Primary Care Joint Committees (PCJC)

10 December 2015

Meeting held at:
Deptford Lounge, Deptford Library, 9 Giffin Street SE8 4RJ

Minutes

Meeting Chair
Dr Greg Ussher (GU)

Executive Support
Tom Bunting (TB)

Bexley Primary Care Joint Committee

Attendees:

Sarah Blow (SB)  Member  CCG Chief Officer
Dr Nikita Kanani (NK)  Member  CCG Chair
Jon Winter (JW)  Member  Assistant Director of Communications (representing Sandra Wakeford)
Theresa Osborne (TO)  Member  CCG Chief Financial Officer (representing Keith Wood)
Dr Sid Deshmukh (SD)  Member  CCG Governing Body GP
Matthew Trainer (MT)  Member  NHS England – London (Director of Commissioning Operations)
David Sturgeon (DS)  Member  NHS England – London (Director of Primary Care)
Dr Richard P Money (RM)  Observer  Local Medical Committee

Apologies:

Sandra Wakeford  Committee Chair (Lay Patient Public Involvement)
Keith Wood  Committee Vice-Chair (Lay Governance)
Mary Currie  CCG Governing Body Nurse
Teresa O’Neill  Health and Wellbeing Board
Dr Jane Fryer  NHS England (Medical Director for South London)
Anne Hinds-Murray  Healthwatch (Bexley)

Bromley Primary Care Joint Committee

Attendees:

Martin Lee (ML)  Member  Committee Chair (Lay Patient Public Involvement)
Harvey Guntrip (HG)  Member  Committee Vice-Chair (Lay Governance)
Sara Nelson (SN)  Member  CCG Governing Body Nurse
Dr Angela Bhan (ABh)  Member  CCG Chief Officer
Dr Andrew Parson (AP)  Member  CCG Chair
Dr Jon Doyle (JD)   Member   Governing Body GP (representing Dr Ruchira Paranjape)
Matthew Trainer (MT)   Member   NHS England – London (Director of Commissioning Operations)
David Sturgeon (DS)   Member   NHS England – London (Director of Primary Care)
Linda Gabriel (LG)   Observer   Healthwatch (Bromley)

Apologies:
Dr Ruchira Paranjape   CCG Governing Body GP
Dr Mukesh Sahi   Local Medical Committee
Cllr David Jefferys   Health and Wellbeing Board
Dr Jane Fryer   NHS England (Medical Director for South London)

Greenwich Primary Care Joint Committee

Attendees:
Dr Greg Ussher (GU)   Member   Committee Chair (Lay Patient Public Involvement)
Jim Wintour (JWi)   Member   Committee Vice-Chair (Lay Governance)
Dr Iyngaran Vanniassegaram (IV)   Member   CCG Governing Body - Secondary Care Clinician
Annabel Burn (ABu)   Member   CCG Chief Officer
Maggie Buckell (MB)   Member   CCG Governing Body Nurse
Dr Ellen Wright (EW)   Member   CCG Chair
Matthew Trainer (MT)   Member   NHS England – London (Director of Commissioning Operations)
David Sturgeon (DS)   Member   NHS England – London (Director of Primary Care)
Dr Hany Wahba (HW)   Observer   Local Medical Committee (representing Dr Dermot Kenny)
Sam Jones (SJ)   Observer   CCG Director of Delivery and Service Transformation
Jade Landers (JL)   Observer   Healthwatch (Greenwich) (representing Leceia Gordon-Mackenzie)
Cllr David Gardner (DG)   Observer   Health and Wellbeing Board

Apologies:
Dr Nayan Patel   CCG Governing Body GP
Dr Jane Fryer   NHS England (Medical Director for South London)

Lambeth Primary Care Joint Committee

Attendees:
Sue Gallagher (SG)   Member   Committee Chair (Lay Patient Public Involvement)
Graham Laylee (GL)   Member   Committee Vice-Chair (Lay Governance)
Andrew Eyres (AE)   Member   CCG Chief Officer
Dr Adrian McLachlan (AM)   Member   CCG Chair
Dr Jenny Law (JL)   Observer   Local Medical Committee
Matthew Trainer (MT)   Member   NHS England – London (Director of Commissioning Operations)
David Sturgeon (DS)   Member   NHS England – London (Director of Primary Care)
Andrew Parker (AP)   Observer   CCG Director of Primary Care Development

Apologies:


Dr Hasnain Abbasi  
CCG Governing Body GP  

Cllr Jim Dixon  
Health and Wellbeing Board  

Catherine Pearson  
Healthwatch (Lambeth)  

Dr Jane Fryer  
NHS England (Medical Director for South London)

**Lewisham Primary Care Joint Committee**

**Attendees:**

Rosemarie Ramsey MBE (RR)  
Member  
Committee Chair (Lay Patient Public Involvement)  

Ray Warburton OBE (RW)  
Member  
Committee Vice-Chair (Lay Governance)  

Professor Ami David (AD)  
Member  
CCG Governing Body Nurse Member  

Martin Wilkinson (MW)  
Member  
CCG Chief Officer  

Dr Marc Rowland (MR)  
Member  
CCG Chair  

Dr Jacky McLeod (JM)  
Member  
CCG Governing Body GP and Clinical Director  

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

David Sturgeon (DS)  
Member  
NHS England – London (Director of Primary Care)  

Ashley O’Shaughnessy (AO)  
Observer  
CCG Associate Director of Commissioning  

Nigel Bowness (NB)  
Observer  
Healthwatch (Lewisham)  

Dr Simon Parton (SP)  
Observer  
Local Medical Committee  

Peter Ramrayka (PR)  
Observer  
Health and Wellbeing Board  

**Apologies:**

Dr Jane Fryer  
NHS England (Medical Director for South London)

**Southwark Primary Care Joint Committee**

**Attendees:**

Richard Gibbs (RG)  
Member  
Committee Vice Chair (Lay Governance)  

Ami David (AD)  
Member  
CCG Governing Body Nurse Member  

Malcolm Hines (MH)  
Member  
CCG Chief Financial Officer (representing Andrew Bland)  

Dr Jonty Heaversedge  
Member  
CCG Chair  

Dr Emily Gibbs (EG)  
Member  
CCG Governing Body GP  

Matthew Trainer (MT)  
Member  
NHS England (Director of Commissioning Operations)  

David Sturgeon (DS)  
Member  
NHS England – London (Director of Primary Care)  

Caroline Gilmartin (CG)  
Observer  
CCG Director of Integrated Commissioning  

Dr Kathy McAdam Freud (KMF)  
Observer  
Local Medical Committee  

David Cooper (DC)  
Observer  
Healthwatch (Southwark)

**Apologies:**

Joy Ellery  
Committee Chair  

Andrew Bland  
CCG Chief Officer  

Dr Jane Fryer  
NHS England (Medical Director for South London)

**Other attendees:**

Jill Webb (JWe)  
NHS England – London (Head of Primary Care)  

Richard Jeffery (RJ)  
NHS England – London (Director of Financial Management)
<table>
<thead>
<tr>
<th>Item</th>
<th>Introduction and apologies</th>
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<tbody>
<tr>
<td>1.</td>
<td>GU welcomed members, observers and members of the public to the fourth meeting of the Primary Care Joint Committees of:</td>
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<td>- NHS Bexley CCG and NHS England</td>
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<td>- NHS Lewisham CCG and NHS England</td>
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<td>- NHS Southwark CCG and NHS England</td>
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<td>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. GU advised that there would be two public open space items during the meeting (one close to the start and the other close to the end) instead of only one, as at previous meetings to date.</td>
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<tr>
<td></td>
<td>Apologies received in advance of the meeting:</td>
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<td>Sandra Wakeford</td>
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<td>Keith Wood</td>
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<td>Dr Dermot Kenny</td>
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<td>Dr Hasnain Abbasi</td>
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### Declaration of Interests

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Joint Committee</th>
<th>Change</th>
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<tbody>
<tr>
<td>Dr Jon Doyle (representing Dr Ruchira Paranjape – CCG Governing Body GP)</td>
<td>Bromley Primary Care Joint Committee – Member</td>
<td>Add entries:</td>
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<tr>
<td></td>
<td></td>
<td>• GP Partner in South View GMS Partnership, Bromley</td>
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<td>• Member practice of the Bromley GP Alliance</td>
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<td>• South View Partnership holds contract from Bromley Healthcare to provide Visiting Medical Officer (VMO) services at Lauriston House</td>
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<tr>
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<td>• South View Partnership contracted to Bromley GP Alliance to provide GP support to transfer of care bureau, 16/11/2015 to 18/12/2015</td>
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<tr>
<th>Jade Landers (representing Leceia Gordon-Mackenzie, Healthwatch (Greenwich))</th>
<th>Greenwich Primary Care Joint Committee – Observer</th>
<th>Add entries:</th>
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<td></td>
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<td>• Policy and Research Officer, Healthwatch (Greenwich)</td>
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<td></td>
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<td>• Metro are Healthwatch Greenwich’s contracts holder</td>
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<tr>
<th>Dr Hany Wahba (representing Dr Dermot Kenny, Greenwich Local Medical Committee)</th>
<th>Greenwich Primary Care Joint Committee – Observer</th>
<th>Add entries:</th>
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<tr>
<td></td>
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<td>• Full-time GP at St Marks Medical Centre, Plumstead. The practice has applied for an Improvement</td>
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</table>
Grant to NHS England (currently being considered and was to be covered on the agenda for this meeting)

- Member of Riverview LLP – part of syndicate for the regional area of Plumstead and Woolwich
- GP Appraiser for NHS England – is paid for the appraisals undertaken
- Medical Director of Grabadoc Healthcare Society Ltd
- GP Member of NHS Greenwich CCG

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<tr>
<th>Sue Gallagher</th>
<th>Lambeth Primary Care Joint Committee – Member</th>
<th>Removal of Stakeholder Governor of Guys &amp; St Thomas’s NHS Foundation Trust and Kings College Hospital NHS Foundation Trust – is no longer Governor at these Foundation Trusts</th>
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<tr>
<td>Dr Marc Rowland</td>
<td>Lewisham Primary Care Joint Committee – Member</td>
<td>Member of Lewisham 4 Health Limited</td>
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<tr>
<td>Dr Simon Parton</td>
<td>Lewisham Primary Care Joint Committee – Observer</td>
<td>Member of Lewisham Healthcare Limited</td>
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3. Minutes of the last meeting, held on 29 September 2015

The minutes were agreed to be a correct record subject to the following amendments:

Lewisham Joint Committee stated that Rosemarie Ramsey was incorrectly referred to as an observer member (representing Healthwatch). Her correct title at that time was Lay Member designate.

Lewisham Joint Committee stated that Denver Garrison was incorrectly referred to as an observer member (representing Healthwatch). Denver Garrison should have been referred to as a member of the public.
It was noted that Frances Hook was incorrectly referred to as a member of Healthwatch (Greenwich) and that this should be corrected to read as “Representative for Keep Our NHS Public (Greenwich).”

**Action log**

Referring to the action tracker for the committees, TB noted that all four of the actions with “open” status (as shown on the version of the actions log at the previous meeting), as well as the two actions that were assigned at the previous meeting had been closed.

4. **Public Open Space**

No written questions from the public had been received in advance of the meeting.

Jennifer Quinton-Chelley enquired as to whether the three-month extension for the completion of the PMS contracts review programme (applied for by all six south east London CCGs, to ensure a full and appropriate level of engagement with patients and public) had been granted by NHS England. GU advised that this matter would be covered in full under item 7 on the agenda (London PMS Contracts Review programme).

**For discussion**

5. **Quality, Performance and Finance**

**Month 7 Finance report**

RJ introduced the Primary Medical Services Financial report for month 7 (circulated as Enclosure D).

The overall financial position for South East London Primary Medical Services was showing an overspend of £1.2m (0.9%) against issued budgets for the 7 months to 31st October. This position comprised small overspends on PMS and GMS budgets with a large shortfall on the QIPP delivery target, which was shown separately.

Year to date accruals: compared with previous years NHS England (London) had been able to write-back £900k, which were used to offset against some of the overspend that had led to the year to date £1.2m deficit.

The forecast outturn was a £1.6m deficit (0.7%) after further mitigation. This forecast was driven by the QIPP shortfall but included further non-recurrent mitigations to be realised before the end of the financial year. This will be net of all of the non-recurrent mitigations. This position is in line with the primary care position across the whole of London, at all levels of co-commissioning arrangements (levels 1, 2, 3). The position for each south east London CCG was detailed in the report.

Capitation report: the numbers for this aspect had been shown in a separate table at the request of one of the CCGs. This was useful in illustrating how the registered populations for primary care had moved over the reporting period, across the patch. There has been a year on year growth of 0.8% in south east London’s weighted population from April 2014 to April 2015. The capitation report showed a growth of 1.3% to 1st October 2015 (quarter 3). Demographic growth had been funded on an aggregate basis at 1.3% in the 2015-16 financial plan. There was considerable variation across the south east London CCGs in terms of growth and reductions.
At present NHS England (London) is managing primary care contracting across the whole of London (with the exception of the level 3 CCGs). The variable level of risk when viewing London as a whole or at SPG level, as opposed to individual CCG areas is considerable (ie the level of risk at individual CCG level from year to year can show much greater levels of risk or benefits within these budgets than at the higher level).

QIPP initiatives: NHS England wrote to all London CCGs in October regarding covering the £3.2m gap (of the target £20m QIPP). Andrew Bland replied to NHS England on behalf of London CCGs. In line with that collective CCG response, NHS England has stated that it will do all it can working across Primary Care to mitigate the QIPP shortfall and to meet any further pressures. Whilst this will largely involve non-recurrent actions, there will be some further recurrent benefits from 2015-16 schemes, and the rate reviews. This will be reviewed again at Month 9, and NHS England (London) has indicated some level of confidence that it will be able to cover the £3.2m gap for London in-year via its non-recurrent resources, as well as (potentially) further accruals from 2014-15, any of the non-recurrent resources in the medical budget (and across the rest of its primary care budget).

A Primary Care Technical Group has been established with Chief Financial Officer representation from all London CCGs and London SPG leads to work with NHS England to understand the co-commissioned/delegated pressures and to recommend options for budget-setting for 2016-17. Subject to the Comprehensive Spending Review settlement and allocations, there is likely to be a QIPP requirement for 2016-17 of 1-1.5% (similar to 2015-16), including any brought-forward recurrent pressures. RJ advised that a fuller position on this would be known by the time of the NHS England Primary Care Management Board meeting taking place on 17 December. The Finance Technical Group will be working through the detail of all aspects of this over the coming months.

Lewisham Joint Committee:

MR raised a question on behalf of the Lewisham CCG Governing Body regarding the justification of having a QIPP for primary care, at a time when resources are being transferred from secondary to primary care. RJ responded by pointing to the significant savings (over £2m) that had been made in the previous two years by NHS England (London) via standardisation of the transactions process. RJ noted that on the transactional side it was unlikely that further financial savings could be made as over £50m had already been made in this period across the primary care budget for London. Therefore NHS England (London) had deemed it necessary to look at making savings from other budget areas. MR followed up on the response from RJ on this point, by pointing to considerable difficulties that these efficiencies on QIPP would cause locally in primary care.

RW queried the release of £912k of accruals from 2014-15 and requested an explanation of this figure as stated in the report. RJ responded by advising that at the end of the 2014-15 financial year the accounts were closed off in accordance to a tight time schedule within NHS England. At that point RJ submitted a best estimate of the costs that were still to come through the system. For a number of items, particularly on QOF and premises costs, there are often long delays on making those settlements and it is only at this stage in the following financial year that those costs have largely come through the system – and that therefore NHS England (London) could now report a more certain position on the amount of unspent monies from 2014-15 for write-back.
Bexley Joint Committee:

RM enquired as to the proportion of the QIPP shortfall (£3.2m - of the total £20m across London) for south east London CCGs that individual south east London CCGs would be liable to meet. RJ responded by advising that NHS England cannot break this down to CCG level responsibility and that it would not be an even distribution across CCGs. Furthermore, some of the shortfall sits outside Medical Services.

Lambeth Joint Committee:

SG asked for clarity that NHS England (London) had achieved £50m on transactional savings during the past two years (as stated in the response to the first question from Lewisham Joint Committee, above), and asked for further clarification on how this had been achieved. DS replied, stating that efficiencies had been achieved across a range of areas in 2013-14 and 2014-15, but predominantly in the areas of practice list maintenance across London (in certain parts of London this had not been undertaken for some considerable time, and so this had brought up significant levels of efficiencies gained); efficiencies brought about from reducing variation across a range of schemes deployed by individual practices across London (ie ensuring that Out of Hours deductions were being made in the appropriate means); and efficiency improvements that had been realised in the collections of clinical waste. All of these improvements had been brought about across London and had contributed to the transactional efficiency saving of £50m as stated.

DS further emphasised the point made earlier by RJ, that as further efficiencies are very hard to find, the onus was now on the transformation side to deliver the QIPP savings required to meet the financial gap, and that London is considered to be over-target for primary care. DS advised that the 2016-17 model for allocations had not been set yet but that it would be unlikely to change significantly. The NHS England (London) team had made some recommendations for inclusion in the model (including factors of English not being first language, turnover and deprivation) – and that these would be reviewed by the Primary Care Management Board for NHS England (London) at its next meeting, on 17 December.

Quality and Performance report

JWe introduced the Quality and Performance report (circulated as Enclosure E). These reports are produced on a quarterly basis by NHS England (London) to indicate quality and performance markers for general practice across London. The previous iteration of this report was at the SE London PCJCs meeting on 6 August. This was the second showing of the report, and the format of it had been altered somewhat since that meeting. A significant number of helpful comments and contributions had been received by the NHS England (London) team from CCGs across London since August. These had informed this second iteration, although not every single comment had been factored into the present iteration due to time constraints.

The report includes the following data sets: GP Patient Survey, Quality and Outcomes Framework, and Friends and Family returns at CCG, SPG, London and national levels (where this is possible), and has begun to include some analysis of the data presented, and indications of trends of the performance and quality data. The data is refreshed at varying intervals (not always quarterly and in some cases annually), therefore each data set is date-stamped to indicate when it had last been refreshed. It also includes a summary of GP contract variations (these had previously been reported separately), in line with NHS England’s Operating Model. This data can be found at the back end of the report.
NHS England (London) has had to redact two of its data sets from this report (Electronic Declarations - to confirm that practices meet certain standards contained in the report - and General Practice Outcomes Standards (GPOS)), because clearance by NHS England (Central team) is required to present these information sources at an aggregated level, as they are not currently available in the public domain. It is hoped that this information will be included in future iterations of the report.

A summary of CQC practice inspection outcomes is planned to be included in this report, once the CQC have carried out inspections of a greater number of practices in south east London and pan-London, so that the comparison of this data will be more meaningful. Any contractual issues that are reported as a result of CQC inspections will be covered in either Part 1 south east London PCJC meetings (or in Part 2 meetings if a decision is required).

JWe also advised that a full narrative comprising an analysis of the data as reported would be presented in future iterations of the report. This would refer to the “So what?” factor – ie the actions and their intended measurable impacts that co-commissioners have agreed in response to quality and performance issues that are contained in the report. The report will potentially also benefit in future from the added inclusion of information that is exclusively held by CCGs regarding general practice quality and performance.

A range of further comments and suggestions were made at the meeting:

**Lewisham Joint Committee:**

RW raised four points regarding the format of the reporting:

- The report would benefit from a bigger font being used as it is quite difficult to read in places. JWe agreed to look into this.
- It is not absolutely clear whether the variances shown in the report are “positive” or “negative” in terms of quality/performace. JWe explained that the benchmarking data on the report is darker the shading of the blue indicates a lower level of quality or performance against London and national performance.
- There is a need to indicate on the data how protected characteristics are affected – this is particularly relevant in some of the more diverse communities in south east London (and elsewhere in London).
- The reporting time period for the graphs needs to be included. JWe believed this was included within each section but agreed to check.

**Southwark Joint Committee**

JH noted the complexity of the data, as borne out by the report. JH then referred to a paper published in the last week by Dr Mark Ashworth (a GP in south east London), which had identified that poor patient experience is directly correlated with low prescriptions of rate of antibiotics (which is something that is generally strongly encouraged within general practice). This paper could be seen as a good illustration of the often complex and competing dynamics involved with primary care quality.

**Bromley Joint Committee:**

ML referred to two apparent trends from the reporting, and enquired as to any thoughts on these as follows:
The reporting for CCG and south London patient satisfaction did not compare favourably with the national comparisons. JWe pointed out that this is a well-established position, owing much to the complexities and diversity of the patient populations in and across London. This appeared to be a key reason in explaining why London did not score favourably against the national benchmarks.

Noted that the reporting showed that of the patients polled, there was a significantly higher rate of trust toward nurses than toward GPs.

Lambeth Joint Committee:

- AM noted that the colour coding clearly indicates the standard deviation away from the mean, but the direction away from the mean is less clear. JWe stated that the darker shades of blue and the further away from the mean indicate a lower level of achievement. AM replied by suggesting that this explanation would indicate that south London CCGs did not score above the mean for any of the indicators on patient satisfaction. JWe and DS agreed to look into this to confirm.

- SG asked if, for the patient satisfaction data sets, it be possible for the report to show the percentage of patients as well as the percentage of practices. It would be more useful if commissioners could see the percentage of populations that are dissatisfied in the various different categories, as the practices vary so much in size. JWe and DS agreed to look into this to confirm.

- SG asked if the report could include clinical effectiveness indicators, or do they not exist nationally? JWe replied that there are many clinical indicators in existence but some indicators have been redacted (ie E-Declaration and GPOS, as noted by JWe in her introduction). There is also a need to work with CCGs to gather further datasets that can be included as part of this reporting (including clinical indicators) and JWe advised that this would be a focus for the ongoing development of the report.

- SG enquired as to the consequences for practices that do not submit returns on the Friends and Family data. JWe replied by advising that it is now a contractual requirement for practices to offer this survey to patients and to gather and submit this data. This is a recent development, and NHS England (London) is going through a process via the practices and LMCs to help and encourage the collection and reporting of this data by practices on a monthly basis. All practices are mandated to submit this data by the end of 2015-16.

GU remarked that the report had improved notably, though it remained as a work in progress, and that it is constantly being informed and improved by the many helpful comments that had been contributed so far, including at this meeting. JWe undertook to factor in the comments received at the meeting to the further development of the report.

6. Primary Care Premises Infrastructure

JWe led this item, which was informed by three documents, which comprised Enclosure F:

(i) NHS England Primary Care Infrastructure Fund Progress report (November);

(ii) Update report on London Improvement Grant Fund (2015-16 applications), produced for NHS England (London) Finance, Investment, Procurement and Audit Capital sub group (reports to the Primary Care Transformation
These papers give an overview of GP-led bids for premises development and improvement. The first tranche of the £1bn four year investment programme in primary care infrastructure across England was announced in December 2014. This culminated in the approval of 721 GP bids, with 182 in London with an estimated capital value of around £34m. The progress of London’s programme, in common with all other regions, has been challenging as a result of a range of issues and risks. These are detailed in its monthly delivery reports to the national PCTF Programme Board. London region’s November 2015 report provides an update on what are currently 214 schemes that are either formally approved, completing their due diligence, withdrawn or deferred (to 2016-17). It also provides the financial profile of London schemes, the associated risks and issues and confirms that it is continuing to work to identify new schemes to mitigate underspend, which comply with PCTF 2015-16 and the recently announced 2016-17 criteria. This programme will roll forward into 2016-17 and is being renamed as the Primary Care Transformation Fund, which will be CCG-led and in line with strategic commissioning priorities.

Alongside this national investment programme, London region also agreed to identify capital from its main 2015-16 capital programme to support what are called ‘London Improvement Grant’ bids, in response to the London Health Commission report ‘Better Health for London’, published in October 2014. This identifies the need for significant investment in the infrastructure of GP premises, to enable primary care commissioners to realise their strategic plans and providers to respond to them. The London Improvement Grant (IG) report provides details of the prioritisation process used to identify 124 out of 369 schemes, which have been approved in principle based on initial technical due diligence requirements, for 2015-16 London IG funding. It also provides the process and timetable for completion of due diligence; a summary of the feedback received from London LMCs about the region’s prioritisation process; a further batch of schemes that could be supported and delivered in year if further London capital programme slippage is identified; and confirms that a bid for 2016-17 capital will be submitted to progress the remaining IGs that meet the identified criteria. Practices will be notified during the week commencing 14th December about the status of their bid; and schemes that receive approval should be able to complete by 31st March 2016, subject to them completing their due diligence requirements in line with the specified timetable.

At the end of October 2015, NHS England wrote to all CCG Accountable Officers and clinical leads to confirm the approach to funding the remaining three years of the PCTF. The national letter (the third paper of the set for this item) clarifies that CCGs (rather than Practices) will be invited to submit bids by the end of February 2016, which should be reflective of their local interim estates strategies that need to be available by the end of December 2015. CCGs will also be responsible for the long term affordability of approved schemes. JWe reported that the London region had opted to produce system-wide Strategic Estates Plans (ie at south east London level) by March 2016. The bulk of the fund will continue to be deployed to improve premises and digital and technological developments in general practice, with access criteria similar to year 1, but with an additional criterion of improving seven day access to effective care. JWe also advised that schemes will no longer need to be completed in the financial year in which they are approved.
**Updates on interim Estates Strategy Developments:**

MH reported that every CCG is developing its own local estates strategy, which will eventually all be approved via the governance processes per CCG. Additional support and funding has been made available through the Healthy London Partnerships, as Estates is one of the thirteen transformation work streams within this, to help assess local estates.

In addition an estates work stream has been established within the Our Healthier South East London strategy programme. The estates work stream group held its first meeting in workshop format recently, and another meeting is scheduled to take place in the coming weeks. This group is not set up to approve each CCG’s estates strategy, but rather to take an overview and share learning and good practice, as well as enabling the agreement of the South East London strategy, which will be agreed in March 2016, as per the above.

A number of questions were raised by the Joint Committees:

**Bromley Joint Committee:**

ML requested clarification that the report is recommending that criteria 8 and 9 should be applied, and to encourage more practices into the London Improvement Grant Scheme, and if so what is the timescale for this. JWe advised that NHS England (London) Finance, Investment, Procurement and Audit sub-committee had received the above paper, that identified a number of other schemes/practices as being deliverable (over and above the 128 listed as already having been approved) and that should be prioritised for inclusion in-year, provided that these have CCG support. NHS England (London) will begin work on those additional schemes in about a weeks’ time (foremost to check on CCG support for them). The more immediate priority is to issue the 128 notifications out for those approved schemes. All London Improvement Grant schemes must be completed by the end of March, therefore NHS England (London) is selecting schemes that can be completed in this timeframe, noting that bids for more funding will be made for 2016-17 to cover those that are viable over a longer timeframe.

**Greenwich Joint Committee:**

DG sought to clarify the role of local authorities in the development of the estates strategy, as this was not obvious from reading the paper. Given the importance of agreeing an overarching plan that might include co-location, DG enquired as to what is the strategic push from the local NHS to increase this role and collaboration. MH advised that the south east London estates group has invited all local authorities to the meetings of the working group and are ensuring a wide distribution of information and meeting papers across all relevant local authority staff in order to be as inclusive as possible in terms of providers and local authorities. It is up to each CCG to ensure this takes place at the borough-level. EW advised that a local authority representative from Greenwich has been involved in the Estates Group in that borough.

**Bexley Joint Committee:**

TO asked when the more detailed guidance would be issued by NHS England (to inform the 29 February submission of bids). JWe advised that the guidance was planned to be issued before Christmas. The deadline for submission of estates strategies is end of December 2015. The intention from Department of Health is that these strategies should be reviewed and refined in the intervening two months prior to
submission of final bids. JWe added that the application process had been simplified compared with the GP-led process of year 1 of the PCIF.

**Lambeth Joint Committee:**

AE noted that the vast majority or all of the approved schemes in the report appeared to be focused on physical estates improvement capacity and asked had there been any schemes approved that are focused on digital capacity. JWe replied by stating that digital schemes submitted in 2015-16 had been scarce, but that it was anticipated that there would be more IT/digital focused schemes in 2016-17, and that the bidding process will support this. The focus had been on physical capacity projects, but the IT/digital schemes that are expected in future will dovetail with the infrastructure capacity schemes already approved.

**Lewisham Joint Committee:**

PR noted the timeline for completion of a range of minor capital schemes by the end of March 2016 and enquired as to what procurement methods were being deployed in order to achieve that. JWe advised that every scheme in this programme is GP-led and that GPs would determine the procurement requirements for the bids. There is a requirement for practices to obtain at least three quotes in doing so, and to ensure that the changes required will deliver what is needed and be cost effective.

RW queried whether there is any indication of the limit of the financial allocations for the bids to be approved, at a CCG level. JWe advised that in the first year there were no financial limits set for CCGs as this was and remains a GP-led process. Over 1,000 GP practices bidded for schemes and there were 721 successful schemes originally approved nationally. There are a range of factors that explain the differing levels of bids coming in from different areas. Some of the levels of bidding has been reflective of the level of investment historically in a given area, ie in an area with high investment the volume and value of bids was seen to be lower by comparison with areas with lower investment. JWe explained that moving forward there would be indicative allocations across the different regions – but at a regional level rather than CCG-level. This will give some flexibility over funding allocations, which is helpful as many of the costs in bids are estimated capital costs (which can be significantly different from the final cost of a scheme).

7. **London PMS contracts review programme**

RG (Southwark Joint Committee) opened the item by describing the intended approach regarding management of any conflicts of interest for the south east London Primary Care Joint Committees brought about by the PMS review and the decisions relating to commissioning intentions that would need to be made at this forum at future meetings. This approach had been tested with RG’s counterparts in each of the SE London CCGs in advance of this meeting.

There is a potentially large conflict of interests inherent in the review and approval of commissioning intentions for the PMS contract premium in this forum due to the attendance of several GP Commissioners in each joint committee. Whilst there is a clear need to manage that, this must also be balanced against the requirement to ensure good quality clinical input into the decisions and the design of services. RG referred to good national guidance available on this issue, as well as local CCG policies and Joint Committee Terms of Reference, that each serve as reference.
points. The latter of these point to the ability of Joint Committees to ask GPs to withdraw from any conversation from which they are deemed to be substantially conflicted, which can then be managed by other (unconflicted) members, provided that the joint committee(s) in question remain quorate in doing so.

The question RG posed for this item was whether or not the recommendations the Joint Committees were being asked to consider represented a substantial conflict for CCG GP members, or not. The answer to that was accepted by the Joint Committees as being “no” – on the proviso that the discussions at this item stayed within the limits set by the recommendations, as set out in the cover paper circulated in advance for it. These recommendations were as follows:

1. Note this update (within the cover paper)
2. Confirm their intention to utilise the extension period for engagement with residents, members and partners
3. Endorse the implementation approach outlined for their borough (appended documents)

RG noted that there would be a need to revisit this question in advance of items on the PMS contract at future meetings, to continue to assure the Joint Committees on this matter of conflicts of interest.

Prior to introducing the paper (update on PMS contract Review programme, which had been circulated as Enclosure G), DS advised the Joint Committees of several significant updates that had emerged since the distribution of the paper.

The London PMS contract offer (based on the Strategic Commissioning Frameworks (SCF), issued by NHS England (London) last year, and supported by CCGs as the direction of travel), had been earlier today agreed by London SPG leads and by the NHS England (London region) Primary Care Management Board. This had been developed following a period of consultation and various iterations. DS advised that this would shortly be taken back to individual CCGs. Main areas to note from previous iterations was a scaled down option for KPIs and the prominence of access to services. DS stated the total value of the London premium is now slightly over £7. There is flexibility for individual CCGs to add to the offer that will be required by NHS England (London).

The final document is being consulted on with LMC at the same time as it will be reviewed by CCGs. The initial meeting with London-wide LMCs (as well as surrounding LMCs from Surrey, Kent and Essex) is scheduled for 18 December. These meetings will focus on how the contract will be delivered rather than the SCF content, which had already been agreed. DS confirmed that the component of the premium will be agreed with London-wide LMCs for and on behalf of all 32 boroughs in London.

All London SPGs had applied for a three-month extension for the review process. DS confirmed that this extension request had been granted by NHS England (London) via its Primary Care Management Board earlier on the day of this meeting, meaning that the deadline for signing of PMS contracts will be 30th June 2016. DS advised that there are some conditions that NHS England (London) has applied to this extension, namely that London commissioning plans per CCG must be submitted by 19 February, and that reviews must be completed by 31 March 2016. The definition of the completion of the PMS review is that commissioning intentions are agreed and in place (including the direction of travel for equalisation across all contract types, but particularly GMS). From there the process will be toward meetings with individual practices and agreeing
all contract documentation in the period to 30th June.

A range of questions were raised at the meeting:

**Bexley Joint Committee:**

NK referred to signing up to the London offer being about equalisation of the PMS offer to all patients across London regardless of which borough the practice they are registered with is located in. NK asked how we can ensure that this is fair across London and in place for CCG boroughs with lower premiums. DS acknowledged that delivery of this over the planning period was a real challenge. There are 17 streams within the strategic framework that were agreed as the patient offer for London. DS noted that CCGs would be aiming to deliver the strategic framework, but that the PMS review was never understood to be able to meet the full needs of all CCGs/boroughs.

SD asked what processes are in place to prevent practices moving to GMS rather than PMS. This question had been raised by member PMS practices that were considering their options, given that the premium offered is the same for PMS and GMS practices, with the latter being protected by a national contract. DS replied by stating that co-commissioners do not want the PMS practices to go back to GMS contracts. PMS specifications will better reflect local population needs and give commissioners greater influence and flexibility to serve their populations in this way. Co-commissioners’ intentions are to preserve the premium, whilst ensuring that patients are not disadvantaged if they are not registered with a PMS practice. Therefore the challenge for co-commissioners is how to get the monies to invest in order to offer to GMS practices what is effectively an enhanced service that will mirror the premium components within the PMS contract.

JWe added that some CCGs (depending on the mix of GMS and PMS practices in each borough) will not be able to equalise as quickly (or at all) – as this will be predicated on them having sufficient funding to do so. Therefore it will take considerably longer for some CCG areas to offer the PMS premium to GMS, which was a consideration that PMS practices wishing to revert to GMS should be advised to take into account.

**Greenwich Joint Committee:**

HW noted that the PMS review does not take into consideration the levels of deprivation and diversity in different borough areas when setting the premium. HW asked why this was the case. DS replied by stating that CCGs have to use their own allocations and work within these limits, in accordance with the direction of the SCF for London. Following correspondence between NHS England (London) and CCGs last year, there was found to no appetite for pooling resources across borough boundaries amongst the south east London CCGs. HW replied by stressing that this was a missed opportunity to impact on the quality of health improvement for patients, as levels of deprivation had been used previously when setting the premium, and that it had been long recognised that achieving quality health improvement for patients in areas of higher deprivation was significantly more difficult for GPs in those areas as compared with GPs in non-deprived areas. DS advised that the weightings were attributed via the Carr Hill weighted formula, which was applied at a national level to ensure an equitable distribution of resources. NHS England (London) is seeking a revision of the formula to take greater account of deprivation (factors including high turnover of staff, and English not being first language amongst workforce). DS also pointed to certain KPIs in the premium that had been included from this year’s London offer, that were intentionally added to encourage practices to address health inequalities.
EW requested a clarification on the breakdown of the total London offer (£7 premium) and whether this was inclusive of all elements of the London offer including KPIs. DS advised that this was the total and that it reflected the total cost of delivering the London offer for practices, although there would be an opportunity for CCGs to supplement this at a local level. JW advised that the first priority was to issue the offer. The full detail will be available to view by CCGs as part of this.

Lewisham Joint Committee:

SP thanked NHS England (London) for the scheduling of the forthcoming meeting with the Lewisham LMC regarding the PMS review and for the information re the London offer disseminated in advance of it. SP also thanked Lewisham CCG for the local engagement on this matter, stating that this engagement was very much appreciated by the LMC. SP requested that when the second offer comes through to the CCG and London-wide, and to the LMC, whether the LMC could receive CCG sensitive data to be able to assess how practices in Lewisham are performing against the KPIs being proposed, to ensure that when there are discussions with the LMC, it can ensure that the KPIs are relevant, achievable for and across the borough. DS agreed that NHS England (London) would share the information on performance of practices on the proposed KPIs with LMCs with the second London offer in advance of the meeting, although this is not currently available as it had only been agreed today. DS also advised that NHS England (London) would be writing to individual practices to set out the current levels of income for that practice in each component part of the PMS contract as per the London offer (that are each subject to the review). DS confirmed that London-wide LMCs and CCGs would be aware of the content of this letter in advance of it going out to individual practices.

SP also reiterated the concern raised by SD in relation to the potential for practices to opt to move to GMS national contracts as opposed to PMS contracts.

To summarise the item, and in line with the approach as agreed at the start, GU referred back to the recommendations for this item within the cover paper as to:

i. Note this update (within the cover paper)
ii. Confirm their intention to utilise the extension period for engagement with residents, members and partners
iii. Endorse the implementation approach outlined for their borough

The Joint Committees noted and were each in agreement with all three points.

For Decisions

8. NHS Bexley CCG: Bexley Group Practice Premises relocation Project Initiation Document

JW introduced the paper (Enclosure H), a request for funding to produce a feasibility study for Bexley Group practice to move premises. Bexley Group practice currently comprises five sites (three in Welling and two in Belvedere). The ultimate aim of the practice is to merge three buildings which are each not fit for purpose into a new proposed building and to retain the two premises at Belvedere.

The feasibility study will enable the CCG to submit a bid for 2016-17 Primary Care Transformation funding, based on clear evidence that the proposal is in line with Bexley CCG’s emerging interim estates intentions. The scheme is deliverable in 2016-17.
Bexley Joint Committee gave its approval for the recommended approach, to support the practice’s feasibility study proposal, at a cost of £11,616.00.

NHS England gave its approval.

**NHS Bexley CCG: Westwood Surgery Contract Breach**

JWe introduced the paper (Enclosure I), which recommended that the joint committee approve the issue of a breach and remedial notice to the practice. This recommendation was informed by a rating of “Inadequate” of the practice by the Care Quality Commission (CQC) following an inspection it carried out on 28 July 2015. NHS England had reviewed evidence in the CQC inspection report and had identified the three contract breaches as set out in Enclosure I.

JWe acknowledged that although the required actions had already been addressed by the practice, it was still appropriate to issue the notice due to the three contract breaches.

Bexley Joint Committee gave its approval for the recommended approach.

NHS England gave its approval.

**NHS Greenwich CCG: Plumstead/Tewson merger**

JWe introduced the paper (Enclosure J) that requested that the Joint Committee consider a proposed merger between Plumstead Health Centre practice and Tewson Road surgery following the receipt of a draft business case which the practices have submitted. JWe reported that the draft business case was compelling in terms of reduction of financial overheads, combining workforce resources, and rationalising space. Furthermore, co-commissioners are supportive of the proposed merger as it aligns with strategic priorities to support larger, more resilient practices, and equity of population based services.

The practices would like to implement the merger from 1st July 2016 or sooner if practical. JWe advised that there were a number of issues regarding clarification and discussion with the practices before a formal recommendation to PCJC could be made. NHS England’s recommended approach is to approve the proposed merger in principle, to take place on 1st July 2016 or sooner if practical, on the condition that the practices agree to undertake to work through the issues highlighted in Enclosure J, in order to provide a final business case that can be endorsed at the February 2016 Greenwich Primary Care Joint Committee meeting.

Greenwich Joint Committee gave its approval for the recommended approach.

NHS England gave its approval.

**NHS Greenwich CCG: Greenwich protected learning time (LIS)**

JWe introduced the paper (Enclosure K), which recommended that the Joint Committee approve the protected learning time Local Incentive Scheme for all practices in Greenwich, on the condition that all practices are encouraged to participate, and that the outcomes are suitably monitored and reviewed.

Greenwich Joint Committee gave its approval for the recommended approach.
NHS Bromley CCG: Green Street Green list closure

JWe introduced the paper (Enclosure L), which asked the Joint Committee to consider a request from Green Street Green GP practice to close its practice list for a period of three months to allow for required training for newly recruited clinician staff. The application had been made as a result of the impact of increased registrations following difficulties experienced by a neighbouring practice, and of patient safety concerns resulting from a recent high turnover in their clinical staffing.

JWe advised that the request has the support of Bromley Local Medical Committee.

The recommended approach as set out in Enclosure L and its supporting papers, was that the agreement to the closure of the list should be conditional upon the practice producing and agreeing an action plan to address a set of key issues (identified in the paper) with NHS England (London).

Bromley Joint Committee gave its approval for the recommended approach.

NHS England gave its approval.

<table>
<thead>
<tr>
<th>Report on decisions taken by NHS England on behalf of CCG</th>
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<tr>
<td>9. Locum reimbursements under London’s Discretionary Funding SOP</td>
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<tr>
<td>The Joint Committees noted the content of this paper (which was circulated as Enclosure M). There were no questions or issues raised following the review of the paper.</td>
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<tr>
<th>Decisions taken outside of the committee to be reported</th>
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<tr>
<td>10. NHS Lambeth CCG: Violent Patient Service</td>
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<td>JWe introduced the paper (Enclosure N), which reported that an urgent unplanned meeting of the voting members of the Lambeth Primary Care Joint Committee had taken place on 11th November. The meeting had considered the options available to NHS England (London), following notice served by one of the current three providers of the Violent Patient Service. Five options were presented to the Lambeth Primary Care Joint Committee – these were not detailed in Enclosure N, but are available on request. The preferred option of Model 2.1.1 of the Violent Patient Scheme options paper (as reviewed at the unplanned meeting of the Lambeth Primary Care Joint Committee on 11th November) had been approved by the Primary Care Joint Committee, as well as the process to invite practices within the South of the South East and South West locality to express an interest in hosting the Violent Patient Scheme in order to provide full coverage in all three localities in Lambeth.</td>
</tr>
<tr>
<td>JWe advised that the request has the support of Lambeth Local Medical Committee.</td>
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<tr>
<td>The Lambeth London Primary Care Joint Committee noted this report.</td>
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<th>NHS Bromley CCG: Winter Resilience Local Incentive Scheme</th>
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<tr>
<td>JWe introduced the paper (Enclosure O), which reported that an urgent unplanned meeting of the Bromley Primary Care Joint Committee had taken place on 19th</td>
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ENCLOSEMENT 12
November. The meeting had been convened to consider Bromley CCG’s Winter Resilience Local Incentive Scheme (LIS), to enable its implementation with effect from 1st December 2015.

The full set of papers that were reviewed at the urgent unplanned meeting are available on demand. The scheme had been approved by the Bromley Primary Care Joint Committee on the condition that the risks highlighted are actioned as set out in Enclosure O and that the schemes are suitably monitored and reviewed, with appropriate action taken to mitigate unexpected variation.

It was noted that the Bromley Local Medical Committee had been consulted on this course of action.

The Bromley Primary Care Joint Committee noted this report.

Public

11. Public Open Space

The following questions were raised by members of the public at the meeting:

Mark Webb asked: Is the personal safety of frontline NHS staff, the number one priority for the NHS in south east London, and if not, why not?

A number of Joint Committee members present contributed to the response to the question.

SB (Bexley Joint Committee) advised that there was a zero tolerance approach to violence toward every NHS staff member. Whilst the issue was not a specific priority in south east London strategies, it is a priority for all for all NHS organisations at a local and national level, and is a matter taken very seriously by all NHS organisations in south east London, particularly those that carry out frontline duties. In cases of violence and aggressive behaviour towards NHS staff, south east London commissioners and provider organisations will take necessary action including prosecutions.

JWe (NHS England) commented that this matter linked in with one of the items covered earlier at the meeting, in that NHS England (London) runs a Violent Patient Service in each borough. These services ensure that there is provision for GPs to report threatening behaviour and/or violence towards NHS staff in GP Practices, and so that NHS England (London) can utilise its statutory responsibility to make General Practice as safe as possible for its staff.

AE (Lambeth Joint Committee) commented that as well as ensuring that NHS services and facilities are safe for NHS staff, all NHS organisations are duty-bound to also ensure that they are safe for members of the public.

Jacqueline Best-Vassell asked a two-part question: (i) What were the benefits and the thinking behind transferring QIPP from secondary to primary care, when there seems to be a lot of objection on this from local primary care providers and commissioners? (ii) When looking at overspends across different local areas, the questioner asserted that it is clear that the largest areas in population size are often also those with the most deprivation. Therefore, to ensure that services to local patients do not suffer, there should be equity of distribution across areas, and there should be a more collective approach across the six boroughs to aid this.

RJ (NHS England) responded by stating that there had not been a transfer of QIPP
from secondary to primary care. CCGs each have their own challenging financial position and therefore their own QIPP targets to meet (noting that CCGs' spend is predominantly on acute/secondary care). RJ also stated that, as per discussions in item 5, the efficiencies achieved around transactional QIPPs during the last two years had now been exhausted, and therefore the focus was to look at the whole amount of spend and ensure that all opportunities for efficiencies across the whole system were being maximised, whilst at the same time investing in primary care to enable it to help deliver some of the savings required in secondary care. In that light, whole health economies are being reviewed together rather than as separate budgets, organisations and services, and that this was very much in line with the Government’s Five Year Forward View.

MR (Lewisham Joint Committee) commented that the value of taking financial resources out of primary care in the aim of achieving efficiency was a contested point, and that all financial efficiencies achieved should remain within primary care for reinvestment in services. This point was reiterated by SP, who referred to a movement of £1.2m out of primary care that had not been reinvested (during the PCT era), and a concern for south London of resources being removed from primary care in future (in the context of the PMS review), asserting that all resources should be retained in primary care in order to carry out its intended role of reducing pressure and overspends within acute services.

MW confirmed that the decision relating to the £1.2m movement of funds away from primary care had been a PCT decision, and not a decision taken by the CCG or NHS England (London).

DS advised that the principles of the PMS review were such that any monies that are currently spend in Personal Medical Services will be retained in general practice.

MR also commented on the second issue raised by the questioner, by referring to the great complexities associated with this issue. MR offered to discuss this in more detail with the questioner away from the meeting.

DS advised that the comparative historical position on primary care spend across boroughs was a position inherited by NHS England (London) when it took over the lead on primary care contracts from Primary Care Trusts (PCTs) at the start of 2013-14. Therefore it followed that there was not necessarily a rationale as to why one borough’s expenditure was greater than that of another borough. Furthermore DS advised that at present there was no model in place to look at patient need at the individual borough level (only at London-level), but that as part of the emerging transition to co-commissioning and full delegation in boroughs, that local borough-based models would be established to respond to the needs of local populations and that alongside the national model this would give a greater sense of where over or under provision of resource allocations were in existence.

AE noted that spend on primary care represents approximately 10% of the total expenditure made by CCGs and NHS England (London) across community-based and hospital-based care. Concerning the equity of distribution of resources, AE explained that the direction was to look across all of the NHS allocations supporting populations and not just single components, such as resources for primary care. This was in line with the key principles of the Five Year Forward View for the NHS to join-up care and support for individuals and to secure improved population-wide health outcomes.

JH (Southwark Joint Committee) reflected on the responses made to the first part of
the question by clarifying that at present the budgets for the different parts of the local health economies sat within different organisations, and that it was hoped in future this would be managed on a whole health system basis, potentially enabling CCGs to move more of their resources into services in the community setting.

JH commented on the second issue raised by recognising that from a review of the financial reporting alone, the notion of an inequitable distribution of resources (or that resources were not distributed based on key factors such as deprivation) could be arrived at. However JH emphasised that across south east London there are a range of collaborative programmes (such as Community Based Care) that are focused on ensuring consistency of quality for all patients in south east London. Commissioners were very aware of the importance of addressing concerns around deprivation, and referred to the point made by DS (above) around moves toward understanding deprivation and the resources required to respond to it in all localities across London, which should provide important answers to this question.

Jennifer Quinton-Chelley asked if practices were able to retain underspends from one financial year to the next, in order to deliver on other priorities for their patients.

RJ advised that NHS underspends were managed on a whole system basis, ie an underspend in one area would be used to offset an overspend in another part of the health system in London. RJ said that NHS England (London) is looking across the whole of primary care in London to try to address the shortfall on primary medical services, and noted that London as a region was just about managing to stay in financial balance, but that other regions in England were in a far worse position, and this, alongside the fact that the acute provider sector was in such a heavily challenged financial position meant that any financial surpluses in any part of the system would necessarily used to offset overspends elsewhere. The ultimate risk that this sought to mitigate was the possibility of the Department of Health’s budget reaching a deficit.

In terms of the position at an individual practice level, DS advised that NHS England (London) held a contract with individual practices under which it pays practices the amount of money they are entitled to receive in order to meet the needs of their patients, as well as the costs associated with their premises as they deem appropriate.

At the end of the second public open space, GU advised the members of public present that they also have the opportunity to address written questions to the Joint Committees in advance of these meetings and that these requests would receive written answers. The advertisements for these meetings (as shown on CCG websites) would provide a contact email address to send questions to (this is tom.bunting@nhs.net) and a timeframe in advance of the next meeting in order to have a response issued at the meeting.

Other business

12. Any other business

GU reiterated the message from previous meetings, that the meetings of the south east London Primary Care Joint Committees are a "work in progress" and that there is ongoing work to improve all aspects of how they are managed, and thanked each Joint Committee for the feedback (on how to improve the meetings) that had already been received, and encouraged further feedback on an ongoing basis. This had been sent in by Chairs of the Primary Care Joint Committees and any further feedback on an ongoing basis would be welcomed and acted upon.
| For information |
|-----------------|--------------------------------------------------|
| 13. Glossary of Terms | The Joint Committees noted the contents of the Glossary of Terms. No updates had been received since the last meeting. |
| Date of Next Meeting | 11 February 2016, 6-8.30pm at Kia Oval, Surrey County Cricket Club, SE1 5SS |

Close
# Primary Care Joint Committees

10 December 2015

**Signed Attendance Sheet (Public and other observers)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation/Group</th>
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<tbody>
<tr>
<td>Gary Beard</td>
<td>NHS England</td>
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<tr>
<td>Sharon Fernandez</td>
<td>NHS England</td>
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<tr>
<td>Leslie Aitken</td>
<td>NHS Lewisham CCG</td>
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<tr>
<td>Bobbie Scott</td>
<td>NHS Lewisham CCG</td>
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<tr>
<td>Bob Skelly</td>
<td>South Southwark Patients and Participation Group</td>
</tr>
<tr>
<td>Mark Webb</td>
<td>Camberwell resident and member of SE5 Forum (Tenant’s Association in Camberwell)</td>
</tr>
<tr>
<td>Martin Dadswell</td>
<td>Member of the public</td>
</tr>
<tr>
<td>Tamsin Bacchus</td>
<td>Save Lewisham Hospital Campaign</td>
</tr>
<tr>
<td>Jacqueline Best-Vassell</td>
<td>Lambeth and Southwark MIND, works for South London and Maudsley NHS Foundation Trust, is on Lewisham Patients and Participation Group.</td>
</tr>
<tr>
<td>Juney Muhammad</td>
<td>Service Manager, South London and The Maudsley NHS Foundation Trust</td>
</tr>
<tr>
<td>Jennifer Quinton-Chelley</td>
<td>Peckham resident, member of the Acorn and Gaumont GP Patients and Participation Group, member of Southwark Pensioners Action Group and Southwark Pensioners Forum</td>
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