ENCLOSURE:

AGENDA ITEM:

South East London Clinical Commissioning Group

Primary Care Commissioning Committee

DATE: 16 April 2020
VENUE: Videoconference due to government advice during COVID-19

Voting Members present

Peter Ramrayka (Chair)	Lay Member: PCCC
Joy Ellery	Lay Member: PPI
Dr Adrian Mclachlan *(for Dr Jonty Heaversedge)*	Chair
Andrew Bland	Accountable Officer
Neil Kennett-Brown	Managing Director Bexley and Greenwich
Dr Angela Bhan	Managing Director Bromley
Martin Wilkinson	Managing Director Lewisham
Sam Hepplewhite	Managing Director Southwark
Neil Kennett-Brown	Managing Director Bexley and Greenwich
Andrew Parker *(for Andrew Eyres)*	Strategic Director Integrated Health & Care Lambeth
Professor Simon Mackenzie	Secondary Care Doctor

In attendance

Folake Segun	Healthwatch representative
Dr Simon Parton	LMC representative
Dr Sid Deskmukh	Lead GP Bexley
Dr Clive Anggiansah	Lead GP Bexley
Dr Ruchira Paranjape	Lead GP Bromley
Dr Krishna Subbarayan	Lead GP Greenwich
Dr Sabah Salman	Lead GP Greenwich
Dr Diane Aitken	Lead GP Lambeth
Dr Jacky Mcleod	Lead GP Lewisham
Dr Faruk Majid	Lead GP Lewisham
Dr Nancy Kuchemann	Lead GP Southwark
Kate Moriaty-Baker	Chief Nurse
Christina Windle	Chief Operating Officer
Jill Webb	Head of Primary Care
Nick Langford	Deputy Head of Primary Care
Nora Simon	Deputy Head of Primary Care
Jessica Arnold	Associate Director of Primary & Community Care Transformation
Irene Grayson	Assistant Director of Primary Care Greenwich
Ashley Oshaughnessy	Associate Director of Primary care Lewisham
Garry Money	Assistant Director of Primary and Community Care Lambeth
Sukh Singh	Assistant Director of Primary Care Service Delivery Bexley
Chima Olugh	Commissioning Manager – Primary Care

1. Welcome from the Chair and Apologies for Absence

1.1 Peter Ramrayka welcomed attendees, noting that it had not been possible to hold the PCCC meeting in public, but that a record would be provided as soon as possible on the CCGs website.

1.2 Apologies were received from Mary Currie, Sarah Cottingham, Andrew Eyres, Dr Jonty Heaversedge, and Usman Niazi

2. Declarations of interest

2.1 Members requested that the register should be updated to remove interests relating to their involvement in former CCGs which had now been dissolved. There were no additional declarations or conflicts identified in respect of agenda items.

3. Actions from previous PCCC meetings

3.1 Jill Webb assured the committee that the few actions pending from previous PCCC meetings had been recorded and would be completed with a record brought to future meetings, as part of the monitoring of legacy logs which had been completed for each of the former PCCCs.

4. Matters arising

4.1 The committee noted the terms of reference for the PCCC, The terms of reference had been developed for a single south east London PCCC as required by guidance, however the membership recognised the importance of strong borough representation given borough responsibilities for primary care.

4.2 In line with the relevant provision in the terms of reference, Dr Jonty Heaversedge and Andrew Eyres, as members of the SE London PCCC, had formally delegated their attendance and voting rights for this and future meetings to Dr Adrian McLachlan and Andrew Parker, respectively.

4.2 Kate Moriaty-Baker pointed out that at the time the terms of reference were developed the post of Chief Nurse had not been agreed for the CCG, and asked if the terms of reference would be changed as it was important that the chief nurse was represented. Christina Windle noted that the terms of reference had been developed as part of the constitution, and although it was not planned to amend the terms of reference at this point, it could be explored in the future.

4.3 Joy Ellery noted that that the terms of reference specified that the committee should be held in public but it had not been possible, and asked for actions to mitigate this such as quick publication of the minutes. Professor Simon Mackenzie suggested the scale of the of the pandemic challenge meant the lack of public meetings was understandable. Christina Windle confirmed that the CCG was following national guidance on committees during the pandemic as well as trying to go beyond by writing to frequent attendees of previous PCCCs and providing a record on its website.

5. Questions received from the Public

5.1 Folake Segun highlighted that a question had been received from a member of the public relating to the duty to reduce inequalities in the committee's terms of reference. The CCG was asked how it would support primary care to mitigate health inequalities affecting outcomes for some groups such as low-income households and BME groups during the pandemic, given that uptake of digital services was lower in areas of health inequality.

5.2 Christina Windle responded that the CCG was working with practices across south east London in consideration of the local demographic in each area. The question and the CCG's response would be published in full on the CCG's website..

5.3 Dr Simon Parton outlined work being undertaken by the LMC to ensure primary care was responding to the crisis. There were concerns that vulnerable patients and parents may be discouraged from accessing primary care and that delayed presentations may result. He asked the CCG to promote the message that primary care was operating differently but open for business. Sam Hepplewhite noted that some details had been circulated already in bulletins, but perhaps could be spread more widely. Christina Windle confirmed that a similar message had already been issued regarding urgent care, but further communications could be developed **Action: Peter Gibson**

5.4 Dr Adrian McLachlan pointed out that there had been an influx of NHS Volunteer Responders, with many yet to find roles, and suggested perhaps they could be directed to support primary care.

6. Report on urgent decisions taken by former PCCC meetings or under former Chair's action.

6.1 Peter Ramrayka noted that decisions had already been taken and signed off by chairs in relation to each report. Jill Webb added that previous PCCC committees had undertaken a large amount of work in preparation for the new CCG and consequentially a large amount of paperwork had been provided for transparency, as it had not been possible to take the decisions in public.

6.2 Dr Simon Parton asked whether the £20 financial support per registered patient from the Briset Corner Surgery would be made to practices receiving the 271 patients living outside Greenwich boundaries. He asked whether the Briset Corner Surgery would be supported with the requirement to print out patient notes for keeping by Primary Care Support England (PCSE). Jill Webb confirmed that in the new single CCG a payment would be made for any practice in south east London that accepted a patient. *Post meeting note: the basis of payments to practices receiving Briset Corner patients is that a practice must exceed 1% of their registered list to qualify for payment of Briset Corner patients thereafter*. Jill Webb also confirmed that Briset Corner Surgery patient notes had been fully printed and provided to PCSE.

6.3 Neil Kennett-Brown observed considering quality concerns with the practice and the lengthy process involved, the successful dispersal could be considered a positive result. Additional support had been provided to ensure patients were safeguarded, and this should be considered in future relevant cases.

6.4 Jessica Arnold shared that Bromley had introduced a rule to make the £20 payments only to practices whose list size had increased by over 2% as a result of absorbing displaced patients.

7. Report of decisions made by Officers under SOP

7.1 Jill Webb introduced the first of its regular reports of decisions made by officers in accordance with London standard operating procedures. The intention was to relieve the administrative burden on the committee by delegating to CCG officers decisions on transactional matters where the current operating model and NHS England and NHS Improvement (NHSEI) protocols applied. Examples included decisions on non-discretionary locum re-imbursements, of which there were a reasonably large number, the issue of improvement plans and remedial compliance notices. Jill Webb explained that officer proposed decisions would be discussed at borough level, in recognition of their continuing responsibility for primary medical care quality, and reported to the PCCC at the relevant time. The committee would retain the right to scrutinise and if necessary challenge any decisions made on its behalf by officers.

7.2 Additional supporting papers would be provided for decisions requiring a greater level of stakeholder involvement at borough level, for example temporary list closures where a practice was under extreme pressure. No such decisions had been necessary since the last PCCCs were held.

7.3 The committee **noted** the report.

8. Recommendations to the PCCC for decisions South east London wide

8a. London Primary Care Commissioning Operating Model

8.1 Jill Webb presented the paper outlining the history of development of the London Primary Care Commissioning Operating Model (LPCCOM), which had been produced to ensure consistency in process, reporting and governance across London, which are not in conflicts with NHS England's Primary Medical Care Policy & Guidance manual . https://www.england.nhs.uk/wp-content/uploads/2019/08/pgm-primary-medical-care-policy-guidance-manual-v3.docx

8.2 Borough based committees had already adopted the LPCCOM in 2018, and the SE London Primary Care Joint Committee before them, and while it remained a 'live' document with frequent additions,

the fundamental principles remained consistent. The SEL CCG was formally asked to accept the model and in future only material changes would be brought back to the PCCC for approval.

8.3 One material change planned had been a revision to the CQC SOPs in consultation with London LMCs, but this change would be delayed because of the COVID-19 pandemic. It was noted that any material additions or amendments to the Operating Model are always subject to London LMC representation from the 3 LMCs that cover London.

8.4 The full London Primary Care Commissioning Committee Operating Model had not been provided due to size and the fact that it was only accessible by people with an nhs.net address, but was available on request, and where this or Standard Operating Procedures were the basis of recommendations in the future the relevant sections would be quoted for members.

8.5 The committee **adopted** of the London Primary Care Commissioning Operating Model.

8b.South East London Patient Allocation Process

8.6 Jill Webb advised that from 1st April 2018 a formal national requirement had been made that un-registered patients should be allocated following a practice list dispersal. The previous process was to provide printed summary records of patients to Primary Care Support England (PCSE) to be held in abeyance until patients re-registered with a new practice which could receive the records. Implementation of the new allocation process in SE London had been delayed due to concerns about whether it was appropriate for commissioners to undertake the process, whether there was sufficiently detailed information to undertake the process, concerns about compliance with regulations such as General Data Protection Regulations, and the significant workload involved, which was over and above core workload. However, a pilot had since been undertaken in Bromley, where a number of dispersals had been necessary. As a result of the evaluation report produced by Bromley, the process had been further informed and has now been produced for approval and review, and engagement with London LMCs after 6-9 months.

8.7 Some issues that had arisen were highlighted including where some clinical systems were now closed and some are managed by a caretaker or the CCG, which would need to be addressed slightly differently as part of the legacy allocation process. In addition, and more recently due to the coronavirus pandemic, whilst there were 13 potential practices near to patient's homes, only a few currently had the infrastructure to accept them; and that where there is a large number of patients to allocate, the workload may be high for some practices, particularly at this time..

8.8 Appendix 1 shows there were 10 practices *(post meeting note: not of which has already completed its allocation process)* and a maximum of 6200 patients requiring allocation since 1 February 2018, although those who had not been seen for more than 5 years would not require allocation in accordance with NHSEI guidance. In view of backlog of work, and the exacting process involved, it would be necessary to prioritise which allocations were undertaken first, and it was proposed to start with the most recently closed practices. Support provided to practices would need to be consistent with the process but each borough would need to consider necessary support on a case-by-case basis.

8.9 Some patients who had re-registered may not have been counted in allocations, and so a small cost pressure up to a maximum £54,900 could arise. There were other financial matters that were highlighted to the committee including that those practices that will receive a large number of allocations may ask for financial support to help with the extra workload or have other support needs. Jill Webb advised that financial support was not part of the Allocations process and was something that boroughs currently review on a case by case basis. It was noted that because some systems have not been interrogated for some time it was not possible to guarantee that there were no vulnerable patients that have not re-registered, however it was known that all patient records and summaries had provided to PCSE.

8.10 Dr Simon Parton re-iterated that all involved would want to avoid un-registered patients, especially vulnerable people. Concerns had been expressed by LMC about the policy on patients who had not been seen for five years, which may put at risk those less able or willing to engage with practices, and may disproportionately affect vulnerable patients and those from BME groups. Dr Simon Parton welcomed the recommendation to engage further with LWLMCs and encouraged conversations to begin immediately on the process so that an effective review could be conducted after six months. Jill Webb responded that CCG officers will engage as soon as Londonwide LMCs has the capacity to do so, in recognition that their priority, consistent with many of us, is dealing with issues pertaining to the pandemic.

8.11 Jessica Arnold reflected on the lessons learned from the Bromley pilot and observed that significant effort was required to support potentially vulnerable patients with multiple attempts at contact. There had been a good team in place in Bromley for the pilot, and prioritising allocations should take into account the availability of CCG staff in boroughs to support the SE London Primary Care Team to carry them out. Additionally as many patients did not re-register until they became ill, it may be best not to prioritise the most recent cases.

8.12 The committee **adopted** the south east London Patient Allocation Process **noting** the points raised in the discussion.

8c. Formal Contractual Action and the Monitoring of CQC Report Action Plans and Contractualised Improvement Plans During Covid-19

8.13 Jill Webb outlined a proposal for agreement relating to the management of CQC inspection reports and improvement plans during the COVID-19 pandemic. Londonwide LMCs had written to commissioners requesting that primary care time be freed-up by reducing bureaucracy during the pandemic, and this was in harmony with both the latter request and recent NHSEI guidance. The proposed set of principles in response to this had been provided to the committee, noting that consideration of CQC matters would normally form part of PCCC meetings.

8.14 The paper proposed that the PCCC would receive no recommendations not to issue new breach notices or remedial notices during the pandemic in response to CQC reports published or yet to be published. In cases where patient safety was at risk, or where another CQC domain was rated inadequate, an action plan would be required as normal, however a remedial or breach notice would not be recommended. It was important for practices to clarify directly with the CQC what their approach would be during the pandemic, rather than to assume one statutory body (the CCG) could speak for another (the CQC).

8.15 Analysis of the current reports shows that 13 practices had patient safety matters needing to be addressed and 5 had 'inadequate' ratings in domains, as well as 5 with neither patient safety matters not inadequate ratings for whom follow-up will be paused. The paper had been shared with LWLMCs for comment, just ahead of the papers being but no response had been received as yet.

8.16 Dr Simon Parton pointed out that the LMCs letter had specified concerns about patient safety only however the proposal added a rating of inadequate in other CQC domains. Jill Webb offered to arrange for her colleague who drafted the paper to discuss the detail but stated that in her view the approach was correct and appropriate and in principle, reflected the spirit of reducing the burden on primary care. However, should any amendments be required, these would be brought back to the committee as a matter arising at the May meeting, together with any changes to the approach. **Action: Jill Webb to arrange discussion with LMC on possible amendments**.

8.13 Joy Ellery expressed her view that the response was proportionate. She asked if the timescales for practices to produce action plans would remain the same. Jill Webb confirmed that the timescale would be consistent, taking into account the proposal to focus on patient safety and other

inadequate domains based on the normal approach but no remedial or breach notice would be issued.

8.14 Dr Krishna Subbarayan requested that any support provided to struggling practices should focus on ensuring that they were providing an adequate response to the COVID-19 pandemic, and providing necessary support to enable this response, for example adequate personal protective equipment.

8.15 The committee **endorsed** the approach set out in the paper for formal contractual action and the monitoring of CQC Report action plans and contractualised improvement plans during Covid-19.

9. Any other business

9.1 The committee noted that papers should be issued with sufficient time to enable members to prepare, noting the bank holiday and the pressure of the COVID-19 response. The papers should also be indexed by page number if possible for ease of reference.

10. Date of the next meeting - 14 May 2020 2-5pm