GOVERNING BODY OF THE CCG
(Hammersmith and Fulham)
IM&T Committee

Monday 11th December, 2.00 – 4.00 pm, Room 3.5, 3rd floor, 15 MBR

Present

Name	Role and Organisation	Initials
Governing Body		
Tony Willis	H&F Clinical Commissioning Group – GP (Chair)	TW

Name	Role and Organisation	Initials
Officers in attendance		
Laurie Slater	IT Lead and GP, Brook Green Surgery IG and Choose and Book lead for HFCCG	LS
Coral McNeilly	Primary Care Commissioning Manager, Hammersmith & Fulham CCG	CM
Dave Thomas	Head of IT Operations, NWL CCGs	DT
Christine Dunne	Head of Primary Care Systems (via tele conference), NWL CCGs	CD
Faisal Siddiqi	Head of Service Delivery and Business IT	FS
Linda Williamson	PMO Manager, NWL CCGs	LW
Tarun Patel	GP IT Project Manager, NWL CCGs	TP
Xavier Yibowei	IT Programme Delivery Manager, NWL CCGs	XY
Zeba Jamal	Senior Primary Care Systems Facilitator, NWL CCGs	ZJ
Bahi Jayadevan	Interim Management Accountant, Hammersmith & Fulham CCG	BJ
Pete Ellis	Project Manager, Commissioning and Delivery	PE
Malaika Ivey	Project Support Officer, , Hammersmith & Fulham CCG	MI
Margaret Kelly	Business Support Manager, Hammersmith & Fulham CCG (minutes)	MK

Item	Agenda Item /Discussion	Action Owner
1.	**Welcome, Apologies and Declaration and Conflicts of Interest**	
1.1	TW welcomed everyone to the meeting. Apologies were received from John Keating. There were no additional declarations and conflicts of interest other than those already declared and published.	
2.	**Draft Minutes**	
2.1	The committee **approved** the draft minutes as an accurate record of the previous meeting.	

3.	Process for Small Innovation Bids	
3.1	LW presented the paper on the one off small digital innovation bids and governance process to be followed for those bids that may cost under or over £10k. LW said that 16K per CCG had been identified for 17/18; however, noted a variable pot due to monthly budget re-forecasting, based on the need to spend ETTF monies in-year and the further in year emerging commitments such as Health Help Now and Unified Comms. LW said that the CCG would receive the funding from Brent CCG and this process had been approved by the NW London CCGs' Collaboration Board on the 5th October. LW stated that the costs could be used towards new software or hardware and noted that Harrow CCG was looking to use the money towards a renal CKD pathway and to procure the provision of EMIS viewer licences so that London Northwest Healthcare Trust (LNWHT) services could lookup patient records from Harrow GP EMIS clinical systems. XY said that something similar was required in H&F for a SystmOne rewrite. The committee discussed the type of bids that could be submitted to assist back office capabilities such as voice dictation software, extended access from home, CTI integration to allow the patient to be identified and to launch the patient record, however would need to consider patient consent and connect with the digital roadmap. Additionally, it discussed the summary care record and data quality work and the high priority area of getting patients on line, which was a large piece of work that the CCG would need to address, however were mindful of the 31st March 2018 timescale for implementation. LW agreed to clarify whether the money could be utilised in 2018/19, if the funding was available for more than one year and would share examples of bids submitted by other CCGs. The committee asked for CM, LW and Dominic Brown to meet to discuss proposals such as patient connect, the work involved with the patient record and data quality, video conferencing solutions and webcam, the dermatology service and equipment for telemedicine and imaging alongside the referral and mobile devices to determine if any of these areas were feasible and to come back to the committee by e-mail with proposals for consideration. TW also mentioned diabetes and the variables and the volume of work that could be undertaken going forward. CM said that some money should remain following the IT refresh and the CCG could look at the tele dermatology service, mobile devices and cameras. LW mentioned that work was underway by Dominic Brown the Technology Development Manager in testing the cameras. LW explained that bids less than £10k would need to be considered by the Digital Programme Team which meets weekly with joint approval required from the Director of Informatics and Director of Primary Care Development and for bids over £10k to go to the next Collaboration Board in January 2018 for approval. The committee **noted and discussed** the process for small Innovation Bids	**LW** **CM, LW/ Dom Brown**

4. GP IT Refresh

4.1 TP introduced the paper on the GP IT refresh. He advised that the NHS England (NHSE) capital allocation was now approved for the two years 17/18 and 18/19, which should allow the hardware refresh to proceed with the 17/18 allocation to be spent by the 31st March 2018 and for the 19/18 allocation by the utilised 31st March 2019. Further detail on the 17/18 and 18/19 values and breakdown of costs for the different areas are outlined below:

Description	Value 17/18	Value 18/19
Centralised infrastructure	£72,600	£9,900
PMO/Project costs	£126,303	£8,459
Hardware contingency	£10,000	£10,000
Project implementation contingency	£36,300	£4,950
Project installation	£34,273	£5,954
GP IT Refresh	£446,524	£59,737
TOTAL	**£726,000**	**£99,000**

TP stated that the PID details the proposed 17/18 spend; with £446,524 of the overall budget to be allocated towards the hardware refresh, with IT to report back on the equipment that was out of warranty.

TP advised the committee that a bid was made to NHSE to secure 17/18 funding based on the inventory of GP IT hardware, with the final recommended list of hardware to be purchased and the associated costs detailed in Appendix A, as follows:

Item type	Qty	Cost	Notes
Desktop PC - Dell 5040	88	£70,108	Replacing PCs out of/coming out of warranty. Includes the delivery and install equipment/asset tagging/logistics/waste management etc.
Mobile Devices	130	£165,709	
Prescription Printers	224	£69,159	
Server Replacement	29	£130,500	Replacing aging servers deemed end of life
Total		**£435,476**	

TP suggested initially focusing on the server replacements at each GP practice, which are three years old; and purchasing new hardware to include a five year warranty. LS asked for a list of all hardware and the expiry date to be compiled and shared with the GP practices and the CCG. TP clarified that a list of all hardware and the expiry dates would be distributed to the CCG and GP practices as part of the closure process, which should also assist with the IG toolkit. TP reported that of the £130,500 budget allocated towards the 29 server replacements, that £11k would remain in the budget to be utilised towards cameras. TP added that £165,709 of the overall budget was allocated towards new laptops, to be purchased before the 31st March 2018. However, alternative areas could be considered if laptops are not required. DT highlighted the additional work for IT staff in looking after the extra laptops.

TW suggested looking at different options such as mobile devices for patients, digital literature for transformation work and smart phones to support behaviour change. TP recommended having patient check-in facilities and said that the CCG should consider similar practice requests. CM clarified that one practice request for check-in facilities was

	received for a new site, but would need to factor in the licence costs. DT said that the CCG would need to be aware that any bids submitted for patients against the ETTF budget would require the CCG to fund replacement costs in 4 years' time. DT also emphasised the importance of clarity around what the providers are required to provide, such as the GP Federation and the CCGs responsibility. LS asked TP to clarify what software was on the 88 desktops currently out of warranty. TP said that £20k would be required to extend the warranty of previous purchases, and recommended paying for the warranty this year, to ensure no underspend against budget. Furthermore, the CCG would need to consider how next year's £99k budget was spent. LS mentioned home visits and the need for good wifi and mobile access to patient data at an individual's home. DT said that the CCG should also consider any running costs linked to the mobile wifi access. The committee discussed back office capability with GPs moving into Networks and agreed that any associated costs should be picked up by the GP Federation. DT said that patient connect and enhanced telephony did not meet the criteria therefore should be excluded. TP agreed to purchase the servers and revise the PID to show a variance of £175k, and include the provider rules and governance around it and then decide how the rest of the money should be spent. The committee noted that the proposal would need to be submitted to TP in the first two weeks in January to allow the devices to be purchased. CM mentioned the importance of factoring in down time to allow for the swap over. TP said that three days would be required for swap over and 1 hour in the afternoon to allow for the server to be connected and to use some of the money to cover out of hours costs to address downtime. LS asked TP to check what other CCGs are purchasing. TP explained that other CCGs are using the money towards infrastructure work, cable, switches and tidying up of cabinets. The committee **noted and discussed** the GP IT refresh update	**TP** **DT/All**
5.	**Local CCG Budget update**	
5.1	BJ presented the paper and IM&T finance update at M7. BJ reported a break-even position for the forecast outturn with a year to-date position of £15k over budget, covering both elements of the total Primary Care IT budget of £527k. BI added that the 2017/18 budget also included £16k for GP Wifi and explained that the year to date position included expenditure from BT, EE, Fine Valley and Daisy Communications against the local expenditure budget. The committee **noted the update** on the IM&T financial position at M7.	
6.	**NWL e-RS update Community Services**	
6.1	ZJ reported that e-RS training has been provided to H&F practices through SystmOne User Groups and through individual practice visits. She explained that training tools were being further developed to be distributed to GP practices in early January. ZJ explained that work was having with Pete Ellis around community services and with DMC and what to do when you refer, looking at the 2-week wait and a video, which should go out at the end of this week. ZJ added that it had produced crib sheets and a one pager and a substantive user guide and video.	

	ZJ reported that intensive training was being provided across NWL. ZJ explained that dialogue with the secondary care providers had been established, in particular with Imperial Trust who was moving to ERS-referrals from August with paper switches to be turned off. ZJ noted that monthly meetings were now scheduled with Chelsea and Westminster Trust, but was aware of the previous difficulties experienced in engaging with the Trust around the e-RS discussions. ZJ said it was aiming to standardise community referrals with referrals to be sent to GP practices. ZJ said that currently in H&F that GPs were managing their own referrals and this paper was focusing on community services in H&F. ZJ said if a patient needed to be referred onto secondary care that currently the patient has to be referred back to the GP in order to be referred on to acute, instead of using community services to refer on to acute direct. LS said that the CCG would need to allow community services to use e-RS to refer into acute direct. CM advised that the Dermatology service which was re-procured has been set up on e-RS, which was a direct referral process and allows for direct referrals to the Trust. CM said that work was underway with the community provider to move their process across. Pete Ellis said that the use of e-RS had formed part of the standard contract terms and conditions going forward regardless of the system that GP practices use for example SystmOne or EMIS. CM commented that a stream of communication out to practices, raising the profile of e-RS, was crucial to reach 80% utilisation by October 2018. In particular reporting on action plans and progress for secondary care providers to practices showing that it isn't just Primary Care where the work is being carried out. TW suggested piloting the referral view for the next service that goes live but this would be dependent on record sharing. TW suggested writing to the collaborative of CCGs to inform them that H&F CCG was moving to e-RS. LS agreed to take this forward. XY said it was important to define the referral standards across North West London (NWL) CCGs. The committee **noted** the NWL e-RS update Community Services	**LS**
7.	**ETTF and Project update – ETTF M5 Capital**	
7.1	LW provided an update on the ETTF M5 Capital. LS explained that the report which goes to the Collaborative Board monthly includes the GP IT capital; the digital workflows to do with e-RS and diagnostic cloud. LS queried why H&F had the smallest proportion of budget. LW explained that this was due to H&F having the smallest list size. TW asked if the budget included the full cost of whole systems. LW agreed to provide a breakdown for the next meeting. The committee **noted** the ETTF and M5 Capital update	**LW**
8.	**General Data Protection Regulations (GDPR)**	
8.1	CD provided a verbal update on the General Data Protection Regulations (GDPR). CD said herself and LS had attended the IG Governance Steering Group to discuss the General Data Protection Regulations (GDPR) and new set of standards that come into effect from May 2018. CD said that work is underway led by David Stone, an external IG Consultant, on the	

	alignment of GDPR and to rewrite the MOU for the Pan-London SLA and data sharing. The committee noted that David would be producing a 2 page practice based checklist and suite of information for GP practices to list the local GP requirements and any legal ramification around consent, with this piece of work to conclude around February. LS said that there would be a bigger piece of work carried out to look at the governance across London, rewrite the MOU, develop a PAN-London SLA, and data sharing agreement for the sharing of direct care, to be rolled out as part of business as usual. LS said that consent would form a big part of the process in particular the requirements around sharing in and out of data at the point of care and whether the new governance processes would alter. The committee agreed for LS, CM and ZJ to meet to review the set of information and package to be rolled out to GP practices and to provide an update on progress at the next IM&T Committee. The committee suggested adding GDPR to the risk register, in particular around obtaining patient consent and to ensure GDPR compliant. LS said that processes would need to be in place for informed consent, and the level of consent required for sharing patient records. XY said that the MOU should set out the principles of sharing and the data controller would enable the information to be shared once, when consent was attained. LS said that the process of documenting and recording consent and where the data was stored would need to be more secure, but the share in and share out element should not change considerably. LW said that IT was looking at their own risks and could escalate the relevant risks and report to the committee on the specific H&F risks bi-monthly. The committee **noted** the verbal update on the General Data Protection Regulations (GDPR) requirements	**LS/ZJ/ CM** **LW**
9.	**Data Controller Console**	
9.1	XY introduced the paper. He explained that the data controller console was an online tool to manage data in a more efficient way, and to allow schedules to be made available. Furthermore, it includes who the information is being shared with, the sharing agreements across the sector and when the information requires review. He advised that the ISA and MOU would need to be revised for NWL CCGs given the number of schedules and specific sharing arrangements for data controller. XY said that the data controller was commissioned by HLP therefore would incur costs going forward after year 1 but do not know the costs currently. XY said that the console shows where to capture patient consent and for which areas, and whether the information was held on a different system. XY advised that the care record locator for London was also built in. XY reported that patient verification and consent would be required before the data was released, however would need to act as a gate keeper to decide whether to share the information. XY said that NWL has limited the scope but need to monitor the tool to be assured. XY noted that the LMC had an issue with indemnity and the sharing of data. LS agreed to discuss the ISA, sub-schedules, data sharing and terms with the LMC, but need to understand which ISA was in ISCRO. The committee noted that the CQC inspection functionality would be published on data controller and linked to the IG toolkit report.	**LS**

	XY said that everyone would need to sign up to the data controller console. LS agreed to check with Caroline Durack whether the GP Federation were connected. The committee agreed that the comms being produced to go out to GP practices through the members meeting and network meetings to be clearer, and for the content to be reviewed prior to being distributed. XY said that sign up was required before the end of January 2018, with organisations uploaded onto the tool in December, along with the schedules for each department. Furthermore, for training to be provided. The committee **noted** the paper on the Data Controller Console	**LS** **XY**
10.	**Informatics IT Project Status Report and ICT Service Report**	
10.1	The committee **noted** the IT Project Status Report ICT Service Report, shared with the committee for information.	
11.	**Any Other Business**	
11.1	No other business was discussed.	
The next meeting is scheduled for Thursday 8th February, 1.30 – 3.30 pm		