AGENDA
A meeting of the Primary Care Commissioning Committee in public

Date: 24 October 2017
Time: 9.30 - 11.30 am
Venue: Cantilever House, Eltham Road, London SE12 8RN
Chair: Shelagh Kirkland

Enquiries to: Hannah Reeves
Telephone: 020 3049 3248
Email:

Members
Diana Braithwaite Commissioning Director
Alison Browne Registered Nurse
Anne Hooper Lay Member
Shelagh Kirkland (Chair) Lay Member
Dr Faruk Majid Clinical Director
Dr Jacqueline McLeod Senior Clinical Director
Tony Read Chief Financial Officer
Dr Marc Rowland Chair
Ray Warburton OBE Lay Member
Martin Wilkinson Chief Officer

Voting Members
a. 3 x Lay Members
   o Chair: Lay Member for Primary Care
   o Vice Chair: Lay Member responsible for Patient Public Engagement
   o Lay Member: Chair of the Audit Committee and Conflicts of Interest Guardian
b. CCG Chair
c. 2 Governing Body GP Members
d. Registered Nurse or Secondary Care Specialist (single member)
e. CCG Chief Officer
f. CCG Chief Financial Officer
g. Director of Commissioning & Primary Care

Non-Voting Members
a. Local Medical Committee Representative
b. Healthwatch Representative
c. Local Authority Representative of the Health and Wellbeing Board (Elected Member or Mandated Officer)

Chair: Dr Marc Rowland
Chief Officer Martin Wilkinson
d. Officers as required to undertake business of the committee

e. NHS England Representative

**Quorum**

1. The quorum shall be a minimum of 4 members, of which 2 must be Lay Members.
2. Where a quorum cannot be convened from the membership, owing to arrangements for the management of conflicts of interest or potential conflicts of interest; the Chair of the meeting will comply with the conflicts of interest policy.
3. This may result in:
   a. The meeting being deferred
   b. A discussion being undertaken but the decision deferred until the next meeting
   c. Discussion being undertaken being deferred to the Governing Body
## Order of Business

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Papers</th>
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<tr>
<td>09:30</td>
<td><strong>Welcome and introductions</strong></td>
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<td>Chair</td>
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<td>09:35</td>
<td><strong>Apologies for absence</strong></td>
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<td>09:37</td>
<td><strong>Declarations of Interest</strong></td>
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<td>Members should discuss any potential conflicts of interest with the</td>
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<td>Chair prior to the meeting.</td>
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<td>09:40</td>
<td><strong>Minutes</strong></td>
<td>1 - 10</td>
<td>Chair</td>
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<td>• To approve the minutes of the PCCC meeting on 15th August 2018</td>
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<td>• Glossary of terms</td>
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<td>09:45</td>
<td><strong>Actions</strong></td>
<td>11 - 12</td>
<td>Chair</td>
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<td>• Review of actions</td>
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<td>09:50</td>
<td><strong>CQC requires improvement - standard operating procedure</strong></td>
<td>13 - 20</td>
<td>Jill Webb</td>
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<td>(a) Lewisham Medical Centre</td>
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<td>Conflict of Interest: There is a personal conflict of interest for</td>
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<td>Dr Rowland. The mitigation will be for Dr Rolwand to leave the</td>
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<td>meeting for this item.</td>
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<td>(b) Triangle Group Practice</td>
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<td><em>Purpose: To consider and approve the recommendations</em></td>
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<td>10:00</td>
<td><strong>Healthwatch: GP Patient Information Audit</strong></td>
<td>21 - 26</td>
<td>Folake Segun</td>
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<td>*Purpose: To note the Healthwatch recommendations and consider any</td>
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<td>follow-up actions/plans.</td>
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<td>10:25</td>
<td>**Queens Road Partnership - Estates Developments (Besson Street</td>
<td>27 - 32</td>
<td>Jacky Malone</td>
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<td>Redevelopment)**</td>
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<td><em>Purpose: To note</em></td>
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<td>10:35</td>
<td><strong>Co-ordinated Care Service: 2016/17 Outcomes &amp; Achievements</strong></td>
<td>33 - 50</td>
<td>Ashley O’Shaughnessy</td>
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<td><em>Purpose: To note</em></td>
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<td>10.</td>
<td>10:45  Primary Care Operational Group - chairs report</td>
<td>51 - 52</td>
<td>Dr Jacky McLeod</td>
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<td>11.</td>
<td>10:55  GP Forward View (GPFV): Update</td>
<td>53 - 66</td>
<td>Ashley O’Shaughnessy</td>
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<td>12.</td>
<td>11:05  Finance Report</td>
<td>67 - 70</td>
<td>Tony Read</td>
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<td>13.</td>
<td>11:15  AOB</td>
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<td>14.</td>
<td>Date of the next meeting: Tuesday 19th December 2017</td>
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Managing Conflicts of Interest: Governing Body, committees, sub-committees and working groups

1. The chair of the Governing Body and chairs of committees, subcommittees and working groups will ensure that the relevant register of interest is reviewed at the beginning of every meeting, and updated as necessary.

2. The chair of the meeting has responsibility for deciding whether there is a conflict of interest and the appropriate course of corresponding action. In making such decisions, the chair may wish to consult the member of the governing body who has responsibility for issues relating to governance.

3. All decisions, and details of how any conflict of interest issue has been managed, should be recorded in the minutes of the meeting and published in the registers.

4. Where certain members of a decision-making body (be it the governing body, its committees or sub-committees, or a committee or sub-committee of the CCG) have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision-making itself (i.e., not have a vote).

5. In any meeting where an individual is aware of an interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair, together with details of arrangements which have been confirmed by the governing body for the management of the conflict of interests or potential conflict of interests. Where no arrangements have been confirmed, the chair may require the individual to withdraw from the meeting or part of it. The new declaration should be made at the beginning of the meeting when the Register of Interests is reviewed and again at the beginning of the agenda item.

6. Where the chair of any meeting of the CCG, including committees, sub-committees, or the governing body, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting. Where arrangements have been confirmed with the governing body for the management of the conflict of interests or potential conflicts of interests in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

7. Where significant numbers of members of the governing body, committees, sub committees and working groups are required to withdraw from a meeting or part of it, owing to the arrangements agreed by the Governing Body for the management of conflicts of interest or potential conflicts of interest, the remaining chair will determine whether or not the discussion can proceed.

8. In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the CCG's standing orders or the relevant terms of reference. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the governing body, committees, sub committees and working groups owing to the arrangements for managing conflicts of interest or potential conflicts of interest, the chair may invite on a temporary basis one or more of the following to make up the quorum so that the CCG can progress the item of business:
   a. an individual GP or a non-GP partner from a member practice who is not conflicted
   b. a member of the Lewisham Health and Wellbeing Board;
   c. If quorum cannot be achieved by a) or b) (above) a member of a governing body of another clinical commissioning group.

9. These arrangements will be recorded in the minutes.

Chair : Dr Marc Rowland

Chief Officer Martin Wilkinson
Primary Care Commissioning Committee  
Tuesday 15th August 2017

Present
Shelagh Kirkland (SK)  
Chair
Diana Braithwaite (DB)  
Director of Commissioning & Primary Care
Anne Hooper (AH)  
Lay Member Public Engagement
Dr Faruk Majid (FM)  
Clinical Director
Tony Read (TR)  
Chief Financial Officer
Jill Webb (JW)  
South East London Primary Care Contracting Team
Martin Wilkinson (MW)  
Lay Member, Chair of the Audit Committee and Conflicts of Interest Guardian

Attending
Jacky Malone (JMa)  
Estates Programme and Project Manager
Colin Paget (CP)  
Director of Operations (CEPN)
Hannah Reeves (HR)  
Administrative Manager (Minutes)
Ian Ross (IR)  
Associate Director of Primary Care
Folake Segun (FS)  
Director, Healthwatch Lewisham
Eileen White (EW)  
Head of Medicines Management

Apologies
Magna Aidoo (MA)  
Lay Member – Healthwatch Representative
Alison Browne (AB)  
Governing Body – Registered Nurse Member
Dr Jacqueline McLeod (JM)  
Clinical Director
Ashley O’Shaughnessy (AOS)  
Deputy Director of Primary Care
Simon Parton (SP)  
Chair, Local Medical Committee
Dr Marc Rowland (MR)  
Chair, Lewisham Clinical Commissioning Group

1. Welcome and Introductions
The Chair welcomed everyone to the meeting.

2. Declarations of Interest
Other than the declarations recorded on the LCCG register, there were no additional declarations made at the meeting.

3. Minutes of the previous meeting
The minutes of the meeting on Tuesday 20th June 2017 were agreed as an accurate record, taking into account 2 administrative changes;
- Marking Jill Webb as sending apologies
- Text change from “Gary Bear” to “Gary Beard”

4. Review of action log
The Committee was advised that all actions were now closed, with the exception of action 12A, which will be discussed at this meeting and subsequently closed.

5. Questions from members of the public
Q – It was requested that information regarding numbers of full time GPs in Lewisham at the time of initiating the CCG, plus the current and predicted future numbers be provided.
A – It was agreed this information would be provided via email outside of the meeting.
Q – Concerns were raised regarding the dispersal of the registered list following the APMS contract coming to a natural end, taking into consideration the impact on other practices in the area and whether this would mean fewer GP’s serving the needs of the Lewisham population as existing GP’s under the current APMS contract might not be retained within Lewisham.
A – It was agreed that these concerns would be addressed later under the agenda item on the APMS contract.

Q – Concerns about the fact that the Waldron is not fully utilised despite the fact that the CCG has to pay for the costs under the PFI contract whether it is full or not.
A – It was confirmed that there are active initiatives currently underway to increase the use of the space within the Waldron Health Centre, acknowledging that the charge is the same to the CCG regardless of occupancy levels. However, it is beneficial to the CCG if the space is fully occupied as the service charges can be allocated to occupants whereas service charges relating to void spaces must be borne by the CCG.

6. Amersham Vale Practice – Estate expansion business case

6.1 Jacky Malone provided the Committee with a summary of the reasoning behind the submitted business case. The Amersham Vale Practice had been contracted by Goldsmiths College to provide medical services to students and therefore require additional space to accommodate this increased capacity. The request is for Room 80 at the Waldron Centre to be allocated, which is located next door to Amersham Vale Practices current suite.
6.2 It was noted that the Practice is rated as outstanding by the Care Quality Commission. However, despite this there are still issues with access to appointments. The CCG will support the practice to monitor the impact of the increased list size. The Committee requested assurance from Amersham Vale Training Practice on what action plans are in place to cope with the potential increase in demand.

ACTION: Request assurance from Amersham Vale Training Practice demand management

DECISION: The Committee approved the business case.

7. Primary Care Operational Group (PCOG) – Terms of reference

7.1 Ian Ross informed the Committee that the operational group is to be set up to oversee the delivery of actions and decisions made by the Committee. It is responsible for establishing and monitoring task and finish groups when appropriate.
7.2 The Committee commented that the membership of the PCOG needs to ensure it is tied into all aspects of the CCG who will undertake work on behalf of the Committee, namely the Business Intelligence team and Finance Team. It was agreed that this would be added to the TORs.
7.3 The Committee requested that the rules regarding quoracy be amended to stipulate that 3 out of the 4 members must be present for decisions to be made, rather than 2 members as currently. Subject to this change the TOR’s were approved.
7.4 It was agreed that the TORs should be monitored and reviewed by the Committee should it become apparent that the membership requires amendment or the PCOG requires different inputs, for example, from Lay Members.

DECISION: The Committee approved the TORs subject to the amendments.

8. Alternative Provider Medical Services (APMS) Contract – Hurley Group, GP registered list (Waldron Centre)
8.1 Jill Webb provided an overview of the types of contracts available for contracting GP services given the questions raised by a member of the public. Jill Webb advised that unlike the other two types of contracts; Personal Medical Services (PMS) and General Medical Services (GMS), which are awarded in perpetuity, an APMS contract is time limited.

8.2 The APMS Contract was initially awarded for a 5 year period with an option to extend for a further 2 years, which was exercised. The existing contract has a final expiry date of 31st December 2017, which is why a decision needed to be taken regarding future commissioning intentions.

8.3 Jill Webb provided the Committee with a refresh on the circumstance surrounding the decision taken in a ‘closed’ Part 2 meeting of the Primary Care Joint Committee on 20th October 2016 to disperse the list of the Hurley Group APMS contract, located at the Waldron Centre. Jill Webb informed the Committee that this was in line with all APMS contracts in London being reviewed. The process to consider dispersing the list in closed meeting was made in order to abide by the rules of procurement for CCGs with regard to competition and commercial sensitivities. If this decision had been made in public, this could have led to potential providers, having an unfair advantage and the procurement being subject to challenge.

8.4 The Committee was informed that there were two conditions that need to be satisfied during this process:
1. An absolute check on capacity; local practices able and willing to take the additional patients from the dispersed list
2. Assurance that quality is sufficient; equal to or better than currently provided under the existing APMS contract

8.5 Jill Webb informed the Committee that patient engagement is still outstanding and that this will commence shortly. That before this point it would have been inappropriate to engage with patients due to the procurement considerations.

8.6 The Committee was informed that a large number of local practices and neighbouring (including one run by Hurley Group which are within the same building) consider they have capacity available to take on the registered list of patients which is being dispersed. It was confirmed that the APMS contract holder would be liable to provide information to the CCG regarding vulnerable patients who may require additional support to complete the process of registering with a new practice.

8.7 A query was raised about the timescale for engagement with the patients as it seemed very late to commence engagement, when the decision had been taken nearly a year ago not to renew the contract and to disperse the list. Especially, as patients would need to register with another practice by the end of this year when this practice would close.

8.8 It was agreed that Diana Braithwaite would have a conversation with the SEL Executive Group to ensure alignment across the 6 CCGs and discuss whether changes could be made in the future to increase the engagement timeframe.

8.9 Ray Warburton thanked Jill Webb for her very clear explanations on the types of GP contracts and the processes that needed to be followed when APMS contracts terminate.

8.10 The Committee noted the arrangements concerning the APMS contract with the Hurley Group.

**ACTION:** Diana Braithwaite to talk to SEL re. Engagement timeframe.

9. Primary Care Prescribing Incentive and Quality Scheme

9.1 Eileen White, Head of Medicines Management for LCCG, joined the Committee to present the Prescribing Incentive and Quality Scheme re-launched as Medicines Optimisation Plan in line national with principles of improving patient outcomes. The scheme aims to promote good quality, evidence based and cost effective prescribing which ensures patients are managed appropriately and ensures the prescribing of
certain medications is also appropriate. The Medicines Optimisation Plan (MOP) is put in place to support GP practices; work streams from the MOP are set in different clinical areas and aligned to Quality Improvement (QIPP) initiatives.

9.2 The Committee raised a number of queries, following the report:

A. Why is the PCCC approving a plan in August, which was implemented in April 2017?
Eileen White advised that the delay was partly as a result of capacity issues within the team and additionally having to wait for electronic prescribing analysis and costs (ePACT) data which is 2 months in arrears, which provides the baseline data and supports target setting.
The Committee requested assurance that the same capacity issues would not be faced at the beginning of the next financial year.
The Committee enquired as to why the data source/implementation dates could not be re-phased to align with approval of the MOP happening at the beginning of the financial year. It was agreed that EW would further investigate this.

B. Clarification surrounding terminology and acronyms used within the report
Eileen White informed Committee members of the meaning behind some of the terminology used within the report. For example DOAC (Direct Oral Anti-Coagulants) and agreed that any future reports submitted to the PCCC would include a glossary of terms used as well as a summary of any documents that include technical vernacular.

C. The report stated both that the CCG is still awaiting the outcome of engagement with LMC and that the LMC endorsed the MOP – Clarification regarding the correct statement required.
Eileen White confirmed to the Committee that the Local Medical Committee had endorsed the MOP.

D. What information will the Practices submit or how else will the CCG monitor success
Eileen White confirmed to the Committee that in the work plan areas which indicate “no paperwork for practice to submit - CCG to monitor”... Changes in prescribing data will be determined using ePACT and compared with baseline data.

E. Will practices be penalised if they do not prescribe in line with the MOP?
Eileen White confirmed that there is not a process for penalising practices which do not achieve the MOP incentives, however, the CCG will work with that practice to review why they have not achieved and support the practice going forward.

F. Clarification on which areas have commenced and which have been delayed and the impact of this on the CCGs QIPP schemes.
Eileen White confirmed to the Committee that the QIPP schemes have been aligned to the phased delivery of the MOP. Most areas have already begun and that the first area - stroke prevention in atrial fibrillation has been rolled out to most practices.

G. Is the incentive programme an ‘all or nothing’ payment criteria?
EW informed the Committee that areas within the scheme are weighted however within these payment would be “all or nothing”.

**ACTION:** Eileen White to investigation why data source/implementation dates could not be re-phased to align with approval of the MOP happening at the beginning of the financial year.
DECISION: The Committee approved the scheme.

10. Primary Care Equalities Objectives – Progress

10.1 The Committee was updated on the work undertaken to deliver against key phases of the 3 year Primary Care Equalities Objectives Programme. The objectives were developed in response to the national GP patient survey results in 2013, where people who identified themselves as being from Black and Minority Ethnic groups felt they were less supported to manage long term conditions.

10.2 The report included an update on all plans within the programme and included RAG ratings. The Committee received assurance that all schemes rated red were being monitored and worked on, including assessing the impacts from new initiatives being implemented, which was expected to be demonstrable within the next year.

ACTION: The Committee requested information on how this work links into the Patient Engagement and Equalities Forum (PEEF) and the Equality and Diversity Steering Group (EDSG), it was agreed that this information would be shared outside of the meeting.

11. CEPN BAME Initiatives

11.1 Colin Paget, Director of Operations for Lewisham CEPN, provided the Committee with an update on the CEPN initiatives actioned to help support the Primary Care Equalities Objectives. This work includes meetings with patients; however it was reported that unfortunately (potentially due to the location of the meetings) the meetings were not well attended by patients, therefore the plan is being re-evaluated.

11.2 Colin Paget informed the Committee that a report following work undertaken to date is expected in September 2017. Following this report a training programme will be developed with implementation anticipated to take place in February 2018.

11.3 It was noted that the training and reporting needs to ensure that the issues raised by patients should not be mythologised and that when putting the training into action, practitioners should effectively apply the training in a bespoke way for each patient.

ACTION: The Committee requested information regarding the levels of BAME representation on Patient Participation Groups.

12. Healthwatch – Primary Care Extended Access Engagement Report

12.1 Folake Segun, Director, Healthwatch Lewisham, joined the Committee to discuss the Primary Care Extended Access Engagement Report carried out by Healthwatch. The Committee was informed that in January 2017 the CCG commissioned Healthwatch Lewisham to deliver 5 engagement activities with seldom heard groups in Lewisham:

1. People from Black African and Caribbean backgrounds
2. People with a learning disability
3. People with a physical or sensory disability
4. People living with mental health issues
5. People living in areas of deprivation

12.2 The Committee was informed that the engagement activities had resulted in key themes being uncovered and recommendations being made, both of which have fed into GP Extended Access delivered by One Health Lewisham Ltd. It was noted that the Extended Access service will be moving re-locating in October 2017 and this will be a prime opportunity to make improvements; such as making sure announcements being at an appropriate volume. It was agreed that more work was required to improve the awareness of staff and patients.
ACTION: It was agreed that a written response to the report be provided to Healthwatch.

13. Community Education Provider Network (CEPN): Summary of activities

13.1 Colin Paget updated the Committee on the current work being undertaken by the CEPN, working with flexible training providers. This work is linking into other CEPNs within the STP footprint and training is also offered out to social care providers.

13.2 It was confirmed to the Committee that the programme does help to develop staff, for example the care certificate which helps to develop nursing staff.

14. Finance

14.1 Tony Read presented Primary Care Finance Report to the Committee, which included information on the year to date financial position for South East London Primary Medical Services. There is an overspend of £35k against total year to date allocations of £62.86k. For Lewisham specifically, the reported year to date position is an underspend of £9k (0.08%).

14.2 Tony Read confirmed to the Committee that conversations regarding the dis-allocation of budgets from NHS England following the CCGs move to level 3 delegated commissioning were not yet concluded.

15. Agenda items 14 and 15.

RESOLVED: It was agreed that agenda items 14 (Co-ordinated Care Service) and 15 (GP Forward View) would be deferred to the Tuesday 24th October Primary Care Commissioning Committee.

16. Any Other Business

16.1 Ray Warburton raised one item of business, in relation to a qualified audit report issued by Deloittes relating to payments made to GP’s by Capita and the effect of these reports following the move to level 3 delegated commissioning.

16.2 It was agreed that Jill Webb would obtain a copy of the audit report and that the SEL Primary Care Executive Board would review this and would report back to the Committee.

16.3 It was further agreed that this matter should be considered at the Lewisham CCG Audit Committee and that this would be added to the forward planner for the Audit Committee meeting and the Audit Committee would report any relevant information to the PCCC and Governing Body.

ACTION: Include forward Audit Committee.
GLOSSARY OF TERMS

AAS Admission Avoidance Service
ACRA Advisory Committee on Resource Allocation
ACS Accountable Care System
ADASS Association of Directors of Adult Social Services
AEC Ambulatory Emergency Care
A&E Accident and Emergency
AEDB – A&E Delivery Board
AfC Agenda for Change
AHP Allied Health Professional
AHSC Academic Health Science Centre
AHSN Academic Health Science Network
APMS Alternative Provider Medical Services
AQP Any Qualified Provider
ASTRO-PU Age, Sex, Temporary Resident Originated Prescribing Unit
AWP Allocation Working Paper
BDA British Dental Association
BMA British Medical Association
BME Black and Minority Ethnic
BNF British National Formulary
BPPC Better Payment Practice Code
CAMHS Child and Adolescent Mental Health Services
CAS Central Alert System
C&B Choose & Book
CBC Community Based Care
CBT Cognitive Behavioural Therapy
CCG Clinical Commissioning Group
CCNT Children’s Community Nursing Team
CEMACH Confidential Enquiry into Maternal and Child Health
CHC – Continuing Health Care
CIO Chief Information Officer
CIP Cost Improvement Programme
CLG Clinical Leadership Group
CNST Clinical Negligence Scheme for Trusts
COPD Chronic Obstructive Pulmonary Disease
CQRG Clinical Quality Review Group
CRL Capital Resource Limit
CPA Care Programme Approach
CPD Continuing Professional Development
CPN Community Psychiatric Nurse
CPR Child Protection Register
CQC Care Quality Commission
CQUIN Commissioning for Quality and Innovation
CQRG Clinical Quality Review Group
CRB Criminal Records Bureau
CSU Commissioning Support Unit
CSP Commissioning Strategy Plan
CSR Comprehensive Spending Review
CSS Commissioning Support Service
CTR Care & Treatment Team
C&V Cost and Volume
CVD Cardiac Vascular Disease+
CYP Children and Young People
CYPFF Children and Young people Partnership Board
DAAT Drug & Alcohol Action Team
DES Direct Enhanced Service
DGH District General Hospital
DH or DoH Department of Health
DTC or DToC Delayed transfer of care
D2A discharge 2 assess
E&D Equality and Diversity
ED Emergency Department
EDS (NHS) Equality Delivery System
EI Early Intervention
EIA Equality Impact Assessment
EIP Early Intervention in Psychosis
EMIS Practice Information System
ENT Ear, Nose and Throat
EPP Expert Patient Programme
EPR Electronic Patient Record
EPRR Emergency Planning Response Register
EPS Electronic Prescription Service
ESR Electronic Staff Record
EWTD European Working-Time Directive
FCE Finished Consultant Episode
FHS Family Health Services
FIC Finance and Investment Committee
FIMS Financial Information Management System
FLAG For Learning and Action Group
FNP Family Nurse Partnership
FOI Freedom of Information
FOT Forecast Outturn
FT Foundation Trust
GAD Government Actuary’s Department
GDC General Dental Council
GDS General Dental Services
GMC General Medical Council
GMS General Medical Services
GOS General Ophthalmic Services
GP General Practitioner
GPEA General Practice Extended Access
GPI General Practitioner Interactive
GPS Government Procurement Services
GPSI or GPwSI General Practitioner with a special interest
GPSoC General Practitioner Systems of Choice
GSTT Guy’s & St. Thomas’s NHS Foundation Trust
HCA Health Care Assistant
HCAI Healthcare-Associated Infection
HCAIs Healthcare Acquired Infections
HCAS High Cost Area Supplement
HEMS Helicopter Emergency Medical Service
HIA Health Impact
Assessment
HIEC Health Innovation and Education Cluster
HMO Health Maintenance Organisation (USA)
HoNOS Health of the Nation Outcome Scales
HRG Healthcare Resource Group
HRG4 Healthcare Resource Group version 4
HSC Health and Social Care (Northern Ireland)
HSJ Health Service Journal
HTA Health Technology Assessment
HV Health Visitors
HWB Health and Wellbeing Board
IAPT Improving Access to Psychological Therapies (programme)
IC Information Commissioner
ICAS Independent Complaints Advocacy Service
ICD International Classification of Diseases
ICDT Integrated Contract Delivery Team
ICE Integrated Communication and Engagement
ICO Integrated Care Organisation
ICP Integrated Care Pathway
ICT Information and Communication Technology
ICU Intensive Care Unit
I&E Income and Expenditure
IFRS International Financial Reporting Standards
IG Information Governance
IMCA Independent Mental Capacity Advocate
IM&T Information Management and Technology
IP Information Prescriptions
IP Inpatient
IPR Individual Performance Review
IRP Independent Reconfiguration Panel
IST Intensive Support Team
JCP Jobcentre Plus
JHWS Joint Health and Wellbeing Strategy
JNC Joint Negotiating Committee
JSNA Joint Strategic Needs Assessment
KPI key Performance Indicator
KSF (NHS) Knowledge and Skills Framework
LA Local Authority
LCFS Local Counter Fraud Specialist
LDC Local Dental Committee
LES Local Enhanced Services
LETBs Local Education and Training Boards
LGA Local Government Association
LGT Lewisham & Greenwich NHS Trust
LIFT Local Improvement Finance Trust
LIMOS Lewisham Integrated Medicines Optimism Service
LMC Local Medical Council
LSMS Local Security Management Specialist
LOC Local Optical Committee
LOS Length of stay
LPC Local Pharmaceutical Committee
SIRO  Senior Information Responsible Officer
SLA  Service Level Agreement
SLaM  South London and Maudsley Mental Health Foundation Trust
SMR  Standardised Mortality Ratio
SNOMED  Systematised Nomenclature of Medicine
SO  Standing Order
SOPHID  Survey of Prevalent HIV Infections that are Diagnosed
SRO  Senior Responsible Officer
SSBU  Shared Service Business Unit
STP  Sustainability and Transformational Plan
SUS  Secondary User Services
TAP  Treatment Access Policy
TIA  Trans Ischaemic Attack- Stroke Indicator
TDA  – Trust Development Authority
TSA  – Trust Special Administrator
TUPE  Transfer of Undertakings (Protection of Employment) Regulations 1981
UCC  Urgent Care Centre
UDA  Units of Dental Activity
VCS  Voluntary and Community Sector
VFM  Value for Money
VPR  Virtual Patient Record
VSM  Very Senior Managers
VTE  Venous Thromboembolism
WHO  World Health Organization
WIC  Walk in Centre
WTD  Working-Time Directive
WTR  Working Time Regulations
<table>
<thead>
<tr>
<th>Date</th>
<th>Reference</th>
<th>Action Description</th>
<th>Due Date</th>
<th>Lead</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.08.2017</td>
<td>5(a)</td>
<td>Provision of numbers of full time GPs in Lewisham at the time of initiating the CCG, plus the current and predicted future numbers.</td>
<td>24.10.2017</td>
<td>Jill Webb</td>
<td>18.10.2017: Update at the meeting.</td>
</tr>
<tr>
<td>15.08.2017</td>
<td>6.2</td>
<td>Request assurance from Amersham Vale Training Practice demand management.</td>
<td>19.12.2017</td>
<td>Diana Braithwaite</td>
<td>18.10.2017: This will be picked up as a part of the APMS dispersal.</td>
</tr>
<tr>
<td>15.08.2017</td>
<td>8.10</td>
<td>SEL re. engagement timeframe.</td>
<td>18.10.2017</td>
<td>Diana Braithwaite</td>
<td>18.10.2017: This is not a regulatory requirement as this is engagement and not a formal consultation. However, 3 months is considered reasonable and best practice.</td>
</tr>
<tr>
<td>15.08.2017</td>
<td>9.2</td>
<td>Eileen White to investigation why data source/implementation dates could not be re-phased to align with approval of the MOP happening at the beginning of the financial year.</td>
<td>24.10.2017</td>
<td>Eileen White</td>
<td>18.10.2017: Update at the meeting.</td>
</tr>
<tr>
<td>15.08.2017</td>
<td>10</td>
<td>Link between Primary Care Equalities Objectives and PEEF and EDSG to be explained and information circulated to Committee members.</td>
<td>19.12.2017</td>
<td>Diana Braithwaite</td>
<td></td>
</tr>
<tr>
<td>15.08.2017</td>
<td>11</td>
<td>Information regarding the levels of BAME representation on PPGs.</td>
<td>19.12.2017</td>
<td>Ian Ross</td>
<td>23.08.2017: One Health Lewisham (GP Federation) have been approached to complete an audit of the representatives from the 4 neighbourhoods on the borough-wide PPG. The CCG does not hold information on the ethnicity of members of individual practice.</td>
</tr>
<tr>
<td>Date</td>
<td>Reference</td>
<td>Action Description</td>
<td>Due Date</td>
<td>Lead</td>
<td>Status</td>
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</tr>
<tr>
<td>15.08.2017</td>
<td>16.2</td>
<td>Include Capita on forward for the Audit Committee.</td>
<td>31.10.2017</td>
<td>Tony Read</td>
<td>CLOSED</td>
</tr>
</tbody>
</table>

**Actions from the last PCCC to be closed**

<table>
<thead>
<tr>
<th>Date</th>
<th>Reference</th>
<th>Action Description</th>
<th>Due Date</th>
<th>Lead</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.06.2017</td>
<td>12 (a)</td>
<td>TR to report the 2017/18 Primary Care Medical Services Budget and expenditure from the next meeting.</td>
<td>15.08.2017</td>
<td>Tony Read</td>
<td>On the agenda for 15th August 2017. CLOSED</td>
</tr>
</tbody>
</table>
ENCLOSURE 3a
Care Quality Commissioner Requires Improvement – Standard Operating Procedure:
Lewisham Medical Centre

MANAGERIAL LEAD: Jill Webb, Head of Primary Care, South East London Primary Care Team

AUTHOR: Julie Partridge, Commissioning Manager, South East London Primary Care Team

RECOMMENDATIONS:
The Primary Care Commissioning Committee (PCCC) is recommended to approve that confirmation is provided to the contractor (Lewisham Medical Centre) that formal contractual action will not be pursued on this occasion.

SUMMARY:
The purpose of this report is to seek approval from the Primary Care Commissioning Committee, to the recommendation that formal contractual action should not be pursued against Lewisham Medical Centre, following the contractual issues and concerns raised as a result of the CQC inspection.

This recommendation is in line with the London region Standard Operating Procedure (SOP) for Primary Medical contracts: A consistent approach to responding to Care Quality Commission (CQC) ‘Requires Improvement’ ratings.

The CQC carried out an inspection of Lewisham Medical Centre on 7th December 2016 and published its report on 12 April 2017. The contractor was rated as ‘Requires Improvement’ for ‘Are services safe?’ and ‘Are services responsive to people’s needs?’ The contractor was rated as ‘good’ for ‘Are services effective?’, ‘Are services caring?’ and ‘Are services well-led?’ They received an overall rating of ‘Requires Improvement’ for the Quality of care. A copy of the report can be found at http://www.cqc.org.uk/location/1-646266447

Lewisham Primary Care Joint Committee (PCJC) previously approved the London region Standard Operating Procedure for Primary Medical contracts: A consistent approach to responding to Care Quality Commission ‘Requires Improvement’ ratings. The considerations within this have been used to determine what formal contractual actions are required, if any, for Lewisham Medical Centre receiving a Requires Improvement notice.

The considerations have included:

1. Should contractual action be considered?: When a contractor is in receipt of a CQC report indicating that they ‘Require improvement’, they have immediately breached their contract ‘The Contractor shall comply with all relevant legislation and have regard to all relevant guidance issued by the Board or the Secretary of State or Local Authorities in respect of the exercise of their functions under the 2006 Act.’ it is therefore proportionate for commissioners to consider further contractual action.

2. Should a breach/remedial notice be issued based on CQC visit report evidence?: Commissioners conclude that the report findings, on which the contractor has had the opportunity to comment, provide sufficient evidence of specified contractual compliance issues, and that it is therefore able
to issue a breach and remedial notice based on the evidence contained within.

3. **What is the Contractor’s track record/contractual history?:** Commissioners conclude that taking into account the full contractual history of this contractor; further contractual sanctions are not deemed reasonable.

4. **Is it a proportionate response to issue a breach/remedial notice?:** Commissioners conclude that taking into account the current level of response of the contractor to the CQC findings set out in their action plan below, it is not proportionate to issue a breach/remedial notice. Lewisham Medical Centre has addressed all of the CQC inspection issues/concerns. We therefore consider no further action is necessary.

The table below shows the completed actions.

<table>
<thead>
<tr>
<th>Issues/Concerns</th>
<th>Actions Taken/Actions not addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most risk to patients were assessed and well managed but there were some that were not well managed (prescription and smart card security)</td>
<td>Completed. The contractor confirmed and sent evidence to the commissioners that the practice has revised its prescription storage and handling policy and procedure. The smart card policy has also been revised and shared with all members of staff.</td>
</tr>
<tr>
<td>Most risk to patients were assessed and well managed but there were some that were not well managed (checks of the defibrillator)</td>
<td>Completed. The contractor confirmed and sent evidence to the commissioners that they had shared with inspectors post inspection, information from the manufacturer that their defibrillator does not require regular switching on and off to perform tests. The contractor also initiated a monthly visual check log to ensure the HCA is monitoring the device periodically.</td>
</tr>
<tr>
<td>Some patients (via the CQC inspection and the national GP patient survey), reported that they had to wait a long time after their appointments to be seen. Waiting times were longer than those at other practice</td>
<td>Completed. The contractor confirmed and sent evidence to the commissioners that the March 17 national patient survey showed that the practice had made a significant improvement in patients waiting 15 minutes or less to be seen.</td>
</tr>
<tr>
<td>The practice responded to issues raised but, were not following their own policy or national guidance when responding, and information provided to patients about how to escalate complaints was incorrect.</td>
<td>Completed. The contractor confirmed and sent evidence they have reviewed and updated their complaints policy in line with national guidance. The updated policy has been discussed and made available to all staff/patients.</td>
</tr>
</tbody>
</table>

Commissioners propose to write to the contractor to set out what has occurred, and confirm that formal contractual action will not be pursued on this occasion, based on the contractor’s current response to the outcome of their inspection, and subject to the re-inspection that took place on 17th October 2017.

**KEY ISSUES:**
1. The contractor was inspected on 7\textsuperscript{th} December 2016 and the report was published in April 2017.
2. They contractor’s overall rating was ‘Requires Improvement’ for the Quality of care provided.
3. There was an initial delay in commissioners following up on the report after which the practice was requested to submit an action plan addressing the adverse findings in the CQC report.
4. The action plan and evidence sent by the contractor to the commissioners in September 2017 showed how it had addressed the actions from the published CQC inspection report.
5. The contractor was revisited on the 17\textsuperscript{th} October 2017.
6. Whilst the contractor is in breach of the following regulations, commissioners have concluded that it is not currently proportionate to issue a breach and remedial notice;
   - Requirement to abide by all legislation
   - ‘Part 19, clause 452 of the PMS Contract of the Contract and Regulations 18, Paragraph 112 (1), (2), (3) and (4), Schedule 5, Part 9 of the PMS Regulations 2004 (as amended) Requirement to have an effective system of Clinical Governance.

**CORPORATE AND STRATEGIC OBJECTIVES:**

*Contract Management:* To manage effectively the CCG’s contract portfolio to ensure that the CCG’s Operating Plan’s commitments are met in 2017/18. This includes ensuring our financial targets are met and value for money is achieved.

**CONFLICT OF INTEREST (CoI):**

Dr Mark Rowland, CCG Chair, has a declared personal interest in the Penrose Group, which includes the Lewisham Medical Centre.

To mitigate this conflict of interest Dr Rowland will be asked to leave the committee meeting for this item.

**CONSULTATION HISTORY:**

N/A

**PUBLIC ENGAGEMENT:**

N/A

**HEALTH INEQUALITY & PUBLIC SECTOR EQUALITY DUTIES:**

No adverse impacts have been identified.

**RESPONSIBLE MANAGERIAL LEAD/S CONTACT:**

Jill Webb, SEL Head of Primary Care; E-Mail: jill.webb3@nhs.net
ENCLOSURE 3b
Care Quality Commissioner Requires Improvement – Standard Operating Procedure: Triangle Group Practice

MANAGERIAL LEAD: Jill Webb, Head of Primary Care, South East London Primary Care Team

AUTHOR: Julie Partridge – Commissioning Manager, South East London Primary Care Team

RECOMMENDATIONS

The Primary Care Commissioning Committee (PCCC) is recommended to;

1. approve that confirmation is provided to the contractor (Triangle Practice) that formal contractual action will not be pursued on this occasion subject to the following condition;
   (i) the contractor providing evidence that the remaining actions relating to their latest Care Quality Commission (CQC) report have been addressed within a 28 day period following them receiving notification from the CCG.
2. Seek evidence of improvement in the uptake of childhood immunisations as currently their performance is below the national average,

SUMMARY:

This recommendation is in line with the London region Standard Operating Procedure (SOP) for Primary Medical contracts: A consistent approach to responding to Care Quality Commission ‘Requires Improvement’ ratings

The contractor was rated as ‘Inadequate for ‘Are services safe?’ The contractor was rated as ‘Requires Improvement’ for ‘Are services effective?’ and ‘Are services well-led?’ The contractor was rated as ‘Good’ for, ‘Are services caring?’ and ‘Are services responsive to people’s needs?’ They received an overall rating of ‘Requires Improvement’ for the Quality of care. A copy of the report can be found at https://www.cqc.org.uk/location/1-559769040

The CQC subsequently carried out a re-inspection of Triangle Group Practice on 9 August 2017, where they received an overall rating of ‘Good’.

Lewisham Primary Care Joint Committee (PCJC) previously approved the London region Standard Operating Procedure for Primary Medical contracts: A consistent approach to responding to Care Quality Commission ‘Requires Improvement’ ratings. The considerations within this have been used to determine what formal contractual actions are required, if any, for Triangle Group Practice receiving a Requires Improvement notice.

The considerations have included:

1. Should contractual action be considered?: When a contractor is in receipt of a CQC report indicating that they ‘Require improvement’, they have immediately breached their contract ‘The Contractor shall comply with all relevant legislation and have regard to all relevant guidance issued by the Board or the Secretary of State or Local Authorities in respect of the exercise of their functions under the 2006 Act.’ it is therefore proportionate for commissioners to consider
further contractual action.

2. Should a breach/remedial notice be issued based on CQC visit report evidence?: Commissioners conclude that the report findings, on which the contractor has had the opportunity to comment, provide sufficient evidence of specified contractual compliance issues, and that it is therefore able to issue a breach and remedial notice based on the evidence contained within.

3. What is the Contractor’s track record/contractual history?: Commissioners conclude that taking into account the full contractual history of this contractor; further contractual sanctions are not deemed reasonable.

4. Is it a proportionate response to issue a breach/remedial notice?: Commissioners conclude that taking into account the level of response of the contractor to the CQC findings set out in their action plan below, and the subsequent CQC re-inspection on 9 August 2017, that it is not proportionate to issue a breach/remedial notice. Instead, it is recommended that a further action plan is required, within a 28 day period following them receiving this notification from the CCG, to evidence what steps have been taken to address the remaining statutory and contractual issues/concerns identified, as the contractor’s current action plan has not yet fully addressed all of the actions in the CQC report.

The table below shows the completed and uncompleted actions.

<table>
<thead>
<tr>
<th>Issues/Concerns</th>
<th>Actions Taken/Actions not addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice was not repeating audits to assess monitor and improve the quality and safety of services. Systems and processes were failing to monitor and mitigate all of the risks relating to the health, safety and welfare of service users. Some policies were incomplete or overdue for review. Staff were not aware of the policies in place.</td>
<td>Completed – Clinicians repeat audits in a timely fashion to assess, monitor and improve the quality and safety of services. Audits are discussed at least quarterly at weekly clinical meetings. All polices have now been reviewed and updated and a system put in place to review them on a regular basis. Staff are aware where the policies and procedures are kept.</td>
</tr>
<tr>
<td>Arrangements to prevent and control infections were not effective; staff had not all received training appropriate to their role, audits were not comprehensive and where issues were identified they were not all followed up.</td>
<td>Not Completed - CQC re-inspection on 9 August 2017, rated ‘Are services safe?’ as ‘Requires Improvement’. Arrangements to prevent and control infections were not effective: there was no infection prevention and control lead and the arrangements for ensuring cleanliness had not ensured a consistent quality of cleaning.</td>
</tr>
<tr>
<td>Not all staff had received appropriate training in child safeguarding. Information received from other health professionals was not being stored in a way that it could be referred to easily when required. The safeguarding policy was incomplete, inaccurate and some staff could not access it.</td>
<td>Completed – All staff have now received training in child safeguarding. The safeguarding policy has been reviewed, updated and is now easily accessible from any PC in the surgery. Information from other health professionals at the MDT meeting is minuted and a note is placed on the patient’s record to confirm this and action taken accordingly.</td>
</tr>
<tr>
<td>The vaccine fridge was over-filled and action had not been taken in response to</td>
<td>Completed – The vaccine fridges are no longer overfilled and ordering is monitored on</td>
</tr>
</tbody>
</table>
temperatures exceeding the maximum range.  

| The use of prescription forms and prescription pads including for controlled drugs, was not monitored. | Completed – There is a monitoring pad which lists the numbers of the forms and are signed for when removed from the locked cabinet which was purchased for this purpose. |
| Fire risk arrangements were not robust | Completed - A fire risk assessment was undertaken in December 2016, with a review put in the diary for December 2017. All staff have now received fire risk training. |
| There was no oxygen or defibrillator and emergency medicines were not all in place. There had been no risk assessment to justify this. | Completed – a defibrillator and oxygen was purchased and staff were trained in their use. Emergency medicines have been reviewed by the Practice Nurse and they are now up to date. |
| Clinical staff and staff under taking chaperoning had not been DBS checked, and this decision had not been risk assessed. | Completed - All staff have now had enhanced DBS checks. |

Commissioners propose to write to the contractor to set out what has occurred, and confirm that formal contractual action will not be pursued on this occasion, based on the contractor’s response to the outcome of their inspection, and subject to the contractor providing evidence that the remaining actions relating to their latest CQC report have been addressed within a 28 day period following them receiving this notification from the CCG.

Commissioners therefore recommends the issue of an action plan – to be completed within 28 days of receiving this notification - as a proportionate response to the second inspection published report - [https://www.cqc.org.uk/location/1-559769040](https://www.cqc.org.uk/location/1-559769040) covering the following areas:

- Policies and procedures processes
- Vaccine storage and management

**KEY ISSUES:**

1. The contractor was inspected on 24 August 2016 and the report was published in February 2017.
2. The contractor’s overall rating was ‘Requires Improvement’ for the Quality of care provided.
3. There was an initial delay in commissioners following up on the report after which the practice was requested to submit an action plan addressing the adverse findings in the CQC report.
4. The action plan and evidence sent by the contractor to the commissioners in September 2017 showed how it had addressed the actions from the published CQC inspection report.
5. The contractor was re-inspected on 9th August 2017 and the report published in October 2017.
6. The contractor’s overall rating was ‘Good’ for the Quality of care provided.
7. Whilst the contractor is in breach of the following regulations, commissioners have concluded that it is not currently proportionate to issue a breach and remedial notice.
- Requirement to abide by all legislation.
- Part 6, Clause 40 (1) and (2) of the PMS Contract and Regulation 18 and paragraph 6 (a) and (b) Schedule 5, Part 1 of the PMS Regulations 2004 (as amended) Requirement to have appropriate storage arrangements for vaccines.
- Part 19, clause 452 of the PMS Contract of the Contract and Regulations 18, Paragraph 112 (1), (2), (3) and (4), Schedule 5, Part 9 of the PMS Regulations 2004 (as amended) Requirement to have an effective system of Clinical Governance.

8. The contractor will be asked to provide evidence that the remaining actions relating to their latest CQC report have been addressed within a 28 day period following them receiving notification from the CCG.

9. The CQC October 2017 report also cites wider concerns relating to the uptake of childhood immunisations with uptake below the national average. The CCG therefore expects to see evidence of wider engagement and improvement in this area.

**CORPORATE AND STRATEGIC OBJECTIVES:**

*Contract Management:* To manage effectively the CCG’s contract portfolio to ensure that the CCG’s Operating Plan’s commitments are met in 2017/18. This includes ensuring our financial targets are met and value for money is achieved.

**CONFLICT OF INTEREST (Col):**

N/A

**CONSULTATION HISTORY:**

N/A

**PUBLIC ENGAGEMENT:**

N/A

**HEALTH INEQUALITY & PUBLIC SECTOR EQUALITY DUTIES:**

No adverse impacts have been identified.

**RESPONSIBLE MANAGERIAL LEAD/S CONTACT:**

Jill Webb, Head of Primary Care; E-Mail: jill.webb3@nhs.net
ENCLOSURE 4
Healthwatch: GP Patient Information Audit

MANAGERIAL LEAD: Diana Braithwaite, Director of Commissioning & Primary Care

AUTHOR: Ian Ross, Associate Director of Primary Care Transformation, NHS Lewisham CCG

RECOMMENDATIONS:
The CCG will formally respond to the recommendations in the Healthwatch Report and will wait to receive feedback before drawing up a final action plan with timelines which will be monitored as part of the quality improvement work of the primary care team within the CCG.

BACKGROUND
Healthwatch Lewisham carried out a research project to assess the consistency and accuracy of GP out-of-hours answerphone messages, website information and complaint procedures across the London Borough of Lewisham. Healthwatch Lewisham carried out a comprehensive review of all public facing information provided by the borough’s 39 GP practices (although the report states 43 practices).

Out-of-hours services are defined by the CQC as; Primary Care Services provided for patients with urgent care needs that cannot wait until their GP practice reopens, between the hours of 18:30 to 08:00, as well as weekends and Bank Holidays. These include NHS 111, A&E, Urgent Care Services and Extended Hours Services.

Healthwatch set out to:
- investigate patient experience of using both online and telephone information;
- identify how comprehensive and accessible online information is;
- identify if complaints procedures are clear and supportive of patients;

The CCG welcomes the report produced by Healthwatch. We want to ensure that patients registered with a Lewisham GP get timely access to health services and that they access the right service at the right time.

Healthwatch Recommendations – Initial CCG responses
1. *All information on GP answer machines should be recorded in one message, without patient’s having to press buttons for further information.*

To make the telephone ‘process’ more efficient, for both patients and staff, some practices do use call queuing technology which allows calls to be directed to the correct person/department in a more timely fashion by selecting an option from a ‘menu tree’. We do appreciate that some practices are constrained by their telephone systems in this regard however and earlier this year, the CCG provided financial support to 8 practices to improve their telephony infrastructure.

2. *Further work is needed to increase awareness of the GP out-of-hours services within Lewisham to improve patient experience and patient outcomes. Further promotion of the new extended access*
service for patients would be beneficial.

Lack of awareness of GP out of hours services in Lewisham has been raised before and we did undertake a campaign to address this including an article in the Lewisham Life magazine.

In regard to the GP Extended Access service, the CCG have extensively advertised this and will continue to do so. When the service first went live in April 2017, 15,000 leaflets were distributed to local GP practices and other key locations i.e. libraries.

We welcome any support that Healthwatch can offer to help us in communicating some of these key services and messages to the Lewisham population.

3. **We also recommend that Lewisham GP practices update their website information regularly to enable patient access to accurate information and the appropriate out-of-hours service. A chart, such as the following at The Surgery, Lee Road, is a useful visual aid.**

Please see the note below regarding the new PMS contract specification which includes a focus on reviewing information on practice websites.

We are also specifically working with all practices now to ensure that information about the GP Extended Access service is included on their websites.

4. **GPs practices that have the facilities in place should allow patients full access to view their medical records online.**

All practices offer GP Online Services to patients which includes booking appointments, ordering repeat prescriptions and accessing medical records online. Indeed, Lewisham is currently the third best performing CCG in London for the number of patients that are registered for Online services.

5. **GP practices should ensure that sufficient details regarding complaints procedures are made available online and displayed in all reception and waiting areas.**

The GP contract states that practices must “establish and operate a complaints procedure to deal with any complaints”. The contract also states that practices should include information on how patients may make a complaint as part of their practice leaflets.

6. **All information should be made available in additional languages on GP practice websites, as per the Accessible Information Standard.**

We have already shared information about the Accessible Information Standard with practices including a GP practice information pack developed by Bexley CCG. We will continue to support practices to fully implement the standard.

7. **NHS symptom checker would be a valuable addition to GP practice website.**

A NHS symptom checker is already available through NHS Choices at http://www.nhs.uk/Conditions/Pages/hub.aspx

As part of the eConsultations GP Forward View programme, we are also looking at developing local solutions to services which are supported by technology e i.e. symptom checkers/video consultations.

8. **To support self-management, the provision of self-care information on websites is a useful tool to empower people to take greater control of their health.**

See above.

9. **PMS contract**

As part of the new PMS contract, scheduled to go live from the 1st January 2018, the CCG has included a service specification which focuses on improving the overall experience of patients making an appointment at their GP practice.
As part of this specification practices will be asked to undertake a self-assessment of current access arrangements and then to develop an action plan to address any areas of challenge. Many of the areas highlighted as part of the Healthwatch report will be addressed as part of this including the use of Patient Online services, reviewing patient information on Practice websites and NHS Choices, sign posting to alternative services and engaging with PPGs to discuss challenges and potential solutions.

**CORPORATE AND STRATEGIC OBJECTIVES:**

*Contract Management – Primary Care:* Establish and embed the CCG performance management processes for core GP contract under Level 3 Delegated Commissioning.

**CONFLICT OF INTEREST (CoI):**

None identified.

**CONSULTATION HISTORY:**

N/A

**PUBLIC ENGAGEMENT:**

N/A

**HEALTH INEQUALITY & PUBLIC SECTOR EQUALITY DUTIES:**

The Healthwatch report identifies some potential adverse impacts in regard to patient access to information. As part of considering the report and the recommendations made, any adverse impacts will be assessed and addressed as part of the development of any resulting action plans.

**RESPONSIBLE MANAGERIAL LEAD CONTACT:**

*Name:* Diana Braithwaite; *Email:* diana.braithwaite@nhs.net

**AUTHOR CONTACT:**

*Name:* Ian Ross, ian.ross5@nhs.net
GP Patient Information Audit - London Borough of Lewisham

Healthwatch Lewisham carried out a research project to assess the consistency and accuracy of GP out-of-hours answerphone messages, website information and complaint procedures across the London Borough of Lewisham. Healthwatch Lewisham carried out a comprehensive review of all public facing information provided by the borough’s 43 GP practices.

Out-of-hours services are defined by the CQC as: Primary Care Services provided for patients with urgent care needs that cannot wait until their GP practice reopens, between the hours of 18:30 to 08:00, as well as weekends and Bank Holidays. These include NHS 111, A&E, Urgent Care Services and Extended Hours Services.

Healthwatch set out to:
- investigate patient experience of using both online and telephone information
- identify how comprehensive and accessible online information is
- identify if complaints procedures are clear and supportive of patients.

Findings
- There is a lack of consistency in telephone and website information for patients in Lewisham.
- 51.5% of those surveyed had used the out of hours services as recommended by their GP practice telephone messages. The majority of these patients had chosen to use A&E.
- Of those who had used out of hours services, 52.8% were satisfied with the service provided locally and felt their health needs had been met.
- 68.2% of patients surveyed stated they had never consulted their GP practice website for information regarding local health care services.
- GP telephone messages were often recorded with a significant amount of background noise which affected the clarity and audibility of the public facing messages.
- There was good provision for people for whom English is a second language, with over 140 language provision on many GP websites.
- There was limited use of online services for either booking appointments or signposting information in the sampled population.
- Sydenham Green Group Practice had excellent patient information around how to make a complaint.
Key Recommendations

Healthwatch Lewisham recommends that all GP practices within Lewisham incorporate the following recommendations:

- All information on GP answer machines should be recorded in one message, without patient’s having to press buttons for further information.
- Further work is needed to increase awareness of the GP out-of-hours services within Lewisham to improve patient experience and patient outcomes. Further promotion of the new extended access service for patients would be beneficial.
- We also recommend that Lewisham GP practices update their website information regularly to enable patient access to accurate information and the appropriate out-of-hours service. A chart, such as the following at The Surgery, Lee Road, is a useful visual aid.
- GPs practices that have the facilities in place should allow patients full access to view their medical records online.
- GP practices should ensure that sufficient details regarding complaints procedures are made available online and displayed in all reception and waiting areas.
- All information should be made available in additional languages on GP practice websites, as per the Accessible Information Standard.
- NHS symptom checker would be a valuable addition to GP practice website.
- To support self-management, the provision of self-care information on websites is a useful tool to empower people to take greater control of their health.

August 2017
ENCLOSURE 5
Queens Road Partnership – Estates Developments (Besson Street Redevelopment)

CLINICAL LEAD: Dr Jacky McLeod, Clinical Director, Primary Care Lead
MANAGERIAL LEAD: Diana Braithwaite, Director of Commissioning & Primary Care

AUTHOR: Jacqueline Malone, Estates Lead

RECOMMENDATIONS:
The members of the Primary Care Commissioning Committee are asked to note this update.

SUMMARY:
The purpose of this briefing is to update the Committee on the current progress with the Besson Street scheme.

This legacy scheme has been deemed by NHS England as having obtained full Business Case approval under the SEL Cluster arrangements in 2012. Therefore, no further approvals are required.

Financial implications:
- Recurring - There are additional rent and rates costs attached to this scheme in the order of £100k per annum that will need to be planned for by the CCG in 2020, when the scheme is finally completed.
- Non-recurring - £84k (inc. VAT) for IT equipment (capital) and £10k (inc. VAT) for project management.

Background
Queens’ Road practice is located in New Cross, which is in Neighbourhood 1 (N1), in the north of the Borough. Although this is an area of designated population growth, the practice has grown slowly in the last couple of years and as of August 2017, their raw list size was recorded as 10,702.

They are currently very short of space and in the utilisation survey carried out in 2016, as part of the Estate Strategy; they were designated as one of only 5 surgeries in Lewisham deemed to be “over-crowded”.

Until recently, they were operating out of two premises on each side of Queen’s Road, and have recently pulled back into the main building, which is challenging, but more efficient. The building they currently occupy is owned by Lewisham Council and leased to the practice.

Business Case Update
In 2012 this practice submitted an Estates Business Case to the former Lewisham PCT to develop new premises on a site in Besson Street, SE14, which is being redeveloped by Lewisham Council to provide new affordable rented homes. The development includes for the capital costs of the new health centre. The scheme is deemed, by NHS England, to be a FIPA approved scheme which was approved by the SEL PCT Cluster before it was disbanded and therefore it remains approved as a
legacy scheme. However, the approval assumed that the project would have been completed in 2014/15 and to have been fully operational throughout 2015/16.

Extract from Business Case

3. Provide an integrated building housing primary and community health services,
4. provide the space to house a wider range of services and the development of new services such as Sexual Health to the neighbourhood and locality by the primary healthcare team.
5. designed working with the Practice and NHS Lewisham in accordance with HBN 11-01.
6. The building will also be designed to allow staff and services from other NHS organisations as well as external organisations including Lewisham Council and community and voluntary groups, to book space and provide services within the new Healthcare Centre.
7. The new Healthcare Centre will be designed for service provision and meetings to take place seven days a week, and in the evenings, as required.
8. Support the development of integrated health services, looking at new models of service delivery, with high standards of building design forming a component of this.
9. Form a key part of the recruitment and retention strategy, ensuring that high quality clinicians and staff are appointed, providing enhanced and quality services to a deprived inner city population.
10. Contribute to meeting the education and training needs of primary and community health services through the provision of training and meeting room facilities.
11. Facilitate improvements in the development of information technology to support more efficient, effective and patient-centred care.

This extract describes some functions which are provided by other NHS organizations to support General Practice to deliver Primary Care and there are no existing commissioning plans to deliver these services at individual GP practice level. The Lewisham Estates Strategy vision is the development of a Hub in each Neighbourhood to allow services allied to general practice to work together and for General Practice to work more at scale via the Hub and Spoke model. The existing Waldron Health Centre is the nominated Hub for N1 and is close to Queens Road. The intention is to rationalize the space at Waldron so that other NHS organizations, council and charities can move in and work together to support both GPs working at scale within the Hubs and the local practices (spokes) such as Queens Road. Providing multi-disciplinary services to local individual practices in their buildings is unsustainable, both in terms of costs and the employment of staff with the right skill mix to support this model. It is more wasteful in paying for additional space that would not be well used due to the limited size of the patient list; it poses, potentially, an additional unfunded revenue pressure. Besson Street is fairly close to the purpose built Waldron Health Centre, which has yet to be fully utilized, the Besson Street schedule of accommodation has been reviewed with the practice to ensure that the scheme is right-sized for the practice’s foreseeable requirements and the multi-disciplinary elements are relocated to the Waldron.

Although the scheme is actively progressing, the Council estimates that the Health Centre will not be completed until sometime in 2020, some five years after the date it had been anticipated in the submitted and approved Business Case. The scheme has not yet been designed and it is anticipated that the developer will apply for planning consent in the summer of 2018, following selection of the development partner by the Council. This provides an opportunity for the NHS to ensure that the scheme is still what is required by the CCG in the current economic climate.
KEY ISSUES:

Rent and rates commitment

The Business Case has assumed that the capital costs of the construction and fit out will be met by the Development Partner or the New Gross Gate Trust. The arrangements are set out in agreed Heads of Terms. The practice will be required to lease the space and to pay a market rent for its occupation.

The rental cost will be met by way of rent reimbursement, paid by the CCG, as determined by the District Valuer (estimated at £100k increase over current per annum).

There is a total Non-Recurring costs commitment estimated for £94k (incl VAT). £84k of this Non-recurring cost needs to be included in the CCG IT capital budget setting plans for the relevant financial year.

2020/21 reimbursement

The first call on the CCG for increased rent reimbursement is expected to be 2020/2021 financial year. As a legacy scheme, it will be for Lewisham CCG to make provision for the annually recurring and the non-recurring costs associated with this scheme.

Other Considerations

The incoming Bakerloo Line into New Cross Gate is expected to contribute to an increase in population pressure but this is at a very early stage and the new station is not predicted to open until after 2029. The Waldron is within 5 minutes' walk of the station and it is envisaged that the population is more likely to register there. The Bakerloo line could result in an increase patient list size when the redevelopment of the Old Kent Road into New Cross is underway. With the Besson Street development and rationalization of space at Waldron, Lewisham CCG predicts that it has sufficient capacity for general practice for the next 10 years.

Results of the Review

The original scheme proposed in the approved Business Case assumed that the total GIA space required would be 980 m². Following review with the practice, it has been possible to reduce the space required by 280m² to 700m², a 28% reduction in area, which reduces the annually recurring rental and rates costs.

The reduced space schedule accords with HBN 11-01 and plans for 14 clinical rooms to serve a potential list size of 14,000. The practice currently operates from a building of 254m². It is suggested that these are approved by the CCG and that the practice and its advisors are advised that the scheme is approvable at this reduced size. The original scheme had an NIA or net lettable area of 833m² and this has now been reduced to 660m².

RISKS:

Risk that Lewisham CCG is mistaken in its analysis and there is insufficient primary care capacity around New Cross to accommodate the incoming population:

Lewisham CCG to continually review the predicted population growth figures from the GLA for the next 15-20 years and to work in Partnership with the Council to mitigate the impact of this growth on local NHS services. To forward review with the Council likely sites that will create housing and the timescales for this. Work in partnership with Southwark & Greenwich CCGs to jointly manage the provision of primary care buildings in areas close to borders with predicted population growth.

Risk that the Hub and Spoke model is not well adopted and space within the practice is required:
It is highly unlikely that a multi-disciplinary team housed in a medium size GP practice to purely to serve their list, will ever be an affordable or achievable model. However, the Besson Street development does include space for list size growth and the new space has been planned at a utilisation rate of 60%, ie 40% of the time the clinical rooms are unused between 8am-8pm. Therefore, there should be sufficient capacity within the 700m² for the practice to house other organisations services albeit on a bookable or more limited basis.

**Risk that the Practice can no longer adequately serve their patients in the current premises for a further 2-3 years:**

The Waldron is a 10 minute walk or 3 bus stops away from the current building. The Waldron is underutilised and is very large at 3500m² and a working party has been developed to increase its utility by 25-30%. This would provide more than enough space for the practice to provide clinical services on a temporary basis if required.

### CORPORATE AND STRATEGIC OBJECTIVES:

*Contract Management:* To manage effectively the CCG’s contract portfolio to ensure that the CCG’s Operating Plan’s commitments are met in 2017/18. This includes ensuring our financial targets are met and value for money is achieved.

### CONFLICT OF INTEREST (CoI):

None identified.

### CONSULTATION HISTORY:

There was a local assembly presentation and public consultation in Kender Primary School on the plans on 24th November 2015. Prior to this Local Assembly consultation, there were workshops that were advertised and held with local people in Besson Street Community Gardens.

The Practice held some other consultation workshops with local people back in 2012, although the details are now lost. From memory, the Practice thinks they distributed questionnaires and held an information stall at some of our regular community event.

Prior to this, in 2010/11, a much wider consultation with local people in the schools, music rooms, library etc, when the second original scheme still looked like it was going to go ahead.

With regard to consultation with NXGTrust (as a representative of the local community), have been in regular contact with the Practice, meeting at least quarterly to update us on progress, which they have been able to pass on to the community by way of news updates.

### PUBLIC ENGAGEMENT:

Public Engagement would have formed part of the original planning process.

With regard to information on the site and its plans, the Practice have kept a webpage updated for local people, and have also put out various articles through the newsletter to keep the local community updated on progress over the past few years whenever there has been some progress to update


### HEALTH INEQUALITY & PUBLIC SECTOR EQUALITY DUTIES:

In December 2012, an Equality Impact Assessment was undertaken using the NHS pro-forma used at that time.
RESPONSIBLE MANAGERIAL LEAD CONTACT:
Name: Diana Braithwaite; Email: diana.braithwaite@nhs.net
PCCC
Primary Care Commissioning Committee
Tuesday 24th October 2017

ENCLOSURE 6
Co-ordinated Care Service (CCS): 2016/17 Outcomes & Achievements

MANAGERIAL LEAD: Ashley O'Shaughnessy, Deputy Director of Primary Care

AUTHOR: Ashley O'Shaughnessy, Deputy Director of Primary Care

RECOMMENDATIONS:
The Primary Care Commissioning Committee is asked to note the update on the Outcomes & Achievements of the 2016/17 Co-ordinated Care Service.

SUMMARY:
The CCS was the first contract to be commissioned from the four neighbourhood GP Federations in Lewisham.

The contract was outcome based, and activity was reported via a monthly performance dashboard.

The following outcomes were supported through the contract:

- Increasing prevalence: Finding those with undiagnosed; i) diabetes ii) COPD and iii) hypertension
- Reducing variation between practices and improving clinical outcomes for patients with diabetes and hypertension
- Supporting newly diagnosed COPD patients to stop smoking
- Increasing uptake of self-management programmes for diabetic patients
- Follow-up of patients with high Cardiovascular (CVD) ‘risk scores’ following NHS Health Checks
- Proactively managing patients who are frequently admitted/frequently attend A&E
- Improving flu & pneumococcal vaccination rates
- Improving childhood immunisation rates
- Delivery of ‘Neighbourhood’ Patient Participation Groups (PPGs) meetings

KEY ISSUES:
- Please see enclosed presentation.

CORPORATE AND STRATEGIC OBJECTIVES:
Contract Management: To manage effectively the CCG’s contract portfolio to ensure that the CCG’s Operating Plan’s commitments are met in 2017/18. This includes ensuring our financial targets are met and value for money is achieved.

CONFLICT OF INTEREST (CoI):
Appreciating the potential conflict of interest for GP members working directly or indirectly with the GP Federations through which this service was commissioned, no financial information is contained in this report.

The Committee are being asked to note the outcomes and achievements of the 2016/17 Co-ordinated
Care Service only.

<table>
<thead>
<tr>
<th>CONSULTATION HISTORY:</th>
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<th>PUBLIC ENGAGEMENT:</th>
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<th>HEALTH INEQUALITY &amp; PUBLIC SECTOR EQUALITY DUTIES:</th>
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<tr>
<td>No adverse impacts identified.</td>
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<thead>
<tr>
<th>RESPONSIBLE MANAGERIAL LEAD CONTACT:</th>
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<tbody>
<tr>
<td>Name: Ashley O'Shaughnessy, <a href="mailto:ashley.oshaughnessy@nhs.net">ashley.oshaughnessy@nhs.net</a></td>
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<tr>
<th>AUTHOR CONTACT:</th>
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<tbody>
<tr>
<td>Name: Ashley O'Shaughnessy, <a href="mailto:ashley.oshaughnessy@nhs.net">ashley.oshaughnessy@nhs.net</a></td>
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</table>
Coordinated Care Service
2016/17

Outcomes & Achievements

Primary Care Commissioning Committee
24th October 2017
Coordinated Care Service (CCS) 2016/17

Key Facts:

• The CCS was the first contract to be commissioned from the four neighbourhood GP Federations in Lewisham

• The contracts were outcome based, and activity was reported via a monthly performance dashboard

• The Federations chose to work on some areas of the service collectively across the borough (i.e. Proactively managing patients who are frequently admitted/frequently attend A&E)
OUTCOME AREAS

- Increasing prevalence: Finding those with undiagnosed; i) diabetes ii) COPD and iii) hypertension
- Reducing variation between practices and improving clinical outcomes for patients with diabetes and hypertension
- Supporting newly diagnosed COPD patients to stop smoking
- Increasing uptake of self-management programmes for diabetic patients
- Follow-up of patients with high Cardiovascular (CVD) ‘risk scores’ following NHS Health Checks
- Proactively managing patients who are frequently admitted/frequently attend A&E
- Improving flu & pneumococcal vaccination rates
- Improving childhood immunisation rates
- Delivery of ‘Neighbourhood’ Patient Participation Groups (PPGs) meetings
 Appropriately diagnosing patients with Long Term Conditions (LTCs) supports them to receive the care they need.

The CCS focused on improving the prevalence of i) diabetes ii) COPD and iii) hypertension. As per the table below, work done under the 2016/17 CCS has led to the recorded prevalence of COPD and hypertension to significantly improve across the borough compared to the standard expected growth. No significant difference was observed for diabetes.

<table>
<thead>
<tr>
<th>Long Term Condition area</th>
<th>Standard annual Growth*</th>
<th>Growth under 16/17 CCS</th>
<th>Difference (figures)</th>
<th>Difference (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>+600</td>
<td>+593</td>
<td>-7</td>
<td>-1.16%</td>
</tr>
<tr>
<td>COPD</td>
<td>+118</td>
<td>+268</td>
<td>+150</td>
<td>+127%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>+600</td>
<td>+1179</td>
<td>+579</td>
<td>+97%</td>
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</table>

*Average growth calculated over the last 5 years (2010-2016) based on combined practice QOF register figures
The Federations worked to reduce variation between practices and improve clinical outcomes, with practices to achieve at least the Lewisham average performance (as per 2015/16).

The four measures were:

1. The % of patients with diabetes, on practice registers, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less
2. The % of patients with diabetes, on practice registers, whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
3. The % of patients with diabetes, on practice registers, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months
4. The % of patients with hypertension, on practice registers, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
Indicator: The % of patients with diabetes, on practice registers, in whom the last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less

39/40 practices achieved at least the Lewisham 2015/16 average performance. *Previous performance for 2015/16 was 19/40 practices below the Lewisham average.*

Indicator: The % of patients with diabetes, on practice registers, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less

39/40 practices achieved at least the Lewisham 2015/16 average performance. *Previous performance for 2015/16 was 12/40 practices below the Lewisham average.*
**Indicator:** The % of patients with diabetes, on practice registers, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months

35/40 practices achieved at least the Lewisham 2015/16 average performance. *Previous performance for 2015/16 was 22/40 practices below the Lewisham average.*

**Indicator:** The % of patients with hypertension, on practice registers, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less

35/40 practices achieved at least the Lewisham 2015/16 average performance. *Previous performance for 2015/16 was 12/40 practices below the Lewisham average.*
As a result of reduced variation between practices, the overall borough performance also improved

<table>
<thead>
<tr>
<th>Page 42</th>
<th>The % of patients with diabetes, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less</th>
<th>The % of patients with diabetes, whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less</th>
<th>The % of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months</th>
<th>The % of patients with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>80%</td>
<td>79%</td>
<td>71%</td>
<td>82%</td>
</tr>
<tr>
<td>March 2016</td>
<td>73%</td>
<td>72%</td>
<td>64%</td>
<td>78%</td>
</tr>
<tr>
<td>Difference</td>
<td>+7%</td>
<td>+7%</td>
<td>+7%</td>
<td>+4%</td>
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</tbody>
</table>
The Federations worked to improve the uptake of HeLP (the online diabetes self-management programme) by:

- registering patients for the HeLP diabetes self-management programme;
- supporting patients to then actually undertake the programme

The goal was for at least 100 patients to be registered on the programme, with at least 75 actively logging in.

The Federations exceeded this goal with 292 patients registered on the programme, and 192 of these logging in.
Across the borough, 21% of newly diagnosed COPD patients in 2016/17 quit smoking (against a target of 15%).

Neighbourhood achievement is shown in the graph below:

Across the borough, 98% of patients who were identified as having a high Cardiovascular (CVD) ‘risk score’ after a NHS Health Check were offered a self-management plan (against a target of 90%).

Neighbourhood achievement is shown in the graph below:
The Federations were asked to proactively manage patients who were frequently admitted as emergencies & frequently attended A&E in 2015/16.

Throughout the year, the following progress was made:

• The identification of 300 patients who were frequently admitted as emergencies in 2015/16.
• The identification of 300 patients who frequently attended A&E in 2015/16.
• The development of a borough-wide plan to co-ordinate care for these patients.
• The signing of data sharing agreements between Practices and the Federations to allow patient data to be shared to support clinical management.
• The establishment of a borough wide (cross-federation) clinical team to work with Practices to proactively manage these patients including a GP Clinical Lead.
• The development of a dashboard to monitor ongoing activity for these patients.
• Joint working with Lewisham & Greenwich NHS Trust and the multi-disciplinary neighbourhood team coordinators.
For the identified cohorts of patients, the following reductions in activity were seen:

<table>
<thead>
<tr>
<th>Patients frequently admitted as emergencies</th>
<th>15/16 activity</th>
<th>16/17 activity</th>
<th>Activity Reduction</th>
<th>% Activity Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients frequently attending A&amp;E</td>
<td>412</td>
<td>201</td>
<td>211</td>
<td>51%</td>
</tr>
<tr>
<td></td>
<td>1623</td>
<td>500</td>
<td>1123</td>
<td>69%</td>
</tr>
</tbody>
</table>
The Federations worked to improve flu and pneumococcal vaccination rates.

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>2016/17 (March 17)</th>
<th>2015/16 (March 16)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu 65 years+</td>
<td>69%</td>
<td>69%</td>
<td>0%</td>
</tr>
<tr>
<td>Flu ‘at risk’</td>
<td>48%</td>
<td>49%</td>
<td>-1%</td>
</tr>
<tr>
<td>Flu pregnant women</td>
<td>50%</td>
<td>44%</td>
<td>+6%</td>
</tr>
<tr>
<td>Pneumococcal 65 years+</td>
<td>75.1%</td>
<td>72.6%</td>
<td>+2.5%</td>
</tr>
<tr>
<td>Pneumococcal ‘at risk’</td>
<td>58.9%</td>
<td>49.0%</td>
<td>+9.9%</td>
</tr>
</tbody>
</table>

Lewisham CCG now have the highest vaccination rate in London for the pneumococcal over 65s cohort and in 2016/17 Lewisham vaccinated almost 3% more than the next highest CCG for this cohort.
The Federations worked to improve childhood immunisation rates in the following areas:

i) MMR (by 2 years),

ii) MMR2 (by 5 years) and

iii) pre-school booster (by 5 years)

<table>
<thead>
<tr>
<th></th>
<th>MMR1 (up to 2yrs)</th>
<th>MMR2 (up to 5yrs)</th>
<th>Pre-school booster (up to 5yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17 Q4</td>
<td>87%</td>
<td>87.9%</td>
<td>80.1%</td>
</tr>
<tr>
<td>2016/17 Q1</td>
<td>87.6%</td>
<td>86.9%</td>
<td>79.5%</td>
</tr>
<tr>
<td>Difference</td>
<td>-0.6%</td>
<td>+1.0%</td>
<td>+0.6%</td>
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</tbody>
</table>
Neighbourhood Patient Participation Group meeting (PPGs) were held in September 2016, and March 2017. The table below shows how many patients attended each meeting.

<table>
<thead>
<tr>
<th></th>
<th>N1</th>
<th>N2</th>
<th>N3</th>
<th>N4</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2016</td>
<td>21</td>
<td>20</td>
<td>18</td>
<td>15</td>
<td>74</td>
</tr>
<tr>
<td>March 2017</td>
<td>17</td>
<td>19</td>
<td>13</td>
<td>19</td>
<td>68</td>
</tr>
</tbody>
</table>

The PPGs held in September 2016 introduced the GP Federations and collected views around collaborative working and the location of services, as well as disseminating information about ‘Advice Lewisham’ *(Advice Lewisham is the network of the main free advice providers in the London Borough of Lewisham).*

The PPGs held in March 2017 updated on the work of the Federations including the GP Extended Access Service and collected views on IT & Innovation as well as the use of clinical pharmacists in GP Practice.
Enclosure 7
Primary Care Commissioning Committee on Tuesday 24th October 2017
Report from Dr Jacky Mcleod, Clinical Director, Primary Care lead and Chair of PCOG (Primary Care Operational Group)
Date of Meeting reported: Friday 6th October 2017
Author: Ian Ross, Associate Director of Primary Care Transformation

1. GP Forward View (GPFV)

The group agreed to the Lewisham Community Education Provider Network (CEPN) proposal for the 17/18 GPFV admin and clerical training funding (£55k) to support the development of Medical Assistant and Care Navigation roles/skills with the following provisos:

- Learning from the current Medical Assistant training programme should be incorporated
- Evaluation should be built into both programmes, particularly in regard to assessing the practical application of the training

An update on the local GPFV Practice resilience programme was given. It was acknowledged that although borough wide activities had progressed to date (e.g. development of a local locum bank), direct support to practices had been limited. The CCG will continue to work with One Health Lewisham (GP Federation) to ensure that maximum benefit of the resilience programme is felt by practices.

In respect of the GPFV General Practice Development Programme, the Quick Start Productive General Practice programme is due to conclude on the 17th October 2017 with a celebration session to which all practices have been invited to share learning and best practice. Work on the Primary Care Quality Academy is still progressing and a detailed update will be taken to the next PCOG meeting.

In regard to eConsultations, national GPFV funding for 17/18 is still to be received. The CCG has already developed an outline plan for eConsultations which is based on video consultations and online symptom checker technology.

2. Primary Care Working at Scale

Supported by GPFV Practice resilience funding, in late September 2017, a number of Lewisham GP practices visited the Modality Partnership in Birmingham. This offered practices an overview of how working at scale could really benefit both staff and patients. It is hoped that this will support local thinking and developments in this regard.

“50p per head” funding is still available to practices to support working at scale. Only £8,292.60 of this funding has currently been drawn down.

The CCG will continue to work with practices to support this agenda, facilitated through the CCG Clinical Lead for working at scale, Dr Riaz Jetha.

3. Primary Care Quality Dashboard

Work is progressing on a local Primary Care Quality Dashboard. It is expected that a first draft will be available for the PCOG to review at its next meeting.
4. **PMS update**

The PMS contract offer was sent to all Lewisham PMS practices on the 30\textsuperscript{th} September 2017, in advance of a 1\textsuperscript{st} January 2018 contract go-live. An equivalent offer will also be made to the four Lewisham GMS practices.

5. **Date of next meeting**

The next scheduled meeting of the Primary Care Operational Group will be 26\textsuperscript{th} October 2017.
ENCLOSURE 8
GP Forward View – Implementation Update

CLINICAL LEAD/S: Dr Jacky McLeod, Clinical Director lead for Primary Care
MANAGERIAL LEAD: Ashley O'Shaughnessy, Deputy Director of Primary Care

AUTHOR: Ashley O'Shaughnessy, Deputy Director of Primary Care

RECOMMENDATIONS:
The Primary Care Commissioning Committee is asked to;
1. Note the update on the implementation of the GP Forward View.
2. Note the CCG GP Forward View delivery plan (as part of the 2017-19 NHS Operational Planning and Contracting Guidance requirement), which has been subject to assurance by NHSE.

SUMMARY:

This paper provides a high level update on the local implementation of the GP FV in Lewisham and also indicates the value of funding that has been made available through the GP FV to Lewisham.

<table>
<thead>
<tr>
<th>GP FV area</th>
<th>Update</th>
<th>Associated funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated Implementation resource</td>
<td>Following initial recruitment in February 2017, as of the 13th October 2017, this post is now vacant. Recruitment for a replacement is currently underway and interim options are being considered.</td>
<td>Joint 8b resource with Bromley CCG for 2 years</td>
</tr>
<tr>
<td>Practice resilience</td>
<td>A high level plan for 2016/19 has been developed jointly with One Health Lewisham Ltd (GP Federation) and LMC to utilise the available funding. Areas already delivered/being delivered: • An all practice diagnostic (led by One Health Lewisham Ltd) to fully assess the level of local resilience support needed has been completed • Immediate support for practices with high need (i.e. finance/business planning/interim resource)</td>
<td>£144k in 16/17 £40k in 17/18 Indicative £44K in 18/19</td>
</tr>
</tbody>
</table>
is in progress

- Practice working at scale workshop held in December 2016
- Support for GP Federation leadership to effectively deliver this programme in progress
- Development of a local Locum Bank of GPs, Practice Nurses, HCAs and other practice support staff

Areas in development:

- Creation of a local GP Resilience Task Force

A more centralist approach has been employed for 17/18. ‘Heat maps’ have been developed centrally by NHSE which identify practices that may be in need of resilience support. The CCG has validated these heat maps based on the local diagnostic exercise – this has now been accepted by NHSE.

Work is now continuing with One Health Lewisham Ltd to deliver the resilience programme and in particular providing direct support to individual practices.

### Admin and clerical training

Programme commissioned through Lewisham Community Education Provider Network (CEPN) for 16/17 to build capability and capacity in core management skills to increase practice efficiency.

For 17/18, the Lewisham CEPN has been commissioned to provide medical assistant training for 6 practices (to be delivered by the Virginia Mason Institute) and care navigation skills training for 100 front line primary care staff.

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/17</td>
<td>£27k</td>
</tr>
<tr>
<td>17/18</td>
<td>£55k</td>
</tr>
<tr>
<td>18/19</td>
<td>Indicative £55k</td>
</tr>
</tbody>
</table>

### Extended access (8-8, 7 days a week)

Standalone hub (8-8, 7 days per week) on Lewisham Hospital site went live as planned on 3rd April 2017 – service provided by One Health Lewisham Ltd (GP Federation).

Nurse appointments commenced as planned in July 2017 and video consultations are also currently being delivered from the Sydenham Green Group Practice site.

The service is due to relocate within the Lewisham Hospital site into purpose built accommodation in late October 2017.

Commercial in confidence as service has been subject to procurement

### General

The Quick Start Productive General Practice

Although direct
<table>
<thead>
<tr>
<th>practice development programme</th>
<th>programme will conclude on the 17\textsuperscript{th} October 2017 with a celebration session to which all practices have been invited to share learning and best practice.</th>
<th>funding is not available to support the Productive General Practice programme, external specialist support and training is provided.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary Care Quality Academy (PCQA) – work is progressing with detailed data collection currently being undertaken at the participating practices.</td>
<td>PCQA - £245k</td>
</tr>
<tr>
<td></td>
<td>eConsultations – CCG currently assessing options for implementation in 17/18 with initial thoughts captured in high level strategy document. National funding yet to be confirmed.</td>
<td>For eConsultations, indicative £83k available for 17/18 and £111k for 18/19.</td>
</tr>
<tr>
<td>Estates Technology and Transformation Fund (ETTF)</td>
<td>Central Lewisham estates bid (£612k) and Population Health Management technology bid (£400k) have been successful and moved into the next phase.</td>
<td>As stated</td>
</tr>
<tr>
<td></td>
<td>London wide ETTF bid to support an accelerated implementation of Patient Online Services in Q4 2016/17 successfully delivered in Lewisham (£50k).</td>
<td></td>
</tr>
<tr>
<td>Clinical Pharmacist in General Practice</td>
<td>One Health Lewisham Ltd have submitted a bid for this scheme (including strong links to LIMOS) which has been successful. This will initially cover a population of approximately 90,000. All parties are now working on implementation including recruitment of pharmacists with an expected go live of January 2018.</td>
<td>60% funded in 1\textsuperscript{st} year 40% funded in 2\textsuperscript{nd} year 20% funded in 3\textsuperscript{rd} year</td>
</tr>
</tbody>
</table>

**CORPORATE AND STRATEGIC OBJECTIVES:**

- **Planned Care:** To support people with long term conditions better with proactive, holistic care which improves the quality of their lives, is provided ‘out of hospital’ and reduces the requirement for hospital based outpatient attendances and inpatient admissions.

**CONFlict OF INTEREST (CoI):**
The Primary Care Commissioning Committee is asked to note this high level update on the local implementation of the GP FV in Lewisham and the supporting GPFV delivery plan.

However, it is recognised that Clinical Directors in their role as General Practitioners may benefit from the funding and support provided through the GPFV. Therefore, in order to mitigate perceived/potential CoI and/or any undue influence;

- All decisions on how GP FV monies are committed will be taken through the appropriate governance structures with any CoIs managed as necessary.
- The funding levels stated in this update are already available in the public domain.
- The update does not contain any practice specific information.

<table>
<thead>
<tr>
<th>CONSULTATION HISTORY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Operational Group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PUBLIC ENGAGEMENT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH INEQUALITY &amp; PUBLIC SECTOR EQUALITY DUTIES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No specific adverse impacts identified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESPONSIBLE MANAGERIAL LEAD CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Ashley O'Shaughnessy, <a href="mailto:ashley.oshaughnessy@nhs.net">ashley.oshaughnessy@nhs.net</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AUTHOR CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Ashley O'Shaughnessy, <a href="mailto:ashley.oshaughnessy@nhs.net">ashley.oshaughnessy@nhs.net</a></td>
</tr>
</tbody>
</table>
**General Practice Forward View (GPFV) – Delivery Plan – updated October 2017**

**Lewisham CCG**

### 1) Extended Access

**What are we doing across London?**

London is an outlier on satisfaction for making an appointment, patients perspectives on the convenience of appointments has got worse since 2014, whilst in the rest of the country this is getting marginally better. In 2016, the % difference between wanting a same day appointment and being able to get one was more than twice that of the rest of the country. This is mirrored with satisfaction in General Practice overall, and affects A&E departments, when patients cannot get an appointment the same day, (3%) more than twice that of the rest of the country. This impacts attendance at A&E; with over double the percentage (7% versus 3% in 2016) reporting attending A&E as a result.

London have agreed with National an approach to share their allocation from the areas who received Prime Minister’s Challenge Funding, across London. This means a share of £26m in 2016, and the same again in 2017. This will provide London with the opportunity to increase access across the capital, providing greater equality of access to General Practice - London has committed to delivering extended access across the city by Q4 2017 to 97% of patients.

**What are the CCG’s plans for delivering extended access, and when will this be delivered? (summary)**

As of the 3rd April 2017, Lewisham has implemented one standalone hub, on the University Hospital London (UHL) site, offering appointments from 8am-8pm, 7 days a week.

Selection of the UHL site for the standalone hub is supported and articulated in the Lewisham System Estates Strategy. The UHL site is centrally located with evidenced good travel links.

25,425 appointments will be delivered in 2017/18 and 29,914 appointments will be delivered in 2018/19.

**What are the CCG’s plans for improving access (wider than delivering extended access?)**

Our focus on Online Patient services continues. Through the successful London wide ETTF bid we have accelerated patient registrations for online services in Q4 16/17 and look to continue this into 17/18

Through our Practice resilience work, a borough wide diagnostic has also been completed with demand cited as a significant challenge by several practices. Through our resilience plans we are looking at how we address this and in particular how we incorporate this into our local plans to implement the Time for Care programme.

In 15/16 we supported training for telephone triage and consultation skills which was taken up by several practices who are now using this approach as business as usual. In 17/18 we will consider options to mainstream this across all practices.

Along with the other CCGs in SEL, Lewisham has also implemented the Health Help Now mobile app and online service to help people in Lewisham to understand where they should go for treatment, especially when they need health care in a hurry or late at night or at the weekend.

**eConsultations (see below)**
In addition, the offer will enable London to have the flexibility to address ‘in hours’ challenges as well as extended hours, with some primary care hubs providing an additional 12 hours of access every day, seven days a week - stand alone hubs, and other areas opting to providing extended hours from 6.30 - 8pm on weekdays and 12 hours per day on weekends - top up hubs.

London has a minimum specification for the extended access hubs (unless evidence is provided for an alternative local approach), which include:
- Appointments must be pre-bookable in advance
- Open to all registered population in the area
- Has access to medical records
- Accessible via multiple routes including 111, online and via the practice

London has also committed to measuring and monitoring appointments and utilisation as required nationally, and regularly reviewing utilisation to ensure capacity is appropriately used, and innovative solutions are found to under-utilisation or capacity challenges.

<table>
<thead>
<tr>
<th>How will patients notice difference?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Increased availability of online appointments</td>
</tr>
<tr>
<td>- Wider choice of access options (i.e. eConsultations)</td>
</tr>
<tr>
<td>- Services more integrated, improving patient experience</td>
</tr>
<tr>
<td>- We would ultimately expect to see improvements in the access elements of the GP Patient survey.</td>
</tr>
</tbody>
</table>
2) Online consultations

<table>
<thead>
<tr>
<th>What are the priorities for online consultation rollout?</th>
<th>What is the timeline for delivery of the priorities?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- This is an emerging market</td>
<td>National funding yet to be confirmed but our expectation is that delivery will commence in 17/18.</td>
</tr>
<tr>
<td>- Lewisham CCG has not yet been directly involved in the provision of online consultations so will be leasing with local CCGs who have been to glean learning and support the development of a robust and deliverable plan with the aim of offering online consultations at every practice</td>
<td></td>
</tr>
<tr>
<td>- The CCG have developed an initial high level strategy document which prioritises video consultations and online symptom checker technology.</td>
<td></td>
</tr>
</tbody>
</table>

3) Provider Development (e.g. Vulnerable Practice, Practice resilience, Time to Care)

<table>
<thead>
<tr>
<th>What are the priorities for delivery in 16/17?</th>
<th>What are the priorities and use of funding in 17/18?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lewisham CCG’s general practice resilience plan outlines how national resources will be utilised to support general practice, the plan covers these areas:</td>
<td>The modest GP FV funding available in 17/18 and 18/19 for GP resilience will be used to continue the work started in 16/17 and in particular support the outputs of our practice wide diagnostic which has identified the practices and areas of most need.</td>
</tr>
<tr>
<td>- An all practice diagnostic to fully assess the level of local resilience support needed</td>
<td>Interventions will continue to have the dual aim of supporting resilience in the short term and on-going sustainability in the longer term and involve a combination of practice based and borough wide initiatives.</td>
</tr>
<tr>
<td>- Immediate support for practices with high need (i.e. finance/business planning/interim resource)</td>
<td>The Productive General Practice Quick Start programme was completed by 11 practices in October 2017.</td>
</tr>
<tr>
<td>- Provision of further information to support practice mergers</td>
<td></td>
</tr>
<tr>
<td>- Creation of a local GP Resilience Task Force (CCG, Federation. LMC, Lewisham and Greenwich NHS Trust, lay representation)</td>
<td></td>
</tr>
<tr>
<td>- Development of a local Locum Bank of GPs, Practice Nurses, HCAs and other practice support staff</td>
<td></td>
</tr>
<tr>
<td>- Support for GP Federation leadership to effectively deliver the programme</td>
<td></td>
</tr>
<tr>
<td>Interventions and activities will be prioritised to focus on practices at high risk of resilience.</td>
<td></td>
</tr>
</tbody>
</table>

A ‘Time for Care’ Expression of Interest was submitted with planned implementation in 17/18 - this has been endorsed by local LMC and GP Federation. We have regular contact with our General Practice Development Programme development advisors and submitted a successful expression on interest for the Productive General Practice Quick Start programme. We have also secured additional funding to take forward a local Primary Care Academy, supported by London Southbank University, which will focus on using data and co-production to understand demand in order to co-design new consultation models and reduce failure demand.

Through our various provider development plans we expect to see improved sustainability of individual practices, increasing numbers of practices working together both informally and formally and the strengthening of a local borough wide GP Federation. We expect all of these to support the delivery of improved outcomes for our population.
What are the objectives (and timeline) of the CCG £3p/h investment

The £3 per head investment will be phased over 2017/18 and 2018/19 and will support 'at scale' working.

For 17/18:

£1 per head has been invested through our borough wide GP federation to support delivery of high impact changes at scale including partnership working and self-care and also to specifically support the establishment of a central call/recall system for general practice. We expect this to lead to increased capacity within practices through reduced demand and workload and also improved uptake and coverage of long term condition self-management programmes and immunisations across our local population. This has been formalised through an agreed contract with our GP Federation which went live on the 1st April 2017.

50p per head has been made available to practices to support working at scale. This will include access to specialist support and facilitation. We expect this to lead to increased numbers of practices taking forward both formal (mergers) and informal (sharing of back office functions) ways of working together at scale and the realisation of the benefits that comes with this including a sustainable and resilient general practice. Applications will be required to include clear and measurable outcomes and demonstrate how these will be realised.
4) Training care navigators & medical assistants

What are the CCG's plans for training care navigators and medical assistants?

Building on work already undertaken with practices to support improved customer service skills/managing difficult conversations, 16/17 GPFV funding was used to commission the Lewisham Community Education Provider Network (CEPN) to deliver a training programme to support non-clinical staff (excluding practice managers) to build practice capability and capacity in core management skills to increase practice efficiency and effectively support their clinical colleagues.

For 17/18, the Lewisham CEPN has been commissioned to provide medical assistant training for 6 practices (to be delivered by the Virginia Mason Institute) and care navigation skills training for 100 front line primary care staff.

Through our local integration programme, we also already have Neighbourhood Team Coordinators (working within each of our four Neighbourhood Care Networks) supporting our practices with the coordination and operation of Multidisciplinary Team meetings – this includes care navigation for some of our more complex patients who are being managed through a Multidisciplinary Team approach.
5) Workforce

What is your local workforce strategy (excluding training outlined in provider development and care navigator sections above)?

The STP has developed a workforce strategic plan and is reviewing its governance, leadership and programme resource arrangements to enable a shift from planning and design to delivery. Detailed delivery plans are now being developed for two strategic programme areas:

1. Productivity (acute SRO, finance lead and SMEs agreed);
   - the initial focus is on the potential merging of back office functions and combined outsourcing of support services (occupational health for example).
2. Clinical change programmes and transformation (commissioning SRO and education SME agreed);
   - the focus is on capacity, capability and skills, culture and behavioural change.

For the CBC clinical programme (transformation) specifically the areas of focus within the themes above are:

- Local Resilience Plans; Federation development; Local Care Networks; Enhanced and new roles; Baselines and projections; Training & education

The STP is also considering a potential third strategic programme: Leadership and Talent management with discussion underway.

Locally, the CCG will continue to work with our local CEPN around recruitment, retention and differential use of workforce, building on the work that has already begun such as our local apprenticeship programme and placements programme for student nurses

As part of our local Practice resilience programme, we have a number of initiatives that will support workforce development. The all practice diagnostic that has been completed by our GP Federation, specifically covered workforce challenges. The outcome of this diagnostic will allow us to take a targeted approach to both short and longer term workforce planning. Support for mergers and the development of a locum bank for all staff groups are also examples of how our local Practice resilience programme will support with workforce planning.

The CCG has a dedicated Practice Nurse Consultant post, supported by PN advisors and a PN forum – these resources are overseeing and delivering our local practice nurse development programme

Our GP Federation have submitted a successful bid for the GPFV Clinical Pharmacist in General Practice programme which will initially cover a population of approximately 90,000.

We already have Mental Health therapists delivering IAPT services from over half of our GP Practices.

We are awaiting details of the GPFV Practice Manager Development Programme so we can confirm local plans to implement this – we will coordinate this through our already established and funded local practice managers forum
### 6) ETTF plans

<table>
<thead>
<tr>
<th>Neighbourhood</th>
<th>What are the expected benefits of the scheme?</th>
<th>When do you anticipate that the scheme will realise these benefits?</th>
<th>How does this scheme support the wider STP plan or priorities?</th>
</tr>
</thead>
</table>
| **Lewisham CCG: Integrated Primary Care Hub (N2)**  
Lewisham CCG’s vision, which is captured in the Local Estate Strategy, is to have four Neighbourhood networks as follows:  
• Neighbourhood 1 – Deptford/New Cross (North) (The Waldron (LIFT))  
• Neighbourhood 2 – Lewisham/Brockley (Central) (Central Lewisham Hub potentially on Hospital Site)  
• Neighbourhood 3 – Downham/Grove Park (South East) (Downham Health Centre (PFI) complemented by a new property in Grove Park to include accommodating the ICO practices).  
• Neighbourhood 4 – Forest Hill/Sydenham (South West) (Sydenham Hub location)  

Each of these Neighbourhoods is to be supported by an Integrated Service Hub.  

In addition to the hub sites there will be a number of other complementary buildings accommodating primary care and other community services, which will assist in meeting the changing needs of the local community and the very significant, proposed housing developments in a  

| Neighbourhood 1 – Deptford/New Cross (North) (The Waldron (LIFT))  
| Neighbourhood 2 – Lewisham/Brockley (Central) (Central Lewisham Hub potentially on Hospital Site)  
| Neighbourhood 3 – Downham/Grove Park (South East) (Downham Health Centre (PFI) complemented by a new property in Grove Park to include accommodating the ICO practices).  
| Neighbourhood 4 – Forest Hill/Sydenham (South West) (Sydenham Hub location)  

This scheme being developed by Lewisham and Greenwich NHS Trust with the full support of the CCG, Lewisham Council and SLAM, will ensure that we are able to offer a wide range of primary care services adjacent to University Hospital Lewisham. This will provide patients with ease of access to Primary Care Services in preference to the busy neighbouring accident and emergency services and host the Urgent Care facility currently located within the hospital confines. This central Hub in an area of substantial population growth, will also host the 24/7 8:8 primary care service, facilitate practice mergers and working at scale by enabling the relocation of smaller practices from neighbouring sites and ensure that the Urgent Care Centre is backed up by a range of primary care services and accessible diagnostics.  

Although primarily a primary care led facility, our vision, subject to Business Case approval, is to include some provision for Mental Health alongside other services and potentially a front door for the services delivered by the Integrated Care Team.  

We anticipate completing the Business Case in 2017/18. The Business Case will include a detailed programme for the health scheme development which will be integrated within a much wider estates regeneration of the area by University Hospital Lewisham, to include the provision of housing for sale and rent.  

This Business Case, to be funded by ETTF, will include being able to confirm all of the services required to be delivered from this site, including some services relocated from the existing hospital site and potentially facilitating greater working at scale within primary care by hosting two or more GP lists.  

The site master plan, including for the Integrated Primary Care Hub has been prepared and is in the process of being shared with planners and is not yet in the public domain. The sites are in the ownership of UHL and the Council and close working between the partners.  

The scheme will involve University Hospital Lewisham in disposing of a substantial element of the site in Lewisham for housing including an element of primary care provision. It is envisaged that the capital costs of the primary care facility, the hub, will be met from the site proceeds. Plus, the Business Case will consider the relocation of some primary care facilities from other sites allowing for further disinvestment and more efficient and effective use of estate.  

The scheme will involve University Hospital Lewisham in disposing of a substantial element of the site in Lewisham for housing including an element of primary care provision. It is envisaged that the capital costs of the primary care facility, the hub, will be met from the site proceeds. Plus, the Business Case will consider the relocation of some primary care facilities from other sites allowing for further disinvestment and more efficient and effective use of estate.
number of wards within the borough.

For the Central Lewisham Hub, the Lewisham CCG, Local Estates Strategy identifies the Lewisham & Greenwich NHS Trust (LGT), Lewisham Hospital site as of strategic importance in the borough. It is highlighted as a potential super-hub site for the emerging Central Lewisham, Integrated Care Network (N2) and the wider borough.

who are also part of the national OPE programme, will ensure that the scheme comes to fruition.

The firm timescales will become known during 2017/18 but will take not less than three years to complete as the hub will be an integral part of a much larger site redevelopment and will rely not only on NHS Business Case approval, but acceptance by planners of the substantial master plan proposal and the procurement of development partners.
| Population Health System to support integrated care (Connect Care) | The population health module will support the delivery of the following objectives identified in the draft South East London LDR:  
• Providing health and care workers with the facility to access any relevant electronic data they need to support care  
• Work with suppliers, AHSN’s and the HIN to promote and support clinical apps which will better support self-care and decision support.  
• Provide a common health and social care record accessible by social care, out of hours, GPs, community and acute health care professionals  
• Enable the development of a single health and social care pathway for the individual client/patient with more community and home based prevention and care  
• Support multi-disciplinary team working for individual care delivery  
• Supporting identification, risk stratification and analysis of health and social needs for cohorts of the population | The timeline for benefit realisation is dependent upon the date of confirmation of funding and the funding amount | The development of population health management and patient/client direct access to their record are key enablers to support the transformation of care delivery as described in the STP. |
<table>
<thead>
<tr>
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<th></th>
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<tbody>
<tr>
<td>This initiative will support and enable a fully integrated health and social care service for Lewisham by providing a common health and social care record accessible when and where needed, enabling multi-disciplinary team working for individual care delivery and supporting identification and risk stratification of health and social needs for cohorts of the population.</td>
<td>The population health system will build on the Connect Care programme (Clinical Portal) identified in the Local Digital Roadmap (LDR) as a key foundation upon which to deliver paper free, electronic health and social care record at the point of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The population health system will build on the Connect Care programme (Clinical Portal) identified in the Local Digital Roadmap (LDR) as a key foundation upon which to deliver paper free, electronic health and social care record at the point of care.</td>
<td></td>
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</table>
ENCLOSURE 9

NHS England: London Region
Financial Report – 5 Months to 31st August 2017
South East London Primary Medical Services

CLINICAL LEAD: Dr Jacky McLeod, Clinical Director – Primary Care Lead

MANAGERIAL LEAD: Tony Read, Chief Finance Officer

AUTHOR: South East London Primary Care Finance Team

RECOMMENDATIONS:
The Primary Care Commissioning Committee is asked to note performance against budgets for the 5 months to 31st August 2017.

KEY ISSUES:
1. Overview:
   - The year to date reported financial position for South East London Primary Medical services is an overspend of £533k against total year to date (ytd) allocations of £103,476k.

2. 2017/18 Budgets:
   - The expenditure budgets have been set for each CCG based on:
     - practice level detailed contractual commitments for April 17 list sizes and at 17/18 prices
     - List growth reserves have been allowed for based on ONS figures for predicted population growth for 17/18 for each CCG
     - Premises budgets have been set based on known practice reimbursements and where not known, for example, 17/18 business rates and impact of in-year rents reviews, reasonable reserve budgets have been incorporated.
     - Other practice level budgets have been estimated based on prior year out-turn adjusted for known 17/18 changes to remuneration, e.g. seniority and QOF.

The total primary care medical services allocation for South East London STP for 17/18 has increased this year by 4.2% over 16/17 but this increase does not fall evenly across CCGs due to their differing distances from target. After allowing for population growth, anticipated increases in premises cost, 1% non-recurrent headroom and 0.5% contingency there is an underlying deficit of £2,707k for the STP to make up on a total Medical Services allocation of £248,232 in 2017/18.

3. Primary Medical Services Expenditure Summary:
   - The expenditure summary for South East London for the current month is set out in Table 1
Table 1

<table>
<thead>
<tr>
<th>South East London Total</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Annual Budget £000's</th>
<th>YTD Budget £000's</th>
<th>YTD Actual Expenditure £000's</th>
<th>YTD Variance £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMS</td>
<td>204,090</td>
<td>85,034</td>
<td>85,177</td>
<td>143</td>
</tr>
<tr>
<td>GMS</td>
<td>23,075</td>
<td>9,614</td>
<td>9,557</td>
<td>(56)</td>
</tr>
<tr>
<td>APMS</td>
<td>18,424</td>
<td>7,676</td>
<td>7,775</td>
<td>99</td>
</tr>
<tr>
<td>Other Medical Services</td>
<td>2,744</td>
<td>1,151</td>
<td>1,499</td>
<td>348</td>
</tr>
<tr>
<td>Total Primary Care Medical Services</td>
<td>248,332</td>
<td>103,476</td>
<td>104,009</td>
<td>533</td>
</tr>
</tbody>
</table>

Lewisham CCG

<table>
<thead>
<tr>
<th>Service</th>
<th>Normalised weighted list as at 01/04/2016</th>
<th>Normalised weighted list as at 01/04/2017</th>
<th>Year on Year % Movement</th>
<th>Year on Year % Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMS</td>
<td>38,434</td>
<td>16,014</td>
<td>16,014</td>
<td>(0)</td>
</tr>
<tr>
<td>GMS</td>
<td>2,363</td>
<td>985</td>
<td>977</td>
<td>(7)</td>
</tr>
<tr>
<td>APMS</td>
<td>932</td>
<td>388</td>
<td>387</td>
<td>(1)</td>
</tr>
<tr>
<td>Other Medical Services</td>
<td>1,392</td>
<td>580</td>
<td>580</td>
<td>0</td>
</tr>
<tr>
<td>Total Primary Care Medical Services</td>
<td>43,121</td>
<td>17,967</td>
<td>17,958</td>
<td>(9)</td>
</tr>
</tbody>
</table>

Brackets denote underspend

3.1 Lewisham CCG

Key Financial Indicator: Over/(Under) spend against budget

- Lewisham CCG is showing a YTD underspend of £9k. There are currently no material variances from budget. Lewisham CCG has forecasted that expenditure will be under budget at the yearend.

3.2 Capitation Report

The latest capitation figures available are at 1st July 2017 shown in the table below:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Normalised weighted list as at 01/04/2016</th>
<th>Normalised weighted list as at 01/04/2017</th>
<th>Year on Year % Movement</th>
<th>Year on Year % Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>219,428</td>
<td>223,645</td>
<td>1.92%</td>
<td>Year on Year % Movement</td>
</tr>
<tr>
<td>Bromley</td>
<td>320,947</td>
<td>323,703</td>
<td>0.86%</td>
<td>Year on Year % Movement</td>
</tr>
<tr>
<td>Greenwich</td>
<td>277,556</td>
<td>288,440</td>
<td>3.92%</td>
<td>Year on Year % Movement</td>
</tr>
<tr>
<td>Lambeth</td>
<td>376,673</td>
<td>385,999</td>
<td>2.48%</td>
<td>Year on Year % Movement</td>
</tr>
<tr>
<td>Lewisham</td>
<td>306,819</td>
<td>311,924</td>
<td>1.66%</td>
<td>Year on Year % Movement</td>
</tr>
<tr>
<td>Southwark</td>
<td>313,341</td>
<td>319,177</td>
<td>1.86%</td>
<td>Year on Year % Movement</td>
</tr>
<tr>
<td>Total SEL</td>
<td>1,814,765</td>
<td>1,852,888</td>
<td>2.10%</td>
<td>Year on Year % Movement</td>
</tr>
</tbody>
</table>
4. Lewisham

- The primary care medical budget calculated for this CCG leaves a surplus position of £1,213k (inclusive of headroom and contingency reserves) against the 17/18 allocation of £43,121k.
- The reported year to date position is an underspend of £9k (0.05%), the surplus has not been factored into the year to date position.
- The CCG weighted practice list size has increased by 1.7% year on year from April 2016 to April 2017 and a further 0.3% to July 2017. The primary care medical services allocation increased by 6.3%.

<table>
<thead>
<tr>
<th>CORPORATE AND STRATEGIC OBJECTIVES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Management: To manage effectively the CCG’s contract portfolio to ensure that the CCG’s Operating Plan’s commitments are met in 2017/18. This includes ensuring our financial targets are met and value for money is achieved.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONFLICT OF INTEREST (Col):</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>CONSULTATION HISTORY:</th>
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</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>PUBLIC ENGAGEMENT:</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH INEQUALITY &amp; PUBLIC SECTOR EQUALITY DUTIES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No adverse impacts identified.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESPONSIBLE MANAGERIAL LEAD CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Tony Read; E-mail: <a href="mailto:Tonyread@nhs.net">Tonyread@nhs.net</a></td>
</tr>
</tbody>
</table>
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