer was still in effect. However, there had been a series of informal discussions between Anne Rainsberry, NHS England (London region) and Dr Michelle Drage (Londonwide LMC) in recent weeks that had been positive. The discussions had focused broadly on the PMS review and the work required toward sustaining and transforming general practice across London, and how commissioners and the Londonwide LMC could work together to achieve this. A number of proposals around communications on the next steps had been discussed, and it was hoped that a joint announcement that NHS England (London region) and Londonwide LMC would be made in the next days, that would signal the restart of formal discussions toward agreement on PMS. LW also advised that the Londonwide LMC had produced a useful vision document on health and wellbeing in London that had clear alignment with the local work on STPs. <u>Estates and Technology Transformation Fund (ETTF) update</u> JWe gave an update and explained that no formal paper had been prepared for this meeting because the NHS England (London region) was still in the process of leading the prioritisation of ETTF schemes across London. LW said that an announcement had been made on 19 October by Simon Stevens (Chief Executive of NHS England) which had stated that approximately 300 ETTF schemes are to be supported for their delivery during 2016-17 (provided that they meet a set of financial due diligence checks that would be applied by NHS England as standard). The announcement also confirmed the number of ETTF schemes that had been completed during 2015-16 in England (which was 560, which were mainly GP premises schemes), and the number of schemes from 2015-16 that were still in progress (316). The announcement stated that one region in England had completed its review of all its schemes (Midlands and East of England region). The announcement also published the list of schemes that were being supported in 2016-17 and for which financial due diligence would be commenced shortly. JWe advised that all regions will be required to publish their approved schemes. It is expected that South east London will publish its schemes as soon as possible after 31 October 2016. The process for the prioritisation of the London ETTF schemes was in its closing stages. JWe said that there had been a strong collaboration between STP system leads and CCGs across London on working through how to rate and prioritise schemes that are in the London “pipeline” of schemes. JWe reminded the Joint Committees that in July, 304 schemes in London had passed the four initial assessment criteria set by NHS England (national team), out of 357 schemes submitted by CCGs at that stage. Those 304 schemes were then reviewed again, to be prioritised against their CCG’s local estates strategy, local digital roadmap strategies, and in accordance with their STP system strategies, and assessed for the likelihood of their delivery (London criteria had been applied to this latter point). The next stage of the process was for the final sign-off of schemes at the London level, in accordance with NHS England (London region)’s governance processes. JWe said that this was expected to be completed in the next two weeks. The announcement by Simon Stevens also included a commitment to the	

	prioritisation of those schemes whose delivery will be achieved during 2016-17. Once NHS England (London region) had approved the phased three year pipeline of schemes, it would write to "scheme owners" (this could either be CCGs or GP practices) to confirm that these schemes could commence. JWe advised that NHS England (London region) was working with STP leads and CCGs to get these agreed as quickly as possible. JWe said that "commencement" of a scheme could mean different things for different schemes, for example it could either mean the commencement of production of a Business Case for a scheme, or it could mean the commencement of contacting prospective suppliers required for the delivery of a scheme. Finally, JWe thanked all of the CCGs for their considerable efforts on this work. <u>NHS Bexley CCG: Westwood Surgery Remedial Action</u> This update was given to inform the Joint Committee on two matters that were outstanding from the Primary Care Joint Committee meeting held in March 2016. 1. JWe advised that the CQC had carried out an inspection of the practice on 28 August 2015. This had resulted in the grading of the practice as "inadequate" and the CQC had then placed the practice under special measures. NHS England (London region) had issued a breach and remedial notice in November 2015 as the practice had failed to comply with Regulation 12 of HSCA 2008, which the practice required to address within 28 days through an action plan. The practice subsequently submitted an action plan confirming compliance with the recommendations and had requested a revisit from the CQC, which was carried out on 18 May 2016. The report of this inspection had been published on 22 September 2016, which gave the practice an overall rating of "good", and confirmed that practice was no longer in special measures. It had been hoped that this could have been reported at the previous PCJCs meeting on 18 August, but the results of the report were not in the public domain at that time so it was not appropriate to do so. This outcome was welcomed by the Bexley Joint Committee. 2. Westwood Surgery had two partners, and three salaried GOs. One of the partners had requested removal from the contract with effect from 31 March 2016. It was proposed that the remaining partner remained the sole PMS contract holder at Westwood Surgery following the retirement of the other partner, for a period of no more than six months at which point Dr Charlotte Letton and Dr Edwin Lim would join the partnership (this was agreed by the Bexley Joint Committee at its meeting in March 2016). JWe reported that the requested contract variation (the addition of further signatories to the PMS contract) had not taken place, and that it looked unlikely that it would do in the short term. The remaining partner (Dr Moir) was actively pursuing possible partnership candidates. JWe said that the practice had managed to take on new salaried GPs and that this was reassuring. NHS England had requested a further update on this in three months, by which time it is anticipated that the partnership plans will have progressed. <u>NHS Greenwich CCG: Horn Park Branch</u> At the south east London PCJCs meeting on 18th August, the Greenwich Joint Committee has agreed to the endorsement of Greenwich CCG and NHS England's proposal to offer the site at 65 Sibthorpe Road to qualifying GP practices in Greenwich as a branch surgery. This followed a request by the Greenwich Health	

	Overview and Scrutiny Committee to explore the potential to offer the above site to local GP practices in Greenwich as a branch surgery and came about as a result of Greenwich CCG's proposal to cease funding the nurse-led service (The Source) at the same location. NHS England (London region) had subsequently issued a specification and asked for expressions of interest amongst local practices. JWe said that unfortunately no response had been received from any practice at this stage, although it was understood that some practices had indicated a willingness to potentially consider this in future. Co-commissioners will leave open the opportunity for practices to come forward in response to this. Prior to the closure of the site on 30 September 2016, information showing the utilisation of the facility during the preceding 12 months had been reviewed (as referred to at the previous meeting). Of the 425 regular users that had been identified as part of the information gathering exercise who were not registered with a GP practice, a list of alternative local practices had been sent to them so that they could register elsewhere locally. JWe said that the information had shown that the vast majority of patients were registered with another practice. For vulnerable patients for whom travel to a practice was not possible, JWe said that home visits were available and were being provided (this is a contractual requirement for general practice, subject to clinical need) to ensure continuity of access. EW expressed disappointment on behalf the Joint Committee at the level of response to the call for expressions of interest for the branch site. EW also said the Joint Committee was grateful that Greenwich CCG could leave open the possibility for expressions of interest. DG (Health and Wellbeing Board representative and observer member on the Joint Committee) thanked JW for this update. DG highlighted concern within the Royal Borough of Greenwich at the closure of the practice. DG said that the public engagement carried out had demonstrated that residents had valued the nurse-led facility at The Source remaining open. DG said that Royal Borough of Greenwich wanted to work with co-commissioners to actively pursue the option of the branch surgery further, citing examples elsewhere in the borough where small practices on estates had worked well. <u>NHS Greenwich CCG: The Slade Medical Centre Dr Sen</u> JWe reminded the Joint Committee that the Slade Surgery single-handed contract had been temporarily suspended by the CQC for up to six months with effect from 18 March 2016. Following this, and due to insufficient time to carry out procurement processes and to ensure continuity of care for patients, short term caretaking arrangements were put in place. Short term caretaking arrangements had been put in place with Plumstead Health Centre (working with the Tewson Road Medical Centre) which commenced on 21 March 2016 for a period of up to six months, from the Garland Road Clinic, whilst the Slade Medical Centre addressed the issues raised by the CQC inspection. That six month period ended on 21 September 2016. JWe reported that in the interests of continuity of quality care for patients, and in light of the fact that the Slade Surgery had not fully addressed all concerns raised by the CQC inspection report (this was assessed to be the case by the CQC following a further visit in late September 2016), that an extension of the suspension of the Slade Surgery contract had been agreed by co-commissioners and put in place for a further period of six months from the 21 September. The caretaking arrangements described above had	

	been extended for this timeframe and JWe expressed gratitude to the Plumstead Health Centre and the Tewson Road Medical Centre for this. JWe also confirmed that the practice was being supported by co-commissioners to address the concerns raised in the CQC inspection report. The Greenwich Joint Committee noted this update. <u>NHS Lambeth CCG: Crown Dale / Norwood Surgery Merger</u> Following agreement at the previous south east London PCJCs meeting for Crown Dale and the Norwood Surgery to merge on 1 October 2016, the practice had since been in discussion with local LMC representatives to facilitate the terms of the partnership agreement and the contractual terms for the retirement of Dr Fernandes. NHS England commissioning managers had not been made aware of the practice's intentions for Dr Fernandes to retire as this had not been included in the business case. JWe advised that the ongoing discussions regarding the terms of the partnership agreement had brought about a number of issues that had resulted in the further delay of the merger by a month (to 1 November 2016), which had been agreed by Lambeth CCG and NHS England (London region). One impact of the delay had been that patients registered with the merging practices had received correspondence stating that the merger would take effect from 1 October. JWe advised that patients were routinely being informed of updates regarding the merger when they contacted either practice, and that patients would not have been inconvenienced as a result of this, as they continue to receive services from the same site as they had previously. The Lambeth Joint Committee noted this update. <u>NHS Southwark CCG: Avicenna Health Centre</u> JWe reminded the Joint Committee that, (as reported at the previous meeting on 18 August), the Avicenna Health Centre CQC registration had been temporarily suspended by the CQC for up to 3 months with effect from Monday 16 May 2016, and that a reinspection of the practice by the CQC had been scheduled for 9th August. Following that reinspection the CQC had given notice that it had lifted the temporary suspension at the Avicenna Health Centre as the two primary conditions contained in its earlier report had been met. At the time of the previous meeting the practice remained in Special Measures. JWe advised that following a clinical handover from the Aylesbury Partnership (now part of the Nexus Group) as the caretaker service provider, it had been agreed by co-commissioners and the CQC that the practice would come out of special measures and JWe reported that the practice had reopened on 1 September 2016. No patient complaints had been reported since this development, and JWe advised that a number of considerable improvements had been demonstrated by the practice, including a new patient appointments system that better met patient's needs, and that this would be revised and adapted as necessary in future. The Southwark Joint Committee noted this update.	

3.	**Public Open Space** GU advised that no written questions had been submitted by members of the public in advance of the meeting. GU advised that the Secretariat had received a complaint from a patient registered at a GP practice in Greenwich, and that Greenwich CCG was investigating this matter with the practice accordingly. Frances Hook (Keep Our NHS Public, Greenwich) raised a concern regarding the Sustainability and Transformation Plans (STPs). Frances said that the public required complete transparency of the STPs, so that any impact they might have to patients regarding services locally would be set out clearly to the public in each borough. Furthermore that the STPs should not place financial efficiencies above provision of quality services for local people. SB (Bexley Joint Committee) said that co-commissioners in south east London were intending to be fully open and transparent on all aspects within the STP and particularly any aspects that are most relevant to services for patients locally. CCGs were presently waiting for the agreement of NHS England for local STPs to be published, and would do so as soon as this was given. SB also advised that it was fully expected by local commissioners that there would be no content in the south east London STP that local people would not recognise. This was because CCGs in south east London had carried out an extensive engagement programme with the public across all south east London boroughs, to proactively set out all of initiatives with the STP and that a document summarising this has been published following this engagement, to ensure that there would be no surprises within the STP in the view of the public following its publication. Responding to the concern raised about efficiencies, SB said that whilst there was a need to deliver efficiencies in the NHS on a national scale, the focus of the STP was not to cut provision of local services, but rather to ensure the delivery of sustainable services locally by thorough and essential planning against the demand forecast on our health and care services locally. SB said that the STP process would mean a linked growth in both funding and of demand for services across the London over the course of the next 5-10 years, noting that the levels of demand on services would be growing at a greater rate. Therefore the STP process was set up to ensure that services were delivered with more efficiency, to prepare for the further increased levels of demand that were anticipated in future. The detail of the growth in terms of funding and anticipated demand on services for the south east London health system will be set out within the STP. DG (Greenwich Joint Committee) acknowledged that Frances Hook had raised an important point. DG noted that some STPs in other parts of the country had already gone into the public domain and that unnecessary concern (over what might be included within the STP) might be generated amongst local populations if publication of an STP is delayed unduly. DG noted in south east London, the engagement carried out by the Our Healthier South East London (OHSEL) team had been a useful and informative exercise for local people on this matter. DG encouraged that the publication of the south east London STP should be published as soon as possible, even in spite of any restrictions on this that might have been applied by NHS England. MW (Lewisham Joint Committee) reiterated the point made by SB regarding the measures taken by local CCGs to ensure full transparency of the emerging STP. All	

	CCGs in south east London wanted and intended to publish the STP as soon as possible. Prior to the completion of the final version of the STP and authorisation from NHS England to publish it, there were a range of ways to proactively inform the public and local interest groups on the content of the STP, and that south east London CCGs were taking this forward in a number of ways. MW advised that a briefing session with interest groups in south east London had taken place to proactively describe the planned initiatives within the STP and to address any concerns raised about these, and that a further session would take place following submission of the draft STP to NHS England (on 21 October) that would look at the financial aspects of the STP in detail, to respond to any concerns raised on this by local interest groups. Frances Hook made a further comment, stating that the NHS Five Year Forward View had not been included within the present government's 2015 election manifesto, or referred to in the 2012 Health and Social Care Act. Frances Hook described the STP as having no legal standing and suggested that a number of Trust Chief Executives from a range of localities nationwide had refused to sign off the STP for their area. Frances acknowledged that capacity to provide services was a significant problem across the country due to ongoing increases in demand, and said that any closure of services would not be the answer to the problem (referring to a number of services that she asserted had been closed in local neighbouring boroughs in south east London since 2000, including Queen Marys Hospital, Sidcup). SB (Bexley Joint Committee) responded to the latter point, and said that Queen Marys Hospital, Sidcup was very much still open and that it had an excellent unit. Commissioners were pleased to advise that a new Cancer Centre would shortly be opening at the Hospital. Martin Dadswell (Co-Chair of Albion Street practice PPG and member of Southwark Engagement and Patient Experience Committee) commented on the new Guys and St Thomas' NHS Foundation Trust Cancer Centre that had recently been opened. Martin had been invited to visit the unit prior to its opening and thanked the Joint Committees for this opportunity and commented that the Cancer Centre looked excellent.	
For discussion		
4.	**Quality, Performance and Finance** <u>Month 5 Finance report</u> RJ introduced the Primary Medical Services Financial Report (Month 5), which had been distributed as Enclosure D. The overall financial position for South East London Primary Medical services showed an underspend of £68k against issued budgets at 5 months to the 31st August. The Year-end forecast variance based on month 5 was largely in line with plan. That position allows for 1% non-recurrent spend to be ring-fenced, which is the requirement of NHS England and of CCGs, as well as the 0.5% contingency. The year to date position includes the non-recurrent benefit of £356k. Further accrual benefit was anticipated to maintain the forecast outturn balances, along with delivery of the 0.5% QIPP and other non-recurrent support. NHS England (London region) was confident that these mitigations would be sufficient at this stage of the year. 2016-17 primary care budgets: the expenditure budgets had been set for each CCG	

	based on contractual commitments and to meet all known and anticipated costs. The average growth in London Medical allocations for 2016-17 is 4.78%, but this does not fall evenly across CCGs due to their differing distance from target. Due to the shortfall on the recurrent QIPP target in 2015-16, there is an underlying deficit to make up on Medical Services in 2016-17. Across London this means in aggregate the 2016-17 cost increases are met by the 4.78% growth. An aggregate QIPP of 0.5% has been included in the plan (*RJ noted that the cover paper had incorrectly referred to this figure as 5%)*, which is forecast to be delivered from transactional savings managed by NHS England, in order to manage this position for level 1 and level 2 commissioners. This will mostly be from the recurrent impact of the rates reductions, reducing premises reimbursement costs. RJ explained that a total of £1.2m recurrent cost reductions were anticipated as a result of this. SP (Lewisham Joint Committee) asked about the QIPP deficit and potential growth monies – and whether there would be no growth monies in 2016-17 as these would be used to cover the QIPP deficit. RJ advised that a proportion of the total growth money for SE London had been used to cover the underlying shortfall on QIPP from 2015-16, which partially explains why the total expenditure budgets were in excess of the published allocations. RJ said that the position had been recovered for 2016-17, that published allocations were now fixed and that the budgets were back to a more steady position than in 2015-16. MH (Southwark Joint Committee) said that the CCGs were required to submit operating plans and budgets for the next two financial years to NHS England, and requested that RJ produce a paper setting out the budget setting process for 2017-18 and 2018-19 and for this to be circulated by early December. RJ agreed to do this. The Joint Committees noted the report and its contents.	**RJ**
For decisions		
5.	**Items for discussion per joint committee:** <u>NHS Bexley CCG: Bexley Group Practice premises relocation</u> JWe gave a brief verbal update. It was originally intended that the Joint Committee would consider a decision to approve the business case for Bexley Group Practice premises relocation at tonight's meeting. Largely as a result of the complexities involved in ensuring that the Business Case for the relocation would address all of the issues that it would be required to, JWe advised that the Business Case was not ready for review by the Joint Committee in advance of this meeting. JWe advised that a decision was likely to be required by the Joint Committee on this in advance of the next Joint Committees meeting, and as such an urgent planned decision would be scheduled by co-commissioners to enable this to happen, in line with the London Operating Model for co-commissioning of primary care services. JWe advised that this was a scheme focused on premises relocation, consolidation and transformation – all elements referred to in the item on ETTF (see above). JWe referred to the need to accelerate high priority ETTF schemes in-year (see above), and advised that this scheme had been rated as a high priority scheme (in the prioritisation process for ETTF schemes). JWe highlighted this as a further important reason to progress this as quickly as possible, as well as the intended benefits that	

would be borne out in the Business Case.

The Bexley Joint Committee noted this update and advised that it would eagerly await the arrival of the Business Case for this scheme.

NHS Bexley CCG: Mill Road Contract Variation

JW introduced Enclosure E, which recommended that the Joint Committee agree to vary the contract with Dr S Sellappah, (a single handed GP at Mill Road Surgery with a PMS contract) to add Dr Bhadra as a signatory to the PMS contract.

JWe explained that a contract variation of this type must come to the Primary Care Joint Committees for decision, in line with the London Operating model for primary care co-commissioning, as PMS contracts are local contracts and therefore cannot be automatically varied.

JWe advised that, as this concerned a relatively small contract, the recommendation on it was at odds to what it might have been without the strategic context provided in the business case. JWe said that the Business Case submitted by the practices had provided a clear understanding of the proposed changes and their benefits and that this proposed change to the Mill Road contract should be regarded as the first stage in a transformation process that would end in the full merger of two PMS contracts, the retirement of Dr Sellappah as a contractor and the closure of Good Health's branch surgery at Barnehurst (the latter being a separate contractual decision, see item immediately below), all subject to the agreement of the Joint Committee. The analysis carried out by co-commissioners (as shown in Enclosure E) had pointed to clear benefits for patients, the practice and commissioners.

If granted, the recommendation to approve the contract variation (as above) will enable the Mill Road surgery site to be retained, thereby affording important access to it for registered patients, and also for more resilient services to be developed in support of this in accordance with the practice merger (these would be completed in the autumn of 2017).

The Bexley Joint Committee confirmed its approval of the recommendation, subject to NHS England receiving and agreeing a Contract Variation Application from Dr Sellappah. The Bexley Joint Committee noted the benefits as set out in the business case, for patients, the practice and for commissioners.

LW gave approval for the recommended approach on behalf of NHS England (London region).

NHS Bexley CCG: Good Health Branch Closure

JWe introduced Enclosure F, which recommended that the Joint Committee approve the notice of proposed closure of the Barnehurst branch of Good Health Practice, which would take effect at the end of January 2017.

Good Health intends to close its Barnehurst Branch Surgery which serves 498 patients (8% of the total 6,200 patients currently registered with Good Health). It is proposed that the Branch Surgery is closed three months following relevant approvals by co-commissioners. Patients currently attending the Barnehurst Branch would be able to attend Erith Health Centre (the practice main surgery), and in the longer term Mill Road Surgery once a proposed practice merger has taken place

	(see above). It was noted that only core services are provided from the Barnehurst branch of the practice, and that the area surrounding the Barnehurst branch is well served by other GP Practices, should patients wish to register with an alternative local GP practice. JWe also advised that the Barnehurst branch surgery needed to be closed by Good Health for reasons of financial viability, which were detailed in Enclosure F. Good Health had engaged with patients and the Patient Participation Group (PPG). The responses to a patient questionnaire had been shared with NHS England - approximately 30 responses had been received at the practice, which had shown no evidence of any insurmountable concerns having been raised by registered patients regarding the proposed closure. Full information on this was included in Enclosure F. LMC engagement on the proposed closure was completed on 04/10/2016, with no adverse comment raised in that process. JWe referred to a number of points raised by Bexley Healthwatch, in response to a letter sent to Healthwatch on this matter by co-commissioners on 10 October. Whilst the overall view of Healthwatch was in support of this approach, feedback had pointed to a need for the intention to engage on this matter to be made known earlier in the process. JWe explained that this had not been possible on this occasion due to the lateness of commissioners' receipt of the associated business case, but that this principle would be followed in future situations like this wherever possible. Healthwatch had suggested that there might be issues for some vulnerable patients brought about by the distance and transport links between the Barnehurst branch and the main surgery. It was noted by JWe that the PPG responses had not indicated any issues about travel between the sites, and that the PPG responses would be made available to Healthwatch in full. Healthwatch had also stated that any closure of practices would need to be carefully considered especially given the ongoing issues of availability of GP appointments. Healthwatch had also indicated that it would have welcomed the opportunity to review the responses of the PPG in detail and to undertake an independent engagement with patients on this. JWe said that co-commissioners would welcome that support and will encourage practices to work with Healthwatch to support their engagement plans. Healthwatch had asked, in addition, for information on the proposals for how patients would be transferred to a new practice and what choice they would be afforded as part of this. JWe advised that NHS England (London region) would be sharing the PPG communications with Healthwatch and would be grateful for any comments on this from Healthwatch. JWe said that patient registrations would remain unchanged and patients would not need to take any action if they wished to remain registered with Good Health. NHS England (London region) will inform patients that they are able to register with another practice if they want to do so, and those patients will be directed to NHS Choices online to help to make this decision. NHS England (London region) will liaise with Healthwatch on the content of the letter before it is issued to patients. Healthwatch had finally asked for information on how access and waiting times will be monitored to ensure that patient experience is not compromised due to the closure. JWe said that the practice had confirmed that appointments that were	

	currently available at the Barnehurst site would be made available at the main branch, including evening appointments. Co commissioners will write to the practices to gain confirmation that there is sufficient capacity at the practice following the closure, pending approval of this decision by the Joint Committee. In summary JWe advised that the view of co-commissioners was that this proposed closure of Good Health's branch surgery at Barnehurst should be regarded as the first stage in a transformation process that will end in the proposed change to the Mill Road contract (see above), the full merger of two PMS contracts, and the retirement of Dr Sellappah as a contractor - all subject to the agreement of the Joint Committee. Furthermore that the overall plan as outlined above aimed to ensure the sustainability of general practice services locally and that local patients would have access to general practice services within a reasonable distance. The Bexley Joint Committee confirmed its approval of the recommendation and also welcomed the feedback received from Healthwatch. LW gave approval for the recommended approach on behalf of NHS England (London region). <u>NHS Bexley CCG: Bexley Care Home Local Incentive Scheme (LIS)</u> TO introduced Enclosure G, which recommended that the Joint Committee approve the Primary Care Support to Care Homes (2017-2020) LIS, on the understanding that all GP practices will have an opportunity to participate within the LIS, with outcomes suitably monitored and reviewed. Furthermore, this would be subject to formal agreement with the LMC. The LIS is revised from a previous scheme in place within the CCG. This scheme was approved by the CCG's Finance Committee on 12 July 2016 and the Quality and Safety Committee on 6 September 2016. The scheme had been discussed with the LMC (which has signalled its agreement in principle with the specification) and a final draft had been sent to the LMC for formal approval. The current three year scheme is due to end on 31 March 2017. The new scheme would be reviewed on an annual basis to ensure that it remains in line with national standards. The scheme fits with a number of strategic and commissioning priorities of the CCG and supports improvement in the quality of primary medical care, as outlined in the paper. The total scheme is valued at up to £207,267. The basic earnings are £127.00 per care home resident, with an additional achievement-based incentive of up to £50 per resident. There is no overlap with existing payments made, as the scheme provides an enhanced service for residents of care homes by encouraging closer working between practices and homes. The Service Specification includes best practice guidelines on; *inter alia*, frailty and End of Life Care, as well as using the NHS Safety Thermometer to ensure successful and uniform implementation across Bexley. All practices are offered the opportunity to participate in the scheme, which is reviewed annually. No incentive payments are made to practices if specified thresholds are not met. JWe reminded all that LIS's are required to be taken to Primary Care Joint Committee meetings for formal agreement in line with the primary care co-	

	commissioning operating model for London. JWe said that the requirements of this LIS were firmly rooted in evidence, and it had been reviewed and fully validated in line with the NHS England (London) Operating Model for primary care co-commissioning. This had been assessed against a standardised template setting out the validation arrangements. The Bexley Joint Committee confirmed its approval of the recommendation. LW gave approval for the recommended approach on behalf of NHS England (London region). <u>NHS Bromley CCG: Bromley Integrated Case Management Local Incentive Scheme LIS</u> ABh introduced Enclosure H, which recommended that the Joint Committee approve the proposal for Bromley CCG to commission the Integrated Case Management (ICM) LIS. The Integrated Case Management (ICM) Local Improvement Scheme (LIS) will provide an enhanced level of care for vulnerable patients that is coordinated through Bromley CCG's new Integrated Care Network's (ICN) Proactive Care Pathway. The purpose of the ICNs is to ensure the sustainability of services to the population of Bromley, with an enhanced focus on prevention and the proactive management of patients. The purpose of the LIS is to introduce a new model for case managing patients most at risk of their health deteriorating, whereby GPs engage in a process of case finding eligible patients, ensuring their needs are being addressed through Multi-Disciplinary Team (MDT) meetings and, reviewing patients to ensure they are stepped down once the patient no longer requires ICM. Delivery of the Bromley CCG Out of Hospital Programme is a strategic priority for the CCG and integrated case management (Proactive care pathway) is a crucial step in mobilising this. The LIS is proposed as a 5 month LIS to be implemented whilst the CCG & NHS England complete discussions relating to the new PMS contract and GMS equalisation. The LIS will improve the quality of care and clinical outcomes for 0.5% of the most vulnerable GP registered adult population of Bromley. The LIS has clear and measurable outcomes and remunerates GPs for the additional work involved in implementing it. The scheme is aligned to the Bromley CCGs Out of Hospital Transformation programme, the aim of which is to provide coordinated care for patients via integrated services and the establishment of three Integrated Care Networks (ICNs), each serving a third of the local population. This will enable services to be more responsive to patients' needs, while ensuring the best possible use of resources, avoiding fragmentation of services and reducing the complexity of the patient journey. This is in line with the OHSEL strategy and commitments from the six SEL CCGs to deliver Local Care Networks. The following outcomes will be collectively delivered and jointly accountable to all members of the MDT, e.g. GP practices, pillar provider organisations, the care coordination team: • Reduced UCC and A&E attendances and admissions • Reduced length of stay in hospital • Better health outcomes for vulnerable people, including the top 2% most at	

risk patients and avoiding deterioration of the second tier down from the most at risk patient
- Improve patient and carer satisfaction with care
- Primarily process outcomes identified at this stage
- Improved self-care and independence of patients for longer
- Support to GPs to manage complex patients, including from social care and the voluntary sector as well as other NHS providers
- Support to GPs to manage the administrative burden of case management
- Improve satisfaction of clinicians and professionals to manage patients more effectively under conditions of increasing demand and complexity

JWe noted that this scheme is different to normal LIS's and it was a greatly innovative scheme that was specific from Direct Enhanced Services (DES) for avoidable unplanned hospital admissions because it is focused on the most vulnerable residents in the borough. The results of the scheme will be keenly anticipated by co-commissioners.

JWe said that the LIS had been reviewed and fully validated in line with the NHS England (London) Operating Model for primary care co-commissioning. This had been assessed against a standardised template setting out the validation arrangements. JWe also said that the LMC had been involved in its development.

JWe also advised that promotion of the LIS to all practices in Bromley would be carried out in order to maximise the support for it.

The Bromley Joint Committee confirmed its approval of the recommendation.

LW gave approval for the recommended approach on behalf of NHS England (London region).

<u>NHS Southwark CCG: Surrey Docks / Albion Street Merger</u>

JWe introduced Enclosure I, which recommended that the Joint Committee approve (in principle) the Business Case for the proposed partnership merger of Surrey Docks and Albion Street practices, to take place from 1 April 2017 onto the renegotiated PMS contract (or a variation of the existing PMS contract for Albion Street Group Practice, should the PMS negotiations not be concluded in time). This will result in a combined list size of just over 24,000 patients covering a combination of their current registration area.

It was proposed that this approval should be subject to:

1. The outcome of consultation with the Oversight and Scrutiny Committee.
2. Confirmation of feedback from Southwark LMC on the merger.
3. Formal approval to the merged practice boundary, taking into account LMC feedback.
4. Confirmation from the practice of the proposed new opening hours across both sites, taking in to account patient views.
5. Evidence that patient and stakeholder views arising from their engagement have – as far as possible – been taken into account, and where this is not possible, an explanation is provided.
6. Evidence of an agreed work plan which will deliver consistent, high quality, safe, compassionate and continually improving primary care across two sites and agreement to include this as a schedule to the merged practice's new PMS

contract. Its inclusion would not be part of contractual performance management, but would enable formal discussion between commissioners and the practice about how expected outcomes within the 2 year transition plan are progressing, and what support can be provided if there are issues preventing the delivery of the plan.

7. An agreed action plan between NHS England/Southwark CCG and the practice to address the areas of underperformance highlighted within this analysis
8. Both practices working with the local GP federation to implement the Southwark Provider Development plan as relevant. This will include developing and optimising workforce and sharing best practice including through the improvement leaders programme.

The proposed merger aligns to NHS Southwark Clinical Commissioning Group's Primary and Community Care Strategy and the General Practice Forward View to deliver primary care at scale within geographical aligned populations. The practice's business case outlines how the merger would support the delivery of local and national strategic priorities including the primary care strategic commissioning framework of proactive, coordinated and accessible care. It includes an analysis of how its current structures limit its ability to deliver local and national priorities and sets out an ambitious plan for the merged practice to address these, which it proposes to develop into a work plan over the next six months.

It was noted that co-commissioners' analysis of the merger proposals was based on both the Business case documentation and the considerable work and communications that had taken place between the practices, NHS England and the CCG in recent months. It was also noted that further work would need to take place to address the matters that the recommended approval was currently 'subject to'.

The Southwark Joint Committee confirmed its approval of the recommendation.

LW gave approval for the recommended approach on behalf of NHS England (London region).

<u>NHS Southwark CCG: Avicenna Care Quality Commission (CQC) Inadequate Breach & Remedial Notice</u>

JWe reminded the Joint Committee of the update regarding this practice, which was given verbally under Matters Arising (see above).

JWe introduced Enclosure J, which recommended that the Joint Committee approve the issue of a breach and remedial notice to the Avicenna Health Centre for the first visit for failure to adhere to and provide:

- requirement to abide by all legislation
- the requirement to have appropriate storage arrangements for vaccines
- requirement to have an effective system of Clinical Governance
- requirement to ensure that the persons providing care or treatment had the necessary qualifications, competence, skills and experience;
- the requirement to provide Essential Services to meet the reasonable needs

	of patients. Dr Kadhim was served with a Section 31 notice and the CQC registration was suspended from 16 May 2016 to 16 August 2016. NHS England put a caretaking arrangement in place with Aylesbury Partnership after the practice was rated as inadequate and placed under special measures on 16 May 2016. Primary care services for Dr Kadhim's patients were provided at one of the Aylesbury Partnership sites (Dun Cow surgery) during the suspension period. Southwark CCG and NHS England (London region) undertook joint meetings with Dr Kadhim after the first inspection to the provide support with the Inspection findings and helped to assess the practice progress against the CQC action plan. Advice and support in relation to policy development and the development of practice systems and processes was offered by Southwark CCG and NHS England and the North Southwark GP Federation - (Quay Health Solutions). The practice also received advice and support from the Londonwide LMC. The practice had improved the following areas during the re-inspection visit: • Staff had undergone training in a number of areas, for example safeguarding, the Mental Capacity Act, chaperoning and basic life support; and additional training had been booked, for example in infection prevention and control. • Reviewing all policies and procedures. • Evidence on several areas of ongoing progress and new documentation for example, the complaint and significant event logs. • Repaired and cleaned the premises and replaced damaged fittings. • The practice provided audits of a Level 3 children safeguarding certificate for the GP from April 2014 and a copy of the Southwark clinical commissioning group (CCG) primary care quality dashboard which outlined the performances of the GPs within the CCG's area. • The practice had engaged an interim practice manager and had given an undertaking to recruit permanently to the post. As a result of the improvements the CQC lifted the 3 months suspension after the second visit (as per update in Matters Arising – see above). NHS England (London region) ended the caretaking arrangements with Aylesbury Partnership on 31 August 2016. The Avicenna Health Centre re-opened on 1 September 2016 and is now fully operational. Due to the timing of the PCJC meetings the paper was not able to be presented for recommendation at the August 2016 meeting. Due to the seriousness of the adverse findings from the first visit NHS England (London region) Southwark CCG considered it proportionate to issue a breach notice to the practice to request assurance that the breaches have been remedied. An action plan will not be requested from the practice for the breaches as NHS England (London region) and Southwark CCG were already in receipt of the action plan. The Southwark Joint Committee confirmed its approval of the recommendation. LW gave approval for the recommended approach on behalf of NHS England (London region). <u>NHS Southwark CCG: Dr Arumugaraasah (at Lister) Care Quality Commission</u>	

(CQC) Inadequate Breach & Remedial Notice

JWe introduced Enclosure K, which recommended that the Joint Committee approve the issue of a breach and remedial notice to the above practice for the first visit for failure to adhere to and provide:

- requirement to abide by all legislation
- the requirement to have appropriate storage arrangements for vaccines
- requirement to have an effective system of Clinical Governance
- requirement to ensure that the persons providing care or treatment had the necessary qualifications, competence, skills and experience
- the requirement to provide Essential Services to meet the reasonable needs of patients.

The practice was inspected by the CQC on 4 May 2016. They practice's overall rating was 'Inadequate' for the Quality of care provided by the practice. The inspection report can be accessed from the CQC website www.cqc.org.uk The report was published on 11 August 2016, which was too late for the link to it to be published in advance of the previous SE London PCJCs meeting (on 18 August 2016).

The practice will be issued with a breach and remedial noticed by NHS England to complete within 28 days. Under the NHS England Standard Operating Procedure (SOP), the regional team has concluded that it is proportionate to issue a breach and remedial notice to the practice under the headings listed above.

It was noted that the CQC had been satisfied with the action plan that had been submitted by the Practice in response to the findings within the inspection report, but that the range of contractual issues outlined above (and detailed within Enclosure K) meant that the above course of action was recommended to the Joint Committee.

Advice and support in relation to policy development and the development of practice systems and processes had been offered by NHS Southwark CCG and NHS England and the North Southwark GP Federation - (Quay Health Solutions). The practice also received advice and support from the Londonwide LMC and the Royal College of GPs.

The Southwark Joint Committee confirmed its approval of the recommendation.

LW gave approval for the recommended approach on behalf of NHS England (London region).

NHS Southwark CCG: Latent TB Local Incentive Scheme (LIS)

It was noted that this item required management of a conflict of interest regarding practices identified to pilot this scheme. RG advised that the Latent TB paper (Enclosure L) asked for a decision on a proposed contract for testing including a payment fee of £20 per screening (para 3.7) that has been endorsed by the LMC. Under Southwark CCG's conflicts of interest policy and in accordance with normal practice of the Joint Committee, it had been agreed that the two GP members (Dr Emily Gibbs (EG) and Dr Jonty Heaversedge (JH) would be conflicted on the payment aspect and that they should therefore not take part in the discussion (of the payment aspect). It has been agreed by the Joint Committee that EG and JH would be required to contribute to this item for their clinical input to it, but that they would be asked to sit in the public area for the part of this item that deals with the decision on

	the payment aspect for this LIS. RG said that the decision on the payment aspect would therefore be taken by a quorum of the remaining unconflicted members. RG confirmed that the Joint Committee was quorate without a GP, in order to take this decision. CG introduced Enclosure L, which recommended that the Joint Committee (i) note the rationale and progress to date for latent TB screening in Southwark, (ii) endorse the proposal to pilot Latent TB screening as part of the new registration processes with identified practices, and (iii) endorse the specification and payment as agreed by the LMC. CG said that Southwark has an incidence of Tuberculosis that is very high compared with the London average rates and thus fulfills the criteria for introducing targeted TB screening and treatment of TB incidence as set out in the Collaborative Strategy for England published in January 2015 (by Public Health England). CG gave an overview of the Latent TB Testing & Treatment Pilot that Southwark CCG is proposing using NHS England funding to deliver in the latter half of 2016-17. The pilot will provide Latent TB screening to eligible patients from 'at risk' countries of origin, when they first register at identified GP practices. The national specification has been localised and was included in Enclosure L. The LIS will be rolled out as a pilot across five practices in Southwark initially, which will allow an analysis of the data, including feedback from the practices taking part: Bermondsey and Lansdowne Medical Mission (site of Nexus Group), the Aylesbury practice (site of Nexus Group), Acorn and Gaumont surgery, Camberwell Green surgery, Albion Street Group Practice. JWe said that the LIS had been reviewed and fully validated in line with the NHS England (London) Operating Model for primary care co-commissioning. This had been assessed against a standardised template setting out the validation arrangements. The difference with this LIS (compared with the majority of LIS's) was that it would not be offered to all GP practices, but rather that it would be targeted at the most appropriate practices. JH and EG gave their endorsement of the clinical aspects of the LIS. It was noted that the scheme fits with the CCG's priorities to reduce health inequalities and improve outcomes for patients. The Southwark Joint Committee confirmed its approval of the recommendation to endorse the proposal to pilot Latent TB screening as part of the new registration processes with identified practices. At this point in the item, JH and EG moved to sit in the public seating area of the meeting room. CG advised that the CCG had held robust discussions with the LMC regarding the specification and payment structure (as outlined above), and that amendments to it had been made as a result. These discussions had also brought an agreement for the CCG to test the infrastructure with the borough's pathology services to ensure that blood test results could be obtained as quickly and efficiently as possible. The specification was currently with the LMC for final approval. The Southwark Joint Committee confirmed its approval of the recommendation to endorse the specification and payment as endorsed by the LMC. LW gave approval for all aspects of the recommended approach on behalf of NHS England (London region).	

	Report on decisions taken by NHSE on behalf of CCG	
8.	**Items for decisions reported per Joint Committee:** <u>NHS Greenwich CCG: Alderwood Urgent Contract End – Urgent Caretaking Arrangements</u> JWe introduced Enclosure M, which confirmed that on 11th October, Greenwich Joint Committee approved the urgent unplanned decision, in line with NHS England (London region)'s recommendation, that urgent short term caretaking arrangements should be put in place through Dr J Lal's Practice with effect from 8am on Monday 17th October 2016. The arrangements are for a three month period whilst NHS England and Greenwich CCG once again review the options available for the long term care of the Alderwood practice patients. The Alderwood Practice intended to hand back its PMS contract with effect from 14th October 2016 and consequently issued notices of redundancy to all its employees effective on that date. A proposed merger between Alderwood practice and Waverly practice was put forward as an alternative. The business case for the merger and the associated improvement plan did not give co-commissioners sufficient assurances that the proposed merger would be in the best interests of patients of the two practices. The Alderwood practice contract was be handed back to NHS England on 16th October 2016. Arrangements to put in place a short term (3 month) caretaking arrangement for the Alderwood patients were required prior to that. The Alderwood premises could only be made available on the basis of a minimum 6 month lease arrangement with NHS England and NHS England (London region) did not feel it is financially viable to commit to these terms for this short term arrangement. JWe said that a paper setting out the options and recommendations for the long term care of Alderwood practice patients will be presented to the next Greenwich PCJC meeting. NHS England (London region) will engage with patients, the Overview and Scrutiny Committee, Healthwatch, LMC and other local stakeholders in carrying forward these arrangements. TT (Greenwich Joint Committee) asked why the proposed merger between Alderwood practice and Waverly practice was not approved, referring to associated performance concerns that had been cited in this regard within Enclosure M. JWe advised that in considering any practice merger proposal, a core issue that commissioners assess is of whether there are clear service benefits that would be brought about as a result of the proposed merger. JWe said that in this instance, commissioners found there to be insufficient evidence of improvements to service provision that would be brought about by the merger, based on the performance of the two practices. This assessment was necessarily made in a relatively short space of time, within the timescale before the contract of Alderwood Surgery needed to be handed back. TT also asked about the future commissioning arrangements in light of this decision and specifically on whether the list dispersal and the audit of the surrounding practices had already been carried out or if this was still yet to come. JWe replied by referring to the fact that caretaking arrangements for the practice had been put in place at this point which implied that further work was needed to assess the capacity of local practices. The focus of co commissioners had been mainly on the caretaking arrangements in the best interests of registered patients, so attention would now move to an assessment of capacity of local practices.	

	NHS Southwark CCG: Acorn Gaumont and Queens Road Relocation JWe introduced Enclosure N, which had asked Southwark Joint Committee on 4th October to approve the urgent planned decision to support the recommendation to the London Capital Committee that Queens Road and Acorn & Gaumont Surgeries should be supported to enable AT Medics to move out of Queens Road into the current Acorn Surgery site, and Acorn & Gaumont surgery to consolidate onto the Gaumont House Surgery site. A request for capital funding to rectify statutory failings identified in connection to the existing AT Medics premises at Queens Road Surgery, 12 Queens Road Peckham, SE15 2PT was submitted to the 5th of July 2016 London Capital Committee (LCC) and approved. These failings were identified from a Statutory Compliance and Health and Safety Survey report undertaken by an external professional advisor. NHS England (London region) and NHS Southwark Clinical Commissioning Group (CCG) had been endeavouring to move the practice from its current premises into Acorn surgery premises, located in the very near vicinity. The Committee confirmed at the 5th of July 2016 meeting that if an alternative solution (i.e. to enable an earlier move into Acorn Surgery) could be facilitated, then LCC would prefer to consider financial support for this option under Direction 6 of the PCD, as opposed to sinking funding into a building with no future). Subsequently to the committee meeting, discussions had been largely successful with the affected practices and a solution identified that would allow AT Medics to vacate the existing Queens Road Surgery during November 2016, mitigating the need to rectify statutory failings. NHS England and the CCG had been in discussions with Acorn & Gaumont House and AT Medics to explore the option of both practices relocating as quickly as possible. This discussion concluded with the in principle agreement undertake the relocations as soon as possible. Following these successful discussions, the CCG appointed and is funding a project manager, who undertook an initial high-level feasibility assessment of achieving the relocations within an acceptable timeframe. The outcome of the feasibility study was the adoption of a two phase methodology: • Phase One: Practice relocations • Phase Two: Reconfiguration of Gaumont House to provide AGHS with sufficient clinical rooms (which will be subject to the outcome of ETTF and a separate business case). IT costs and programme were currently unknown. South East CSU had been engaged and has met with the practices, however, at the time of writing this paper the CSU had yet to provide their cost and programme information. A full patient engagement plan will be carried out in relation to these changes. NHS Property Services will hold the head lease for both retained properties. However, full lease will not be in place prior to the practice relocations. Therefore, short-term tenancies at will are to be used. It was noted that Acorn & Gaumont House would be operating with a reduced number of clinical rooms, until phase 2 is completed. The Southwark Joint Committee had endorsed this request on the 4th of October 2016 via an unplanned urgent decision.	

Public		
10.	**Public Open Space** In relation to the final item in the above section (NHS Southwark CCG: Acorn Gaumont and Queens Road Relocation), Martin Dadswell (Co-Chair of Albion Street practice PPG and member of Southwark Engagement and Patient Experience Committee) confirmed that the patient groups had been consulted with by commissioners on the above relocation and had held a joint meeting involving the PPGs between the two surgeries as well as individual meetings for either surgery, and that further meetings on this were scheduled. Frances Hook (Keep Our NHS Public, Greenwich) raised a concern about the emerging policy/trend of amalgamation of GP practices into larger scale practices, and the affect that this would have on travelling times for patients (most notably elderly and young families) and the reduction of localised services within local communities, in her view. Frances linked this to the Sustainability and Transformation Plan for south east London, and recent Board papers published by Greenwich CCG, suggesting that it was in line with a policy requirement for practices to have minimum list sizes of 10,000. Frances suggested that commissioners should deliver more proactive information campaigns for local residents, to warn of changes to practices (for example brought about by practice mergers or closures) before they happen, rather than as these changes are taking place. JH (Southwark Joint Committee and clinical lead for Planned Care for the south east London STP) made a point of clarity – that there is no reference within the STP for south east London that sets a minimum general practice list size of 10,000. RS (Greenwich Joint Committee) made a point of clarity – that in the Greenwich CCG Estates Strategy there is a commitment that, when looking at the allocations for resources for general practice premises developments, the CCG will prioritise those practice investments that are required by practices with a population of 10,000 or more. RS made it clear that there is a clear statement within the CCG's Estates Strategy that that this principle could apply to an amalgamation of practices. Therefore it would not be accurate to infer that the CCG's Estates Strategy states a leaning for priority of funding to be applied to practices with a minimum list size of 10,000. RK (Greenwich Joint Committee) reported that Healthwatch Greenwich had received a number of concerns from local residents about the ability of any unregistered patients to register with a GP practice if they did not hold a permanent address. Although NHS England guidance clearly states that this should not be a block to any patient wanting to register with a practice, RK was aware of some anecdotal evidence that showed that some GPs locally were setting requirements that would go against this guidance. RK advised that Healthwatch Greenwich was planning to carry out an audit of GP practices to better understand which practices in the borough are following the guidance. JWe said that NHS England (London region) had issued clear guidance on this to practices via the LMCs, and will be interested to see the results of this audit so that any issues can be addressed jointly, in the interests of local patients. Addressing the point raised about information for patients, JWe emphasised the importance of patient communications and engagement generally, referring to the range of items at this evening's meeting that illustrated the important role afforded to local patients in terms of consultation on local decisions. JWe said that it would be	

	very rare that an item for decision would be taken at a PCJC meeting that was not informed/underpinned by good patient engagement, where it is possible to do so. JWe advised that co-commissioners would not tend to issue large scale general notices to residents regarding changes to services in future in a whole neighbourhood, but rather that the information issued to patients was more concerned with individual changes that directly affect certain people or groups of people (for example those on the list of a practice for who a change was being proposed or had been agreed). A key reason for this approach was to guard against unnecessarily raising alarm for any patients or groups within communities that are not affected by the changes that were the subject of the communications. Frances Hook also raised concerns about the closure of Walk-in-Centres in Greenwich in recent times (citing The Clover and The Source as examples), and asserted that often, Walk in patients were amongst the most vulnerable in society, and not registered with a GP practice (for example homeless patients or those who suffered from mental health or addiction illnesses). Frances said that more needed to be done to support these patients, and that often the only place they could access care was via urgent care services. EW (Greenwich Joint Committee) acknowledged that commissioners had closed two Walk in Centres, but advised that in the same timeframe the CCG had opened two GP extended access hubs in the borough, which are list-based. The CCG had taken these decisions in order to provide a much better service for all residents. EW said that in the extended access hubs, the GP seeing each patient has access to that patient's GP record via Visions 360, and could see the notes for each patient as made by their regular GP, therefore enabling more holistic care. Although the patients attending the access hubs were mainly patients registered at nearby Greenwich practices, the GPs within the hubs are able to see unregistered patients and will proactively encourage unregistered patients to register at a practice convenient to them when seeing them. EW further advised that the Urgent Care Centre at Queen Elizabeth Hospital is open 24 hours per day, to cater for any other unregistered patients. Frances Hook raised a concern in response to the current review of Orthopaedic Services and the move to two elective centres. Keep Our NHS Public (Greenwich) feel that the clinical case for this change has not been proven and would like an audit to be carried out on patients that have had knee replacements to determine how many of those patients had had realignment. Frances said that further research into the evidence base to support the case for moving to two elective orthopaedic centres was required. Frances also asserted that a significant number of patients in local SE London boroughs had not received adequate follow-up treatment due to a lack of available physiotherapists in the locality and questioned whether there are the required facilities in the locality to assist with post operation rehabilitation. SB (Bexley Joint Committee) first responded on the point raised regarding the minimum list sizes for GP practices. SB reiterated the point made by JH, that there was no reference within the STP for south east London that sets a minimum general practice list size of 10,000. SB said that commissioners would be happy to look at where this figure has been quoted from and would respond to it accordingly. Responding to the concerns raised by Frances Hook regarding the review of Orthopaedic Services, SB advised that commissioners and STP leads were considering a proposal with local NHS hospitals to create specialist elective orthopaedic centres using existing sites. SB agreed with the view put forward by Frances Hook on behalf of Keep Our NHS Public (Greenwich), that the proposal	

	would be reviewed fully on the basis of clinical evidence. In terms of the community pathway (including rehabilitation and post-operative assessment), SB reported that SE London Commissioners were working with providers to review this pathway and to identify how it might be improved in the interests of patients. SB said that the proposals had already been discussed extensively with local residents, patients, voluntary and community organisations and a wide range of other partners, and that commissioners and STP leads had also recently completed a targeted series of engagement activities to speak to people who could be most affected by these proposals, which has been independently endorsed. Furthermore, a Joint Health Overview and Scrutiny Committee will provide oversight on these proposals. All engagement activity and information on how feedback is used is routinely published on the Our Healthier South East London website (http://www.ourhealthiersel.nhs.uk). SB emphasised that nothing had been decided regarding the proposal and that commissioners are continuing to use feedback from local people to inform plans for a full public consultation later this year, which will be widely publicised. ML (Bromley Joint Committee) referred to a discussion at the previous meeting (18 August), where it had been established that the STP for south east London does not contain any reference to minimum practice size requirements. JWe suggested that the guidance ML was referring to was likely to be concerned with the Alternative Provider Medical Services (APMS) contract (which NHS England now procures consistently across London) which is time limited. JWe said that a piece of Londonwide research into patient list size and the income associated with this had been carried out. JWe explained that APMS contracts are time limited and priced differently from GMS or PMS contracts. NHS England (London region) had established that 6,000 was the optimum list size (as the income that can be achieved on that contract enabled practices to deliver the comprehensive range of services within that contract). This was a London piece of work rather than for a national contract. JWe also clarified that NHS England does procure contracts that are for lists sizes smaller than 6,000 as well. ML felt that this was right. JH (Southwark Joint Committee) warned the Joint Committees and all attendees that there is no clinical evidence setting an optimal list size for delivering good general practice for patients. JH said that there is some evidence to suggest that practices working in isolation tend to have poorer outcomes for patients compared with those practices that work collaboratively with other practices, but that does not necessarily in itself mean that smaller practices will have poorer outcomes for patients.	
Other Business		
11.	**Any other business** None.	
For reference		
	Glossary of Terms The Joint Committees noted the contents of the Glossary of Terms.	
	Date of Next Meeting Thursday 15th December 2016 Room G02 ABC, Ground floor, 160 Tooley Street, London SE1 2QH	
Close		

Primary Care Joint Committees

20 October 2016

Signed Attendance Sheet (Public and other observers)

Gary Beard	NHS England
Nick Langford	NHS England
Martin Dadswell	Southwark Engagement and Patient Experience Committee
Frances Hook	Greenwich Keep Our NHS Public
Bob Skelly	S. Southwark PPG