NHS North Central London CCG
Primary Care Commissioning Committee
Thursday 23 July 2020
11am to 12:30pm
Virtual Meeting

Item	Title	Lead	Action	Page	Time
	Pre-meet to be held for committee members from 10:30am to 10:55am				
	AGENDA **Part 1**				
1.0	**INTRODUCTION**				
1.1	Welcome and Apologies	Ian Bretman	Note	Oral	11.00am to 11:10am
1.2	Resolution to exclude members of the public from the meeting for the protection of public health	Ian Bretman	Approve	4	
1.3	Declarations of Interest Register	Ian Bretman	Note	6	
1.4	Declarations of Interest relating to the items on the Agenda	All	Note	Oral	
1.5	Declarations of Gifts and Hospitality	Ian Bretman	Note	Oral	
1.6	Minutes of the NCL Primary Care Committee in Common Meeting on 20 February 2020	Ian Bretman	Note	11	
1.7	Legacy Actions from the NCL Primary Care Committee in Common	Ian Bretman	Note	19	
1.8	Matters Arising	All	Note	Oral	
1.9	**Questions from the public relating to items on the agenda received prior to the meeting** Members of the public have the opportunity to ask questions. These must relate to items that are on the agenda for this meeting and should take no longer than three minutes per person.				
2.0	**BUSINESS**				
2.1	Finance Report	Tracey Lewis	Note	21	11:10am to 11:40am
2.2	NCL Quality & Performance Report	Paul Sinden	Note	29	
2.3	Primary Care Covid Update	Paul Sinden	Note	40	

3.0	**ITEMS FOR DECISION**				
	Contract Variations				
3.1	**All Boroughs** • PMS Changes <u>Barnet</u> Woodlands Pactice – removal of a partner Woodlands Practice – addition of a partner <u>Camden</u> West Hampstead Medical Centre – removal of a partner James Wigg Practice – removal of a partner <u>Enfield</u> Nightingale House Surgery – removal of a partner Medicus Partnership – 24hr retirement Winchmore Hill Practice – addition of a partner <u>Haringey</u> Fernlea Surgery – addition of a partner Fernlea Surgery – 24 hr retirement Lawrence House Surgery – 24hr retirement Lawrence House Surgery – addition of a partner	Vanessa Piper / Borough Rep	Approve	53	11:40am to 12:10pm
3.2	**Barnet** • Longrove Surgery co-location with Vale Drive Practice	Vanessa Piper / Borough Rep	Approve	67	
3.3	**Barnet** • Park View Surgery – Request to approve (i) closure of branch surgery (ii) increase in rent	Vanessa Piper / Borough Rep	Approve	72	
3.4	**Barnet** • Derwent Practice Relocation	Vanessa Piper / Borough Rep	Approve	78	

4.0	**ITEMS TO NOTE – URGENT DECISIONS TAKEN SINCE 1 APRIL 2020**				
4.1	**Barnet** • Barnet Care Homes LCS	Colette Wood	Note	83	12:10pm to 12:15pm
4.2	**Camden** • Rosslyn Hill and Hampstead Group Merger	Vanessa Piper / Borough Rep	Note	117	
5.0	**GOVERNANCE AND COMMITTEE ADMINISTRATION**				
5.1	PCCC Terms of Reference	Paul Sinden	Note	124	12:15pm to 12:25pm
5.2	PCCC Risk Register	Paul Sinden	Note	136	
5.3	PCCC Forward Planner	Ian Bretman	Note	146	
6.0	**ANY OTHER BUSINESS**				**12.25**
6.1	Any other Business				
7.0	**DATES OF FUTURE MEETINGS**				
	• Thursday 20 August 2020 – 11am to 12:30pm • Thursday 22 October 2020 – 2:30pm to 4pm • Thursday 17 December 2020 – 2:30pm to 4pm • Thursday 18 February 2021 – 11am to 12:30pm				

Resolution to exclude observers, the public and members of the press from the remainder of the meeting.

By reason of the confidential nature of the business to be transacted in accordance with Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960 and clause 22 of the Terms of Reference of this Committee and clauses 9 and 10 of the Standing Orders of this Committee.

North Central London CCG
Primary Care Commissioning Committee Meeting
23 July 2020

Report Title	Resolution to Exclude Members of the Public from the Meeting for the Protection of Public Health	**Date of report**	15 July 2020	**Agenda Item**	1.2
Lead Director / Manager	Paul Sinden, Executive Director of Performance & Assurance	**Email / Tel**		p.sinden@nhs.net	
GB Member Sponsor	Ian Bretman, Chair of NCL CCG Primary Care Commissioning Committee				
Report Author	Vivienne Ahmad Board Secretary	Tel/Email		v.ahmad@nhs.net	
Name of Authorising Finance Lead	*Not Applicable*	**Summary of Financial Implications** *Not Applicable*			
Report Summary	The UK is currently in a state of national emergency due to the Covid 19 pandemic. The Government has introduced a number of measures to control the rate of infection and reduce the number of deaths. This includes social distancing and restrictions on gatherings of people. To support this, better protect people's health and to eliminate the risks associated with meetings in public at this time the **Primary Care Commissioning Committee (PCCC)** is asked to pass a motion excluding members of the public from the meeting in accordance with the Public Bodies (Admission to meetings) Act 1960. To support public engagement and transparency the following measures have been put into place and published on the CCG's website: • The PCCC papers have been published on the CCG's website; • Members of the public can submit questions to the PCCC as normal to a central mailbox; • Questions received before the meeting will be addressed; • Within two weeks of the meeting the CCG will publish the minutes of the meeting and the answers to public questions.				
Recommendation	The PCCC is asked to **PASS** the following motion: • The PCCC resolve to exclude member of the public from the PCCC meeting on 23rd July 2020 for the protection of public health in accordance with the Public Bodies (Admission to meetings) Act 1960.				
Identified Risks and Risk	This report helps to eliminate the health risks associated with members of the public attending a meeting in public of the PCCC during the Covid 19 pandemic.				

Management Actions	
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy.
Resource Implications	This report supports the CCG in making effective and efficient use of its resources by eliminating the risk of holding a meeting in public.
Engagement	This report is presented to the PCCC which includes lay members and clinicians.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	*Not Applicable.*
Next Steps	*Not Applicable.*
Appendices	*None.*

North Central London CCG
Primary Care Commissioning Committee Meeting
23 July 2020

North Central London Clinical Commissioning Group

Report Title	Declaration of Interests Register – Primary Care Commissioning Committee Meeting	**Agenda Item:** 1.3

Governing Body Sponsor	Mr Ian Bretman Committee Chair and Governing Body member	Tel/Email	Ian.bretman@nhs.net
Lead Director / Manager	Mr Ian Porter Executive Director for Corporate Services	Tel/Email	Ian.porter3@nhs.net
Report Author	Vivienne Ahmad Board Secretary	Tel/Email	v.ahmad@nhs.net
Name of Authorising Public and Patient Engagement and Equalities Lead	*Not Applicable*	**Summary of Financial Implications**	*Not Applicable*
Report Summary	Members and attendees of the Primary Care Commissioning Committee Meeting are asked to review the agenda and consider whether any of the topics might present a conflict of interest, whether those interests are already included within the Register of Interest, or need to be considered for the first time due to the specific subject matter of the agenda item. A conflict of interest would arise if decisions or recommendations made by the Governing Body or its Committees could be perceived to advantage the individual holding the interest, their family, or their workplace or business interests. Such advantage might be financial or in another form, such as the ability to exert undue influence. Any such interests should be declared either before or during the meeting so that they can be managed appropriately. Effective handling of conflicts of interest is crucial to give confidence to patients, tax payers, healthcare providers and Parliament that CCG commissioning decisions are robust, fair and transparent and offer value for money. If attendees are unsure of whether or not individual interests represent a conflict, they should be declared anyway.		
Recommendation	To **NOTE** the Declaration of Interests Register and invite members to inspect their entry and advise the meeting / Board Secretary of any changes.		

Identified Risks and Risk Management Actions	The risk of failing to declare an interest may affect the validity of a decision / discussion made at this meeting and could potentially result in reputational and financial costs against the CCG.

Conflicts of Interest	The purpose of the Register is to list interests, perceived and actual, of members that may relate to the meeting.
Resource Implications	*Not Applicable*
Engagement	*Not Applicable*
Equality Impact Analysis	*Not Applicable*

Report History and Key Decisions	The Declaration of Interests Register is a standing item presented to every meeting of the Primary Care Commissioning Committee Meeting.
Next Steps	The Declaration of Interests Register is presented to every meeting of the Primary Care Commissioning Committee Meeting and regularly monitored.
Appendices	The Declaration of Interests Register.

NCL CCG Primary Care Committee Declaration of Interest Register - July 2020

Name	Current Position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest - (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or Indirect?	Nature of Interest	Date of Interest			
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	Date declared	Updated
Members											
Ian **Bretman**	Lay Member of NCL CCG Governing Body Member of Covid Response Oversight Committee Member of NCL CCG Governing Body Chair of Patient and Public Engagement Committee Chair of Primary Care Procurement Committee Member of Audit Committee Member of Remuneration Committee Attend other committee meetings as and when required	Citizens Advice Bureau, Barnet	No	Yes	No	Direct	Trustee	01/04/2017		14/08/2019	11/05/2020
		Biomedical Healthcare Ltd	No	No	Yes	Indirect	Son is a senior technical manager in a company offering an App for people to manage prescription requests and long-term medication programmes	01/04/2017		14/08/2019	11/05/2020
		Timewise Foundation CIC	No	No	No	Direct	Provides occasional consultancy services for this social enterprise that helps organisations make better use of flexible working.	17/10/2018		14/08/2019	11/05/2020
		Timewise Jobs Ltd	No	No	no	Direct		15/05/2019		01/10/2019	11/05/2020
		Timewise Solutions Ltd	No	No	no	Direct		15/05/2019		01/10/2019	11/05/2020
Dr Peter **Christian**	Haringey Clinical Representative, NCL CCG Governing Body member of Audit Committee Chair of IFR Panel Member of Primary Care Committee	Muswell Hill Practice	Yes	No	No	Direct	Practice Partner	15/03/2018	current	07/11/2018	11/05/2020
		Muswell Hill Practice is a member of Federation4Health, the pan- Haringey Federation of GP Practices	Yes	No	No	Direct	Practice Partner	15/03/2018	current	07/11/2018	11/05/2020
		Muswell Hill Practice is a member of WISH - Urgent Care Centre provider at Whittington Hospital	Yes	No	No	Direct	Practice Partner	15/03/2018	current	07/11/2018	11/05/2020
		Muswell Hill Practice provides anitcoagulant care to Haringey residents under a contract with the CCG	Yes	No	No	Direct	Practice Partner	15/03/2018	current	07/11/2018	11/05/2020
		The Hospital Saturday Fund - a charity which gives monet to health telated issues	No	No	Yes	Direct	Member	15/03/2018	current	07/11/2018	11/05/2020
		The Hospital Saturday Fund - a charity which gives money to health related issues	No	No	Yes	Indirect (Wife)	Patron	15/03/2018	current	07/11/2018	11/05/2020
		The Lost Chord Charity - organises interactive musical sessions for people with dementia in residential homes.	No	No	No	Indirect (Wife) Direct	Patron	15/03/2018	current	07/11/2018	11/05/2020
		North West Primary Care Nework	Yes	No	No	Indirect	Practice is a member	01/07/2019	current	04/09/2019	11/05/2020
		Haringey Health Connected, the federation of West Haringey GP Practices.	No	No	Yes		Pactice Manager is Finance Manager	15/03/2018	current	07/11/2018	11/05/2020
Simon **Goodwin**	Chief Finance Officer of NCL CCG Member of NCL CCG Governing Body NCL Finance Committee Attendee, NCL Audit committee NCL Strategy and Commissioning Committee NCL Primary Care Commissioning in Common Attend other meetings as and when required.	East London NHS Foundation Trust	Yes	No	No	Indirect	Wife is a senior manager at the Trust	14/06/2017	current	12/10/2018	11/05/2020
Claire **Johnston**	Registered Nurse of NCL CCG Governing Body Member of Primary Care Committee Member of Quality Committee Member of Medicines Management Committee Member of Public and Patient Engagement Committee Member of Covid Reponse Oversight Committee Member of IFR Panel	Our Time	No	Yes	No	Direct	Chair of Trustees for this charity supports children with parents with mental health issues			12/09/2019	12/05/2020
		Nursing and Midwifery Council	No	Yes	No	Direct	Registered Member			12/09/2019	12/05/2020
		The Guardian	No	No	No	Indirect	Spouse is Public Services Editor			12/09/2019	12/05/2020
Kay **Matthews**	Attend Governing Body Attend NCL Committee Meetings as required Member of NCL CCG Executive Management Team Member of Barnet Directorate Management Team Attend Covid Response Oversight Committee	No interests declared	no	no	no	no	Nil Return				11/05/2020
Dr Subir **Mukherjee**	Secondary Care Clinician, NCL CCG Member of Covid Reponse Oversight Committee Member of the Quality and Safety Committee						Secondary care consultant				

NCL CCG Primary Care Committee Declaration of Interest Register - July 2020

Arnold **Palmer**	Lay Member of NCL CCG Governing Body Chair of Remuneration Committee Member of IFR Appeals Panel Member of Strategy and Commissioning Committee Member of Finance Committee Member of Audit Committee Member of Public and Patient Engagement Committee	A & C Palmer Associates	Yes	No	No	Direct	Director and Owner of private LTD company, providing training, executive coaching and consultancy services. Spouse is also a shareholder and company secretary.	01/01/2006	current	16/04/2020	
Dr Dominic **Roberts**	Clinical Director, Islington borough, NCL CCG		y	y	n	direct	Clinical Director	07/11/2018	current	02/08/2019	10/05/2020
			y	y	n	direct	member	07/11/2018	current	02/08/2019	10/05/2020
		Conflict of interest issues for the Governing Body and CCG.	n	y	n	direct	Lead	07/11/2018	current	02/08/2019	10/05/2020
		Caldicott Guardian for Islington & Haringey	n	y	n	direct	Caldicott Guardian	07/11/2018	current	02/08/2019	10/05/2020
		Freedom to Speak up Guardian for Islington & Haringey	n	y	n	direct	Guardian	07/11/2018	current	02/08/2019	10/05/2020
		Freedom to Speak up Guardian for Islington Federation	n	y	n	direct	Guardian	07/11/2018	current	02/08/2019	10/05/2020
		Individual Funding Request Panel				direct	Chair	07/11/2018	current	02/08/2019	10/05/2020
		Locally Commissioned Services Working Group				direct	Chair	07/11/2018	current	02/08/2019	10/05/2020
		Islington & Haringey on the NCL Primary Care Joint Committee				direct	Clinical representative	07/11/2018	current	02/08/2019	10/05/2020
		Supporting and managing the Clinical Leads (including Darzi fellow) - recruitment, bi-monthly network meetings, appraisals, finance.				direct	Support and manage	07/11/2018	current	02/08/2019	10/05/2020
		Medicines and devices Safety Officer (MSO & MDSO)				direct	Safety Officer	07/11/2018	current	02/08/2019	10/05/2020
		MSO/MDSO network for local CCGs and Providers				direct	Chair	07/11/2018	current	02/08/2019	10/05/2020
		Controlled drugs safety lead and Antimicrobial stewardship lead.				direct	Lead	07/11/2018	current	02/08/2019	10/05/2020
		Whittington Care Quality Review Group				direct	member	07/11/2018	current	02/08/2019	10/05/2020
		Map of medicine team				direct	Provide clinical leadership	07/11/2018	current	02/08/2019	10/05/2020
		Serious incident reviews & patient safety				direct	Provide clinical leadership	07/11/2018	current	02/08/2019	10/05/2020
		GP Practice Quality				direct	Provide clinical leadership	07/11/2018	current	02/08/2019	10/05/2020
		Pressure ulcer task and finish group.				direct	Provide clinical leadership	07/11/2018	current	02/08/2019	10/05/2020
		Federation Working Group				direct	Provide clinical leadership	07/11/2018	current	02/08/2019	10/05/2020
		Chair board Link visits				direct	Chair	07/11/2018	current	02/08/2019	10/05/2020
		NLP IG Working Group				direct	Chair	07/11/2018	current	02/08/2019	10/05/2020
		Locum GP	y	y	n	direct	Homerton Hospital OOH care, Paradoc emergency home visiting service , Tower Hamlets, SELDOC GP OOH services and Croydon (ad hoc sessions in various GP surgeries across London, excluding Islington)	07/11/2018	current	02/08/2019	10/05/2020
		Greenland Passage residential association	n	y	y	direct	Board Director	07/11/2018	current	02/08/2019	10/05/2020
		1-12 Royal Court Ltd	n	y	y	direct	Secretary & director	07/11/2018	current	02/08/2019	10/05/2020
		Novo Nordisk pharmaceutical company.	n	n	n	Indirect	My Sister is a Medical Advisor	07/11/2018	current	02/08/2019	10/05/2020
		St Helier Hospital in Sutton.	n	n	n	Indirect	Partner is an ITU Consultant	07/11/2018	current	02/08/2019	10/05/2020
		BMA	y	y	n	direct	member	07/11/2018	current	02/08/2019	10/05/2020
		Elizabeth Avenue practice	n	n	n	Indirect	Personal friend of GP Partner	07/11/2018	current	02/08/2019	10/05/2020
		City and Hackney Local Medical Committee	n	y	n	direct	member	07/11/2018	current	02/08/2019	10/05/2020
		City & Hackney Urgent Healthcare Social Enterprise -providing out of hours care for City & Hackney CCG residents.	y	y	n	direct	I am a GP - I do shifts for the Paradoc emergency home visiting service.	07/11/2018	current	02/08/2019	10/05/2020
		Communitas, a private provider seeing NHS patients,	y	y	n	direct	I undertake clinical sessions in my role as a GP with a Special interest in ENT.	07/11/2018	current	02/08/2019	10/05/2020
		Haringey CCG as an external GP	y	y	n	direct	as an external GP on their transformation group and investment committee. I also support some of their procurement work streams and other CCG duties as required as an external GP.	07/11/2018	current	02/08/2019	10/05/2020
		Babylon, a private provider for digital GP consultations.	y	y	n	direct	locum GP. Babylon supports the 111 service in London.	07/11/2018	current	02/08/2019	10/05/2020
		Hackney VTS GP training scheme	y	y	n	direct	Programme director, employed by the London Specialty School of General Practice, Health Education England.	07/11/2018	current	02/08/2019	10/05/2020
		I am a GP Appraiser for the London area.	y	y	n	direct	GP Appraiser	07/11/2018	current	02/08/2019	10/05/2020
		I am a mentor for GPs under GMC sanctions.	y	y	n	direct	GP Mentor	07/11/2018	current	02/08/2019	10/05/2020
		I am currently mentoring a salaried GP at a practice in Haringey.	y	y	n	direct	Salaried GP	07/11/2018	current	02/08/2019	10/05/2020
Paul **Sinden**	Executive Director of Performance & Assurance Exec Lead for Primary Care Committee Member of NCL CCG Executive Management Team	No interests declared	No	No	No	No	Nil Return	30/04/2018	current	16/08/2019	15/05/2020
Attendees											
Vivienne **Ahmad**	Board Secretary	No interests declared	No	No	No	No	Nil Return	25/10/2018	current	16/10/2019	
Dr Julie **Billett**	Public Health Representative	Director of Public Health Camden and Islington	Yes	Yes	No	Direct	Salaried Employee	01/02/2013	current	08/08/2019	
		London Association of Directors of Public Health	No	Yes	No	Direct	Chair of	15/11/2016	current	08/08/2019	
Saloni **Thakrar**	Healthwatch Representative	Camden Healthwatch	No	Yes	No	Direct	Chair	29/06/2017	current	18/10/2019	10/07/2020
		Chomley Garden Surgery Practice	No	Yes	No	Direct	Patient Participation Group Representative	06/01/2016	current	18/10/2019	10/07/2020
		UK National Thalassemia and Sickle Cell Group (NHS England)	No	Yes	No	Direct	Lay Member	06/01/2016	current	18/10/2019	10/07/2020
		Little Village Charity	No	No	Yes	Direct	Trustee	12/07/2017	current	18/10/2019	10/07/2020
		Seeds of Peace, UK Charity					Executive Committee member	01/05/2019	current	10/07/2020	
		London Antenatal Screening Programme	No	Yes	No	Direct	Lay Member representative	12/07/2017	current	18/10/2019	10/07/2020

NCL CCG Primary Care Committee Declaration of Interest Register - July 2020

Dr Tamara **Djuretic**	Public Health Representative	Public Health Barnet	no	yes	no	Direct	Director of Public Health Barnet, which has a statutory duty to provide a 'core offer' to the CCG	03/05/2018	current	11/09/2019	
		Royal Free London Group	no	yes	no	Direct	Royal Free London Group Director of Public Health	01/09/2019	current	11/09/2019	
Dr Will **Maimaris**	Interim Director of Public Health, Haringey Council	No	n/a	n/a	n/a	n/a	n/a	30/08/2018	current	009/08/2019	
Patient rep - TBC											
Jane **Betts**	LMC Representative										
Noelle **Skivington**	Healthwatch Enfield	Healthwatch Enfield (under the name: Combining Opinions to Generate Solutions CIC)	Y	N	Y	Direct	Board member	May-13	current	10/07/2020	
Anthony **Marks**	Senior Primary Care Commissioning Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30.10.2018	30/08/2019
Su **Nayee**	Assistant Head of Primary Care, NHS England	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	20.10.2018	14/07/2020
Vanessa **Piper**	Head of Primary Care, NC London, NHS England, London Region										
Ruth **Donaldson**	Executive Managing Director (Job Share): Enfield Attend Governing Body Attend NCL Committee Meetings as required Member of NCL CCG Executive Management Team Member of Enfield Directorate Management Team	No interests declared	No	No	No	No	Nil Return	27/02/2018	current	03/09/2019	08/05/2020
Sarah **D'Souza**	Executive Managing Director (Job Share): Enfield Attend Governing Body Attend NCL Committee Meetings as required Member of NCL CCG Executive Management Team Member of Enfield Directorate Management Team	No interests declared	No	No	No	No	Nil Return	01/03/2019	current	14/09/2019	08/05/2020
Tony **Hoolaghan**	Executive Managing Director: Haringey & Islington Attend Governing Body Attend NCL Committee Meetings as required Member of NCL CCG Executive Management Team Member of Haringey and Islington Directorate Management Team Attend Covid Response Oversight Committee	Sidney Estates Tenants and Residents Association, Tower Hamlets	No	No	Yes	No	Chair	21/06/2017	current	02/10/2019	08/05/2020
Sarah **McDonnell-Davies**	Executive Managing Director: Camden Attend Governing Body Attend NCL Committee Meetings as required e.g. Borough Commissioning Committee Member of NCL CCG Executive Management Team Member of Camden Directorate Management Team	PA Consulting	Yes	No	No	Direct	Shareholder PA Consultancy	15/06/2018	current	20/06/2018	11/05/2020
Kay **Matthews**	Attend Governing Body Attend NCL Committee Meetings as required Member of NCL CCG Executive Management Team Member of Barnet Directorate Management Team Attend Covid Response Oversight Committee	No interests declared	no	no	no	no	Nil Return				11/05/2020

NORTH CENTRAL LONDON PRIMARY CARE COMMITTEE IN COMMON

(Meeting held in public)

Minutes of Meeting held on Thursday 20 February between 3pm and 4:30pm

Enfield CCG - Committee Rm, Holbrook House, Cockfosters Road, Barnet, Herts EN4 0DR.

Voting Members Present:	
Lay Members	
Ms Cathy Herman **(Chair)**	Governing Body Lay Member, Haringey CCG & Chair of PCCC
Ms Sorrel Brookes	Governing Body Lay Member, Islington CCG & Vice Chair of PCCC *(deputised for Ian Bretman, Barnet CCG)*
Ms Karen Trew	Governing Body Member, Enfield CCG
Ms Glenys Thornton	Governing Body Member, Camden CCG
GP Representatives	
Dr Dina Dhorajiwala	Governing Body GP Member, Haringey CCG
Dr Dominic Roberts	Clinical Director, Islington CCG *(deputised for Dr Kevan Ritchie, Camden CCG)*
Dr Janet High	GP Clinical Lead, Enfield CCG
Dr Louise Miller	Clinical Lead, Barnet CCG *(deputised for Dr Murtaza Khanbhai, Barnet CCG)*
Officer Representatives	
Ms Deborah McBeal	Director of Primary Care Commissioning and Deputy Chief Operating Officer, Enfield CCG
Mr Liam Beadman	Head of Primary Care Development, Islington CCG *(deputised for Clare Henderson, Islington CCG)*
Ms Victoria Wicks	Head of Primary Care, Haringey CCG *(deputised for Rachel Lissauer, Haringey CCG)*
Mr Simon Wheatley	Assistant Director of Primary Care, Camden CCG
Mr Daniel Glasgow	Deputy Director of Primary Care Transformation, Haringey CCG *(deputised for Colette Wood, Barnet CCG)*
Mr Paul Sinden	NCL Director of Performance, Planning and Primary Care
In Attendance	
Ms Charlotte Cooley	Governing Body Practice Nurse, Camden CCG
Ms Tracey Lewis	Head of Finance, Camden CCG
Ms Vanessa Piper	Head of Primary Care, NCL Primary Care Commissioning & Contracting Team
Ms Vicky Weeks	Medical Director for North Central London, London wide LMCs *(deputised for Greg Cairns, London wide LMCs)*
Ms Vivienne Ahmad **(Minutes)**	Board Secretary, Islington CCG
Apologies:	
Dr Kevan Ritchie	Governing Body GP Member, Camden CCG
Dr Murtaza Khanbhai	Governing Body GP Member, Barnet CCG
Mr Ian Bretman	Governing Body Lay Member, Barnet CCG
Ms Colette Wood	Director of Primary Care Transformation, Barnet CCG
Ms Clare Henderson	Director of Commissioning & Integration, Islington CCG
Ms Rachel Lissauer	Director of Commissioning & Integration, Haringey CCG

Ms Neeshma Shah	Director of Quality & Clinical Effectiveness, Camden CCG
Mr Simon Goodwin	NCL Chief Finance Officer
Ms Noelle Skivington	Healthwatch Representative, Enfield
Mr Greg Cairns	Director of Primary Care Strategy, London wide LMCs
Members of the Public	
Mr Philip Richards	
Lian Edwards	
Andrew Perugia	Special Projects Lead at Central and North West London Foundation Trust

1.	**Welcome & Apologies**
1.1	The Chair welcomed members and attendees to the meeting. Apologies were recorded as above.
1.2	The Chair recommended that as this was the last NCL Primary Care Committee Meeting before the changes that come into effect from 1 April 2020, whether the Committee agreed to delegate the final sign off, of both the minutes and the action log, to the Chair. The Committee agreed to the recommendation.
1.3	**Action:** • Final PCCC minutes and action log to go forward to the new NCL CCG Primary Care Committee after sign off from Chair. (Vivienne Ahmad)
1.4	The Committee **APPROVED** the recommendation of delegating the final sign of the minutes and action log to the Chair.
2	**Declarations of Interests Register**
2.1	The Chair further advised that the Committee Declarations of Interest Register had been circulated with the meeting papers.
3	**Declarations of Interest Relating to Items on the Agenda**
3.1	The Chair invited members of the Committee to declare any interests in respect to the items on the agenda. None were declared.
4	**Declarations of Gifts and Hospitality**
4.1	There were no declarations declared.
5	**Minutes of the meeting held on 19 December 2019**
5.1	The minutes were **APPROVED** as an accurate record of the meeting subject to the following amendment:
5.2	To correct Janet High's job title as GP Clinical Lead rather than Governing Body GP member.
5.3	**Action:** • To correct Janet High's job title as GP Clinical Lead rather than Governing Body GP member. (Vivienne Ahmad)

6	**Actions from the meeting held on 19 December 2019**
6.1	The action log was reviewed and the Committee agreed to close all the actions except the following which would be left open and forwarded to the new NCL CCG Primary Care Committee:
6.2	• Action 3 from the meeting on 19 December 2019 regarding the draft 2020/21 budget - it was agreed the 2020/21 delegated commissioning budget could be presented to the first meeting of the new NCL CCG Primary Care Committee in 2020/21.
6.3	• Action 9 from the meeting of 19 December 2019 regarding an update on the management of practices that close half a day –three practices in Barnet had yet to meet the required cover arrangements for half-day closures. Remedial Notices were to be issued to them in early March and a further update would be provided from April 2020.
7	**Matters Arising**
7.1	There were no matters arising.
8	**Questions from the public**
8.1	Mr Phillip Richards posed two questions in advance to the Committee:
8.2	**What involvement do the NCL CCGs have to ensure there are patient participation groups (PPGs) in each GP practice?** When undertaking practice visits CCGs would request updates on the status of their PPGs as part of practice contract requirements. Other opportunities for patients to engage with their practices included duty for Primary Care Networks (PCNs) to engage with their population, and through other organisations including Enfield over 50s forum (which recently held a presentation on PCNs showing how they engage with their population) and through Healthwatch. Both Healthwatch and PCNs could help reduce the variability in activity of PPGs across NCL. It was noted as good practice for practices to involve their PPGs in Care Quality Commission (CQC) visits and inspections.
8.3	**Is it possible for patients to access the CQC Reports for their practice?** It was noted the NHS Choices website provides the CQC reports for each of the practices.
8.4	At the Committee, Mr Andrew Perugia asked whether the Committee could provide support for primary care and practice involvement in research projects. Paul Sinden agreed to discuss this after the meeting.
8.5	The Chair thanked the members of the public for their questions.
ITEMS FOR DISCUSSION	
9	**Finance Report – Month 9**
9.1	Tracey Lewis provided a summary of the financial position for Month 9 for delegated primary care budgets.
9.2	The following key points were reported: • Month 9 forecast was breakeven on delegated budgets for Barnet, Enfield, Haringey and Islington and an ongoing forecast overspend position for Camden;

	• The GP at Hand risk was largely removed from primary care budgets at Month 9, as 90% of the GP at Hand cost was attributable to acute, mental health, and community services rather than primary care. The residual element (10%) relating to primary care remained a cost pressure in the delegated allocation.
9.3	The following was noted in discussion of the report: • The Committee queried whether GP at Hand costs were based on real figures or an estimate of people who had left local GP lists to join the service. Costs were based on an estimate. Accountability for the service was being addressed through the NHS England digital first primary care report consultation that included a requirement for a local contract if the service had more than a thousand patients on the list. The report, and recommendations, was being picked up through the London Primary Care Management Board; • The Committee asked about the delay in list cleansing being carried out by Capita. The updated timetable had been included in the risk register.
9.4	The Committee **NOTED** the report.
10	**NCL Quality & Performance Report**
10.1	Paul Sinden presented the report.
10.2	The following key points were reported: • As indicated in previous reports, the data had been sourced from publically available information; • Practice mergers had increased the average list size for practices in Haringey; • Care Quality Commission (CQC) Ratings had changed for a practice in Barnet (which had moved from good to requiring improvement) and one in Enfield (which moved from good to inadequate). These practices would be required to provide a remedial action plan in line with the contract; • It was noted there was one practice had been assessed by the CQC as good in all domains but required improvement as an overall rating. This may have been due to the CQC undertaking an interim evaluation where there were areas of concern, and would be updated in due course; • Urgent Emergency Care – the data focused on primary care activity and capacity. In North Central London 45% of appointments were carried out on the same day compared to the national average of 40%; • Development of the early warning system for struggling practices would be carried forward into the new NCL CCG Primary Care Committee.
10.3	The following was noted in discussion of the report: • The uptake of digital online access, in order to book appointments or request repeat prescriptions, was lower in Enfield compared to the other four CCGs. This was due to patients being recorded as not having online access in 14 of the Enfield practices; • The DNA rates for online appointments across NCL was rising. It was noted the above points were being picked up by the Digital Programme Board; • The number of complaints remained static year on year, and any information on changes in underlying themes (and the learning from them) was requested. This information was held by NHS England • The Urgent and Emergency Care element of the report was also used by A&E Delivery Boards across NCL to look at overall system capacity.
10.4	**Action:** • To carry forward the early warning system for general practices and the themes from Complaints into the new NCL CCG Primary Care Committee. (Paul Sinden).
10.5	The Committee **NOTED** the report.

11	**Update on GP Contract & Primary Care Networks DES**
11.1	Paul Sinden presented the paper, with the following key points being reported: • The paper provided a summary of the updates to the national GP Contract announced on 6 February 2020; • Towards the end of 2019, NHS England / Improvement published the draft primary care networks (PCN) DES service specifications for engagement, with the specifications generating significant feedback including from NCL. This resulted in major changes including expansion of the additional roles scheme, reimbursement for some roles moving from 70% to 100%, measures to support training and recruitment, and further improvements to the Quality Outcome Framework (QOF) with additional domains and modules such as learning disabilities and early cancer diagnosis. With learning disabilities, it was noted the access to health checks was variable for NCL; • The phasing of the service specifications which the primary care networks were to introduce in 2020/21 had been changed with a couple of specifications being pushed back to 2021/22; • As a result, much of the feedback had been addressed but payment of London weighting was still an ongoing issue for the PCN roles in inner London.
11.2	The following was noted in discussion of the report: • If London weighting was not included in DES payments recruitment to the additional roles would result in a local cost pressure or leave practices unable to recruit to posts. Other areas were considering the use their PMS commissioning intentions to close the funding gap. A conference on March 11 2020 would discuss the London Weighting issue. An update would be provided at the first NCL CCG Primary Care Committee; • The variability of delivering health checks for people with learning disabilities across NCL needed addressing in line with the Equality Act 2010 stated this cohort was a protected group. The Committee was informed this was also a priority in the NHS Long Term Plan and operating plan guidance for 2021. Each CCG had an improvement trajectory for health checks coverage built in the long term plan.
11.3	**Action:** • To provide an update on London weighting at the new NCL CCG Primary Care Committee from April 2020. (Paul Sinden)
11.4	The Committee **NOTED** the paper.
ITEMS FOR DECISION	
	Contract Variations
12	**All Boroughs – Personal Medical Services (PMS) Contract Changes**
12.1	**Barnet – Derwent Medical Centre**
12.1.1	The Committee was asked to approve the addition of four GP signatories onto the contract with effect from 1 April 2020. The shortfall on nursing appointments would be addressed with the practice.
12.1.2	The Committee **APPROVED** the recommendation.
12.2	**Barnet – Torrington Park Medical Centre**
12.2.1	The Committee was asked to approve the addition of one GP signatory with effect from 1 April 2020. There were no concerns with GP or nursing appointments.
12.2.2	The Committee **APPROVED** the recommendation.

12.3	**Barnet – Millway Park Medical Practice**
12.3.1	The Committee was asked to approve the addition of two GP signatories with effect from 1 April 2020. This would increase the number of signatories to the contract from seven to nine. The Practice was offering fewer nurse appointments than recommended, and this would be addressed with the practice.
12.3.2	The Committee **APPROVED** the recommendation.
13	**Barnet – Wentworth Medical Centre – request to increase rent**
13.1	The Committee was asked to approve the increase in rent at Wentworth Medical Centre by one room for the additional admin space, with approval based on the condition that Commissioners would instruct the District Valuer (DV) to verify the increase in rent, as the building was owner occupied
13.2	The request covered the use of a vacant room previously used by a dentist, with the request being to convert the room to increase admin space to enable a merger of admin functions with another local practice. This would result in a rent increase in rent of £3,000 and the DV would be requested to assess the value of the increase.
13.3	The Committee asked for further clarification on the payment of rent in an owner occupier building. In this situation a notional rent was paid.
13.4	The Committee **APPROVED** the recommendation.
14	**Haringey – Charlton House Practice – Premises relocation**
14.1	The Committee was asked to approve the relocation of Charlton House Surgery.
14.2	The landlord of the current premises had served notice on the lease and had offered a new lease for only a five year term, with an increase in annual rent to £65k from £49k. There was limited scope to negotiate an extension of the lease as the building was grade two listed and in need of extensive work to make the building compliant. The CCG had found an alternative site within 50 metres from the current practice site, with the practice taking the first two floors of the four storey building. Rental costs would be the same as the current amount with the exception of the cost of additional parking space made available to the practice. There were some risks associated with relocation to the new premises from ongoing building works on the top two floors, and the practice had been asked to seek safety guarantees from the builder.
14.3	The Committee was asked to approve the relocation on the basis that the current market rate would stay the same but there would be an additional cost of £750 per annum for the three car parking spaces. The additional car spaces was part of the premises cost directions. It was noted the District Valuer would review the value of the rent.
14.4	The Committee **APPROVED** the recommendation.
15	**Haringey – Lawrence House Surgery – PMS Contract Variation – Finance agreement**
15.1	The Committee was asked to approve a variation to the PMS Contract of Lawrence House Surgery for an initial period of 12 months.
15.2	Lawrence House merged with another practice in early 2015 but had great difficulty in recruiting admin staff. The practice therefore received admin support from Whittington Health also located in the same building providing community services. In 2017, the Trust served notice and there was an agreement to TUPE transfer some of the admin staff over to the practice. The practice PMS contract was varied at the time, but the variation had not been included in the PMS contract review process and there was no written evidence of the original variation. Legal advice was therefore sought which

	confirmed that a formal contract variation could go into the PMS contract. The Committee was asked to note the conditions that would be put into the approval of the variation including making contact with the practice to check that admin staff were still employed within the practice, provide evidence on payment of staff salaries, and the assurance that the practice would still require the additional funding, as over time the list had grown.
15.3	It was noted the practice would be given 28 days to respond and an update would be provided at the new NCL CCG Primary Care Committee meeting from April 2020.
15.4	**Action:** • To provide an update on Lawrence House Surgery at the new NCL CCG Primary Care Committee from April 2020. (Vanessa Piper)
15.5	The Committee **APPROVED** the recommendation.
ITEMS TO NOTE - URGENT DECISIONS TAKEN SINCE 19 DECEMBER 2019	
16	No urgent decisions were taken.
ITEMS TO NOTE AND INFORMATION	
17	**PCCC Risk Register**
17.1	The Committee noted the new risk of the GP at Hand service which was requested at the last meeting and would be an ongoing risk into the next financial year. Although 90% of the financial risk sat outside of the remit of the Committee.
17.2	There was also a proposal to carry forward all ongoing risks into the new NCL CCG Primary Care Committee except for risk PCCC014 on the Special Allocation Service as the procurement was now complete and new service in place. The Committee approved the ongoing risks to be carried forward.
17.3	**Action:** • To carry forward any ongoing NCL primary care risks into the new NCL CCG Primary Care Committee. (Paul Sinden & Chris Hanson)
17.4	The Committee **APPROVED** the risk report.
18	**Items to forward to the new NCL Committee**
18.1	The Committee had agreed earlier in the meeting that ongoing actions plus actions from this meeting would be signed off, along with the minutes, by the Chair and go forward to the new NCL CCG Primary Care Committee.
18.2	The Committee had previously considered the Terms of Reference for the new NCL CCG Primary Care Committee at the Seminar held on 31 January 2020.
18.3	In the addition to this it was requested that the new Committee would continue to focus on: • Alignment of the primary care provider landscape across the GP Federations and Primary Care Networks, including financial sustainability; • The interface between Primary Care Networks and integrated borough partnerships, and how the CCG would support that through the governance structure; • To maintain the independent clinical leadership voice in the Committee to help avoid conflicts of interest.

19	**Any other Business**
19.1	There was no other business.
20	**Date of next meeting**
20.1	TBC

NCL CCG Primary Care Committee - Action Log for April 2020

Open Actions

Meeting Date	Action No.	Minutes Ref	Action	Action lead	Deadline	Status update	Date closed
20.02.20	1	1.3	**Welcome & Apologies –** Final PCCC minutes and action log of 20 February 2020 to go forward to the new NCL CCG Primary Care Committee after sign off from the Chair.	Vivienne Ahmad	**TBC**	**23-06-2020.** Minutes signed off. Legacy actions on agenda for 23 June 2020 Primary Care Committee. **Recommend to close the action**	
20.02.20	2	5.3	**Minutes of the meeting held on 19 December 2019** – To correct Janet High's job title as GP Clinical Lead rather than Governing Body GP Member.	Vivienne Ahmad	**TBC**	**21.02.20** – This was duly amended. **Recommend to close the action.**	
20.02.20	3	10.14	**NCL Quality & Performance Report** – To carry forward the early warning system for general practices and the themes from Complaints into the new NCL CCG Primary Care Committee.	Paul Sinden	**TBC**	**23-06-2020.** Early warning system will be picked up through covid primary care recovery workforce and resilience workstream. **Recommend to close the action.**	
20.02.20	4	11.10	**Update on GP Contract & Primary Care Networks' DES** – To provide an update on London weighting at the new NCL CCG Primary Care Committee.	Paul Sinden	**TBC**	**23.06.2020** – An update will be provided under the finance item. **Recommend to close the action.**	
20.02.20	5	15.4	**Haringey – Lawrence House Surgery – PMS Contract Variation Finance Agreement** – To provide an update on Lawrence House Surgery at the new NCL CCG Primary Care Committee.	Vanessa Piper	**TBC**	**23.06.2020** – An update will be provided at the Committee meeting on 23 June 2020. **Recommend to close the action.**	
20.02.20	6	17.3	**PCCC Risk Register** – To carry forward any ongoing NCL primary care risks into the new NCL CCG Primary Care Committee.	Paul Sinden & Chris Hanson	**TBC**	**23.06.2020** – Risk register on committee agenda including carry forward actions. **Recommend to close the action**	

19.12.19	2	8.10	**Finance Report -** To add the draft 2020/21 budget to the PCCC Forward Planner for February 2020.	Tracey Lewis	**TBC**	**20.02.20 –** The delegated primary care commissioning budget to be presented to the NCL CCG Primary Care Committee. On agenda for 23rd June 2020. **Recommend to close the action**	
19.12.19	9	16.11	**Barnet, Camden & Haringey: Management of practices that close half a day** – To provide an update on management of practices that close half a day at the next PCCC meeting on 20 February 2020.	Vanessa Piper	**TBC**	**20.02.20 -** A verbal update was provided. At the last meeting there were eight practices that closed half a day. After the December papers were published this went down to five practices and post December this has now gone further to three practices in Barnet that closed half a day. Remedial Notices were to be issued to them in early March 2020. **A further update would be provided at the new NCL CCG Primary Care Committee from April 2020.**	

North Central London CCG
Primary Care Commissioning Committee Meeting
Thursday 23rd July 2020

Report Title	M3 NCL Primary Care Delegated Commissioning Finance Report	**Date of report**	13th July 2020	**Agenda Item**	2.1
Lead Director / Manager	Paul Sinden, Executive Director of Performance and Assurance	**Email / Tel**		p.sinden@nhs.net	
GB Member Sponsor	*Not applicable*				
Report Author	Tracey Lewis, Head of Finance Primary Care	**Email / Tel**		tracey.lewis9@nhs.net	
Name of Authorising Finance Lead	Benjamin Catlin	**Summary of Financial Implications** The Committee's Terms of Reference sets out its operating structure and therefore how the Committee makes financial decisions.			
Report Summary	This report presents the Primary Care Delegated Commissioning budget for 2020/21 and the financial position as at Month 3 (June 2020).				
Recommendation	The Committee is requested to: • **NOTE** the Primary Care Delegated Commissioning Budget and the Month 3 position.				
Identified Risks and Risk Management Actions	The Committee will provide oversight and scrutiny of the CCG's key risks within the area of its remit.				
Conflicts of Interest	This report was written in accordance with the CCG's Conflicts of Interest Policy.				
Resource Implications	This report supports the CCG by providing oversight and scrutiny of delegated primary care commissioning and in making effective and efficient use of its resources.				
Engagement	The Committee includes Lay Members and clinicians. Patient Representatives are also invited to Committee meetings as Standing Attendees.				
Equality Impact Analysis	The report was written in accordance with the provisions of the Equality Act 2010.				
Report History and Key Decisions	For noting by the Committee.				
Next Steps	None.				
Appendices	None.				

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

Primary Care Delegated Commissioning Budget 20/21 and Finance Report M3 20/21

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Executive Summary

- This report presents the 2020/21 Delegated Primary Care Budget and the Month 3 financial position across the five North Central London (NCL) localities (Barnet, Camden, Enfield, Haringey and Islington) as at Month 3, June 2020.

- The report summarises the Month 3 expenditure against budgets. The budget has not yet been fully allocated for the year due to COVID 19 risk therefore the report presents the position against a current allocation up to Month 4 forecast only.

- As at Month 3, the NCL Primary Care budget is forecasting a net over-performance of £0.7m against an interim allocation of £57.5m up to Month 3 and a forecast over-performance of £1m against an interim allocation of £76.6m up to Month 4.

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

2020/21 NCL Primary Care Delegated Commissioning Budget Summary

- The table below summarises the 2020/21 NCL Primary Care Delegated Commissioning Budget Summary
- The total Primary Care Delegated Allocation for 2020/21 is £232.8m (19/20 £220.5m)
- However due to COVID 19 financial risk the 20/21 allocation has currently only been received up to Month 4 in the sum of £76.6m only.

NCL Delegated Primary Care Medical Services
Budget Summary - 2020/21

Description	Barnet	Camden	Enfield	Haringey	Islington	Total NCL
	£000s	£000s	£000s	£000s	£000s	£000s
2020/21 Allocations	56,296	41,437	47,107	46,890	41,068	232,798
Surplus/Deficit Contribution to Core Operating Plan	1,221	(1,744)	869	762	1,892	3,000
2020/21 Delegated Primary Care Budget	55,075	43,181	46,238	46,128	39,176	229,798
Weighted Population - 1st April 2020 List Size	391,506	300,101	318,708	310,724	276,838	1,597,878

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

2020/21 NCL Primary Care Delegated Commissioning Budget Detail

- The table below summarise the 2020/21 NCL Primary Care Delegated Commissioning budget by locality

NCL Delegated Primary Care Medical Services
Budget Detail by Locality - 2020/21

Description	Barnet	Camden	Enfield	Haringey	Islington	Total NCL
	£000's	£000's	£000's	£000's	£000's	£000's
GMS	20,528	12,622	9,757	10,057	22,696	**75,660**
PMS	18,334	16,327	21,457	19,084	1,590	**76,792**
APMS	476	2,876	2,047	3,980	1,658	**11,036**
Subtotal Core Contract	**39,339**	**31,825**	**33,261**	**33,121**	**25,943**	**163,489**
Demograghic Growth Reserve	558	362	443	397	370	**2,130**
QOF (inc reserves)	4,672	2,645	3,967	3,056	2,524	**16,864**
Enhanced Services (excluding PCN)	380	207	375	323	338	**1,623**
PCN	3,606	2,708	2,907	2,844	2,434	**14,498**
Premises	5,593	6,164	5,148	4,304	4,581	**25,790**
Premises Growth @ 3%	149	172	120	121	128	**690**
Administered Funds (inc Seniority,Maternity ,Sickness etc)	560	877	508	598	413	**2,955**
Personally Administered Drugs(PAD) & Other	220	86	144	97	95	**642**
Subtotal Other Services	**15,737**	**13,222**	**13,612**	**11,740**	**10,883**	**65,194**
Total Medical Services	**55,076**	**45,047**	**46,872**	**44,861**	**36,826**	**228,683**
CQC	274	191	224	215	187	**1,090**
Other (Dv, Occ H, sterline)	5	5	5	5	5	**25**
Total Delegated Primary Care Budget	**55,356**	**45,243**	**47,101**	**45,080**	**37,000**	**229,798**

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

2020/21 NCL Primary Care Delegated Commissioning as at Month 3

Financial Summary - 3 Months to 30th June 2020

NCL Total

Service	Annual Budget £000's	YTD Budget £000's	YTD Actual Expenditure £000's	YTD Variance Fav/(Adv) £000's	Forecast Outturn £000's	Forecast Variance Fav/(Adv) £000's
PMS	32,060	24,045	23,964	81	32,060	0
GMS	32,797	24,598	25,020	(422)	32,797	0
APMS	4,398	3,299	3,265	33	4,398	0
Other Medical Services	6,366	4,775	4,766	9	7,344	(978)
Other Committed Funds	1,000	750	1,186	(436)	1,000	0
Total Primary Care Medical Services	**76,622**	**57,466**	**58,202**	**(735)**	**77,600**	**(978)**

The NCL delegated budgets are forecast to overspend by £1m which relates to a shortfall in the allocation received up to Month 4 for delegated commissioning. The Month 3 position shows a 0.7m overspend due to the shortfall in allocation received to date.

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

2020/21 Primary Care Delegated Commissioning Expenditure by Locality as at Month 3

Barnet	Annual Budget £000's	YTD Budget £000's	YTD Actual Expenditure £000's	YTD Variance Fav/(Adv) £000's	Forecast Outturn £000's	Forecast Variance Fav/(Adv) £000's
PMS	7,722	5,792	5,712	80	7,722	0
GMS	8,722	6,541	6,671	(129)	8,722	0
APMS	186	140	139	0	186	0
Other Medical Services	1,558	1,169	1,279	(111)	1,795	(237)
Other Committed Funds	407	305	305	0	407	0
Total Primary Care Medical Services	**18,595**	**13,946**	**14,106**	**(160)**	**18,832**	**(237)**

Camden	Annual Budget £000's	YTD Budget £000's	YTD Actual Expenditure £000's	YTD Variance Fav/(Adv) £000's	Forecast Outturn £000's	Forecast Variance Fav/(Adv) £000's
PMS	6,999	5,249	5,205	45	6,999	0
GMS	5,497	4,123	4,209	(87)	5,497	0
APMS	1,188	891	961	(70)	1,188	0
Other Medical Services	1,244	933	943	(10)	1,418	(174)
Other Committed Funds	(581)	(436)	0	(436)	(581)	0
Total Primary Care Medical Services	**14,347**	**10,760**	**11,318**	**(558)**	**14,521**	**(174)**

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

2020/21 Primary Care Delegated Commissioning Expenditure by Locality as at Month 3

Enfield	Annual Budget £000's	YTD Budget £000's	YTD Actual Expenditure £000's	YTD Variance Fav/(Adv) £000's	Forecast Outturn £000's	Forecast Variance Fav/(Adv) £000's
PMS	9,022	6,767	6,699	68	9,022	0
GMS	4,445	3,334	3,387	(54)	4,445	0
APMS	845	634	626	7	845	0
Other Medical Services	1,266	949	985	(36)	1,464	(198)
Other Committed Funds	290	217	217	0	290	0
Total Primary Care Medical Services	**15,867**	**11,900**	**11,915**	**(14)**	**16,065**	**(198)**

Haringey	Annual Budget £000's	YTD Budget £000's	YTD Actual Expenditure £000's	YTD Variance Fav/(Adv) £000's	Forecast Outturn £000's	Forecast Variance Fav/(Adv) £000's
PMS	7,704	5,778	5,896	(118)	7,704	0
GMS	4,473	3,355	3,404	(49)	4,473	0
APMS	1,466	1,100	1,009	91	1,466	0
Other Medical Services	1,256	942	776	166	1,453	(197)
Other Committed Funds	254	191	191	0	254	0
Total Primary Care Medical Services	**15,154**	**11,365**	**11,275**	**90**	**15,351**	**(197)**

Islington	Annual Budget £000's	YTD Budget £000's	YTD Actual Expenditure £000's	YTD Variance Fav/(Adv) £000's	Forecast Outturn £000's	Forecast Variance Fav/(Adv) £000's
PMS	613	460	453	6	613	0
GMS	9,660	7,245	7,349	(104)	9,660	0
APMS	713	535	530	5	713	0
Other Medical Services	1,042	781	787	(5)	1,214	(173)
Other Committed Funds	631	473	473	0	631	0
Total Primary Care Medical Services	**12,659**	**9,494**	**9,593**	**(98)**	**12,832**	**(173)**

North Central London CCG
Primary Care Commissioning Committee Meeting
23 July 2020

Report Title	Primary Care Quality and Performance Report	**Date of report**	15 July 2020	**Agenda Item**	2.2
Lead Director / Manager	Paul Sinden, Executive Director of Performance & Assurance	**Email / Tel**		p.sinden@nhs.net	
GB Member Sponsor	*Not Applicable*				
Report Author	Paul Sinden, Executive Director of Performance & Assurance	**Email / Tel**		p.sinden@nhs.net	
Name of Authorising Finance Lead	*Not Applicable*	**Summary of Financial Implications** *Not Applicable*			

Report Summary

1. Introduction

This report sets out:

- The latest Quality and Performance Report for comment;
- A summary of actions accruing from the quality report;
- An extract from the NCL urgent and emergency care report that sets out measures of primary care capacity.

The report is carried forward from the previous NCL CCGs Primary Care Committee-in-Common. The Committee-in-Common had asked that the report be further developed to include:

- Reports by Primary Care Network;
- Trend information;
- Future reports will also include appointments data and patient feedback information that will be provided through the new GP contract.

A report to support the development of Primary Care Networks has been drafted and this will come to the Committee in September for information, once local feedback has been received and reflected in the report. The report focuses on both primary care (including quality and patient experience indicators) and use of secondary care metrics.

Appointment data is sourced from the NCL urgent and emergency care report, and appointment trends from April 2019 to May 2020 are summarised in the report.

Some reporting lines in the urgent and emergency care report have been suspended nationally during the covid pandemic and will be reinstated for future reports including:

	• The mix of GP appointments across face-to-face, telephone / video, and home visit, with an expectation that this shows a material swing towards remote (telephone / video) consultations introduced as part of the response to covid; • The level of same-day appointment for in-hours general practice compared to London and National performance; • Extended access hub utilisation.
Recommendation	The Committee is asked to: • **COMMENT ON** future development of the quality and performance report to support onward quality and performance improvement; • **COMMENT ON** the identified actions to carry forward into NCL CCG governance structures.
Identified Risks and Risk Management Actions	The report outlines areas where support to practices is required, and where formal action requiring remedial actions plans are required.
Conflicts of Interest	Conflicts of interest are managed robustly and in accordance with the CCG's conflict of interest policy.
Resource Implications	The report helps to identify practices in need of resilience funding. Local primary care development plans, including the GP Forward View and developing primary care at scale seek to address variations in care and access described in the report.
Engagement	The report includes patient experience measures from the Friends and Family Test and GP Patient Survey carried out by Ipsos MORI.
Equality Impact Analysis	This report was written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	The Quality Report provides an overview of primary medical services contracts delegated to the CCG from NHS England.
Next Steps	Local reporting will be further extended through work to develop reporting to support the development of Primary Care Networks in NCL.
Appendices	1. Quality and Performance Report to the NCL Primary Care Committee-in-Common; 2. Quality dashboard for each Borough; 3. Summary of Quality Outcome Framework changes for 2020/21

NCL CCG Primary Care Committee-in-Common Quality and Performance Report – Appendix 1

1. Introduction

This report sets out:

- The latest Quality and Performance Report for comment;
- A summary of actions accruing from the quality report;
- An extract from the NCL urgent and emergency care report that sets out measures of primary care capacity.

A report to support the development of Primary Care Networks has been drafted and this will come to the Committee in September for information, once local feedback has been received and reflected in the report. The report focuses on both primary care (including quality and patient experience indicators) and use of secondary care metrics.

2. Quality Report

The report is a consolidation of publicly available information on individual practice performance, and is therefore included in Part I of the Committee (a meeting in public).

This report aims to highlight practice sustainability through an aggregation of national indicators and local knowledge. The table draws together a multitude of indicators from an array of sources, including data from Care Quality Commission (CQC) ratings, GP Patient Survey (GPPS) results and practice demographics.

The metrics in this report have been used to identify and support practices in difficulty through the resilience programme. Local teams were asked to identify those practices which were considered in difficulty and those which would benefit from Resilience Programme support.

National criteria in this report were created for use as a screening tool by local commissioners to guide their assessment with local stakeholders on offers of support to improve sustainability and resilience.

The report will be developed to incorporate information on patient experience and appointments that will be provided through the new GP contract that was published in February 2020.

3. Actions accruing from the report

This section summarises how the report is used to make commissioning decisions and apply primary care medical contracts where applicable. The table below summarises commissioning actions undertaken against the performance domains in the report:

Domain	Indicator	Description of action taken
Quality	Care Quality Commission (CQC) ratings; Complaints	1. Informal remedial action - Number of practices under improvement plan review 2. Formal remedial action - number of practices issued a remedial notice 3. Practice mergers 4. Infection control audits
Efficiency	Quality Outcomes Framework (QOF); List size changes; Friends and Family Test (FFT)	1. Performance improvement plans 2. Quality Improvement Support Teams (QISTs) to reduce unwarranted variations 3. Care Closer to Home Integrated Networks (CHINs) / Neighbourhoods development 4. Resilience funding 5. Financial assistance (Section 96)
Workforce	Age profile; Full-time equivalents (FTE) for GPs and Nurses	1. Pharmacists in Practice 2. GP retention scheme 3. Medical Assistance Programme 4. Training programmes

Patient Experience	GP Patient Survey	1. National access programme 2. GP access Hubs 3. Performance improvement plans
Patient Online	Online appointments; Repeat Prescriptions	1. Differential access linked to deprivation levels in some CCGs – ensure digital inclusion part of roll-out.
Extended Access	Extended access days; Direct Enhanced Service (DES) sign up	1. GP Hubs 2. DES sign up 3. National access programme
Premises	New schemes; Relocation into compliant buildings; Void space	1. Improvement grant awards 2. Capital funding awards 3. Service charge financial assistance applications

The report will also be used to provide as a source of information to help develop and early warning system to identify struggling practices and enhance current levels of support prior to any regulatory action being taken. The early warning system will be developed across North Central London.

The report has enabled the following actions to be undertaken:

- Remedial notices have been issued to practices receiving Care Quality Commission (CQC) ratings of inadequate or requires improvement, with practices developing action plans to address CQC findings. This has in turn prompted the following work by CCGs:
  - Establishing the workforce and resilience workstream as per of the primary care recovery plan from the covid pandemic. Within this an early warning system to identify struggling practices will be developed;
  - Practice Caretaking arrangements put in place where required to secure service continuity;
  - Practice resilience support programme;
  - CCG have facilitated practice mergers to support struggling practices and reduce variations in care;
- Practices with low Quality Outcomes Framework (QOF) scores receive a performance report with a series of actions agreed with NHS England Medical Directorate to improve delivery;
- Actions to address workforce gaps includes participation in international recruitment, focus on workforce in general practice strategy for NCL, employment of greater skill-mix in practices (this will now be supported by the new GP contract and extended definition of core staff that will attract funding);
- CCG teams have been working with practices in response to the results of the patient survey;
- The identification of differential access to patient on-line initiatives according to deprivation;
- Access developments include action to ensure all practices have adequate cover arrangements for any half-day closures in operation. Full population coverage for extended access schemes is in place across NCL;
- Development of NCL-wide process to identify both major capital schemes for general practices and the award of minor improvement grants. Estates and Technology Transformation Funds (ETTF) received for general practice strategic developments, and consideration of amendments to premises directions to ensure premises are used effectively and support primary care development.

4. Overview of performance

This section sets out an overview of performance across CCGs from the quality report. The report sets out performance by Borough and an overview of practice outliers in performance compared to CCG averages.

Performance for practices, and across Boroughs, should be assessed against the range of indicators provided (Care Quality Commission ratings, patient experience responses, Quality Outcomes Framework achievement, and written complaints received) to arrive at a rounded view of performance rather than using single measures of performance. Demographic, finance, and workforce information is then provided as context.

4.1 Demographics

This section provides a summary of population profiles for practices including:

- Deprivation in a range of 1-5, with 1 being the most deprived and 5 the least deprived, percentage of patients aged over 75, and proportion of the practice list made up of people from lack and ethnic minorities;
- Average list size per practice and list size change over the 12 months to March 2020.

	Barnet	Camden	Enfield	Haringey	Islington
Contract type	GMS 29/52 PMS 23/52 APMS 0/52	GMS 15/35 PMS 15/35 APMS 5/35	GMS 17/47 PMS 27/47 APMS 3/47	GMS 15/36 PMS 19/36 APMS 2/36	GMS 28/32 PMS 2/32 APMS 2/32
Deprivation:					
1 = most deprived	1	6	22	15	16
2	3	12	4	9	15
3	14	8	12	7	1
4	29	5	6	4	0
5 = least deprived	5	2	3	0	0
Null	0	2	0	2	0
Patients aged > 75 on list	7%	4%	6%	4%	4%
% list black & ethnic minority	37%	35%	40%	42%	33%
Average list size	8,346	9,204	7,453	8,989	8,363
Annual list size change	+2%	+4%	+2%	+2%	+4%

To note:
- The relatively high rates of deprivation in Enfield, Haringey and Islington;
- The higher rate of over 75s in Barnet and Enfield;
- The lower average list size per practice in Enfield compared to the rest of NCL (although many practices work collaboratively within Medicus Health Partnership in Enfield). Average list sizes are highest in Camden and Haringey;
- List sizes, and annual changes, are based on March 2020, with all CCGs showing a minimum annual increase of 2%, with a 4% annual increase in Camden and Islington.

4.2 Care Quality Commission

The Care Quality Commission (CQC) rates general practices to give an overall judgement of the quality of care. The CQC applies four ratings to practices, as is the case for other health and social care services. Practices are assessed across five key areas for quality of care (caring, effectiveness, responsiveness, safety, being well-led). The table below summarises Care Quality Commission (CQC) overall ratings for practices within each CCG as at March 2020:

CQC ratings	Barnet	Camden	Enfield	Haringey	Islington
Overall rating:					
Outstanding	0	0	0	1	0
Good	50	35	43	33	31
Requires Improvement	2	0	2	0	1
Inadequate	0	0	2	2	0
Yet to be rated	0	0	0	0	0
Total	52	35	47	36	32

To note from the above:
- The majority of practices assessed to date have received a good rating, with this including all practices in Camden. All practices in NCL have now received a CQC inspection and rating;
- The first practice in North Central London has received an overall “outstanding” rating – West Green Road Surgery in Haringey;
- Four practices in NCL are currently rated as inadequate by the Care Quality Commission (CQC), with two in Haringey (Staunton Group Practice and Tynemouth Medical Practice) and two in Enfield practice (Eagle House Surgery and Keats Surgery). Two of the practices received and inadequate rating across all of the CQC domains (Eagle House Surgery and Staunton Group Practice). These practices are subject to formal remedial action through the primary care medical services contract, as well as being required to complete an action plan to address concerns raised by the CQC;
- Five practices (previously seven practices in January 2020) across NCL have received a requires improvement rating. These practices are also required to develop a remedial action plan;
- Two practices are still to receive a visit from CQC and/or are yet to receive their report. All practices have inspections scheduled with the CQC;

- The CQC only carried out inspections in areas with a risk to patient safety during the covid pandemic, all other inspections were suspended.

4.3 Quality Outcomes Framework

The Quality Outcomes Framework (QOF) was introduced as part of the new General Medical Services contract in April 2014, with the intention to improve the quality of care patients are given by rewarding practices for the quality of care they provide to patients.

The table below summarises performance for each CCG area, and for comparison the national achievement was 94.7%. Note the data is now available for 2017/18 as well as 2016/17 and 2015/16.

Quality Outcomes Framework	Barnet	Camden	Enfield	Haringey	Islington
% achievement in 2017/18	96.8%	96.3%	95.3%	95.8%	96.4%
% achievement in 2016/17	96.7%	96.3%	95.2%	95.8%	96.4%
% achievement in 2015/16	95.8%	96.3%	95.2%	96.1%	96.4%
Practices with less than 70%	0	0	0	0	1
Practices with less than 80%	0	1	0	0	0
Practices with 80% to 90%	2	2	6	2	1

Aggregate performance for each CCG is above the national average. The table reports by exception the number of practices in each CCG with achievement materially below CCG average scores. Quality Outcomes Framework (QOF) outcomes for those practices achieving less than 90% when cross-referenced to Care Quality Commission ratings show:

- For the 2 Barnet practices both practices have an overall good CQC rating;
- All 3 Camden practices have an overall good CQC rating;
- For the 6 Enfield practices 5 practices have received an overall good CQC rating and 1 practice a requires improvement rating;
- For the 3 Haringey practices 2 practices have an overall good CQC rating, with the other practice yet to receive an assessment. The 3 practices with an inadequate rating all have QOF scores in excess of 90%;
- For the 2 Islington practices 1 practice has an overall good CQC rating and 1 practice has an overall requires improvement rating.

NHS England has invested an additional £10m nationally into the Quality Outcomes Framework (QOF) in 2020/21, supported by a number of changes to the QOF Domains for Asthma, COPD, Heart Failure, Diabetes, Early Cancer Diagnosis, and Learning Disabilities. The changes are summarised in Appendix Three below.

4.4 Patient experience

The GP patient survey is an independent survey run by Ipsos MORI on behalf of NHS England, with the survey being sent to over one million people nationally. The survey results presented were published in August 2018 and cover the period from January to March 2018.

The Friends and Family Test asks patients how likely they are to recommend their GP service to friends and family based on their most recent experience of service use, with the results showing those likely or extremely likely to recommend their practice. Results are from December 2018.

Patient Experience	Barnet	Camden	Enfield	Haringey	Islington
GP patient survey – good overall experience of the practice	79%	83%	78%	78%	83%
GP patient survey – easy getting through by phone	64%	79%	63%	71%	79%
GP patient survey – satisfied with type of appointment offered	68%	73%	67%	70%	72%
Friends and family test:					
Average recommendation %	84%	88%	85%	87%	89%
Practices with results	19/52	13/35	26/47	21/37	15/32
Range of recommendation %	60% - 100%	76% - 100%	50% - 100%	54% - 100%	70% - 100%

The friends and family test does not provide an outcome for each practice, so the average is shown for those practice with a patient response recorded. A broad range of recommendation across practices is shown within each CCG area.

In October 2019 the previous Committee-in-Common received an overview of local patient survey results compared to London and National performance, and in August 2019 received an overview of work being undertaken with practices by CCG teams in response to patient survey results.

4.5 Complaints

The NHS Complaints procedure is the statutorily based mechanism for dealing with complaints about NHS care and treatment and all NHS organisations in England are required to operate the procedure. The table shows the average number of written complaints made by patients and/or their carers during 2017/18 per practice and in total, previous figures for 2016/17 are in red.

Written complaints received	Barnet	Camden	Enfield	Haringey	Islington
Number of complaints received in 2017/18 and 2016/17	582 610	430 416	530 527	411 394	346 377
Complaints escalated to NHSE	31/582	8/430	39/530	36/411	18/346
Average received per practice	10 11	12 13	11 11	11 11	11 11
Average per 1000 people on list	1.4 1.4	1.5 1.5	1.5 1.5	1.2 1.3	1.5 1.4
Range received per practice per 1000 people on the list	0 – 4.8 0 – 6.7	0 – 5.9 0 – 7.4	0 – 4.9 0 – 5.7	0 – 3.4 0.2 – 3.1	0 – 4.8 0 – 4.0

The number of complaints received by per head of population, and by practice, is consistent across the five CCGs. Within each CCG there is a broad range of complaints received across practices.

This report adds in the complaints escalated to NHS England as they have not been resolved locally by the practice.

In response to the Committee request to have a view of complaints themes and trends – the national team at NHS England have been asked to check the granularity of the information available through reporting on the governance portal.

4.6 Access and Digital Access

The table below shows that all practice lists have extended access to general practice services seven days per week through primary care hubs. The table also shows coverage of digital access for on-line booking of appointments and ordering of repeat prescriptions.

Access to general practice	Barnet	Camden	Enfield	Haringey	Islington
Seven-day extended access to general practice though primary care hubs	100%	100%	100%	100%	100%
% of population with on-line booking of appointments enabled	35%	33%	19%	31%	27%
% of population with on-line ordering of repeat prescriptions enabled	35%	33%	19%	31%	27%
Practices **not** offering patient on-line access	0/52	1/35	14/47	1/36	0/32

Coverage is lowest in Enfield with fourteen practices not recording any uptake of patient on-line initiatives. The Camden practice not offering on-line access is the Special Allocations Service.

4.7 Workforce

The table below provides on overview of workforce information for each CCG. The information is sourced from the workforce minimum data set collected by NHS Digital. The information is experimental and needs to be treated with caution. The information is based on the position as at March 2018 and was published in September 2018.

Workforce	Barnet	Camden	Enfield	Haringey	Islington
% of GPs aged over 55	32%	19%	32%	40%	28%
% locum GPs	2%	5%	11%	7%	6%
% of nurses aged 55 and over	46%	21%	55%	53%	50%
Number of patients per full-time GP	2,288	2,021	2,455	2,661	2,144

The information shows the need for succession planning for the GP and nurse workforce, some of which will be provided through the use of new skill-mix in general practice including pharmacists, physicians, physiotherapists and mental health professionals through the Primary Care Network (PCN) Directed Enhanced Service (DES).

The Sustainability and Transformation Plan workforce workstream have been asked to provide an overview of work on developing the primary care workforce for the proposed Committee Seminar in November 2019.

5. NCL Urgent and Emergency Care Report

An extract on GP appointments from the NCL urgent care report for June 2020 is set out below.

The report seeks to capture performance along the urgent and emergency care pathway – pre-hospital (including primary care capacity), in hospital and post-hospital. The report is being developed to provide a system view of performance, over and above delivery of the A&E waiting time standard, to support the work of the NCL urgent and emergency care programme board and A&E Delivery Board

The graph shows a reduction in GP appointments during April and May, with the reduction accruing from people presenting less due to the covid pandemic. It is expected that appointment levels will return to pre-covid levels in June and July, as practices reinstate planned care and chronic disease management work and people become more willing to make appointments. Whist appointment levels fell practices reported that this was offset by the acuity and complexity of patients being seen.

Practices stood down some planned care work in line with national advice at the height of the pandemic, and recent guidance was received on 10th July 2020 that practices should reinstate this work where capacity existed.

The downturn in appointments in general practice was echoed elsewhere in the NHS with Emergency Department appointments falling by 60% locally at the height of the pandemic and referrals for planned care falling by 75%.

In line with other parts of the NHS productivity will fall in general practice due to implementing new infection prevention control procedures introduced during the covid pandemic.

Some reporting lines in the urgent and emergency care report have been suspended nationally during the covid pandemic and will be reinstated for future reports including:

- The mix of GP appointments across face-to-face, telephone / video, and home visit, with an expectation that this shows a material swing towards remote (telephone / video) consultations introduced as part of the response to covid;
- The level of same-day appointment for in-hours general practice compared to London and National performance;
- Extended access hub utilisation
- We are awaiting the outcome of the national review of extended access services which is currently underway. This will inform future commissioning decisions – particularly as funding for extended access services will be transferred to primary care networks in 2020.

Quality Outcome Framework (QOF) Indicator changes from April 2020 – Appendix 3

Asthma domain

- Practices will be required to establish and maintain a register of patients aged 6 years and over with a diagnosis of asthma, in line with NICE guidance;
- Practices will be expected to use a minimum of two diagnostic tests to confirm an asthma diagnosis. These tests should be performed up to 3 months before any date of diagnosis and up to 6 months after this date;
- The content of the asthma review has been amended to incorporate aspects of care positively associated with better patient outcomes and self-management;
- Practices will be required to record smoking exposure in children and young people under the age of 19 years.

COPD domain

- Entry to the COPD register will be determined by the presence of a clinical diagnosis plus a record of post bronchodilator spirometry FEV1/FVC ratio below 0.7 recorded between 3 months before or 6 months after diagnosis in diagnoses made on or after 1 April 2020;
- The annual review will include a requirement to record the number of exacerbations in order to help guide future management and potentially avoidable emergency admissions.

Heart Failure domain

- Any new diagnosis of heart failure should be confirmed by an echocardiogram or specialist assessment between 3 months before or 6 months after diagnosis;
- There will be changes to the denominator for treatment with beta-blockers;
- An annual review indicator has been agreed to provide a focus upon functional assessment and the up-titration of medication to address symptoms.

Diabetes

- A new indicator will be introduced to incentivise practices to offer an annual HbA1c test in people known to have non-diabetic hyperglycaemia**.** The aim of this test is to support early identification of those who would have gone on to develop Type 2 diabetes. This indicator will be worth 18 points. It will be supported through both new investment and the retirement of the current CVD-PP001 indicator.

New Quality Improvement modules

- In 2019/20 a new Quality Improvement domain were introduced worth 74 points. In year one, this comprised two modules: Prescribing Safety and End of Life Care. Whilst these modules will change in 2020/21, we encourage practices to continue to consolidate and mainstream the successful improvements made;
- In 2020/21, the modules will focus on improving care of people with a learning disability and supporting early cancer diagnosis. These modules have been developed by the RCGP in collaboration with NICE and the Health Foundation.

The aims of the Early Cancer Diagnosis module are to:

- Improve participation in the national breast, cervical and bowel cancer detection and screening programmes;
- Improve referral and safety netting practices for patients suspected of having cancer. It has been developed to support the roll out of the PCN early cancer diagnosis service specification;
- The full details of the specification are set out in the Network Contract DES https://www.england.nhs.uk/wp-content/uploads/2020/03/network-contract-des-early-cancer-diagnosis-guidance.pdf

Learning Disability module:

- The Care of People with a Learning Disability module builds upon the work published earlier this year to improve the identification of people with a learning disability in general practice. It aims to promote increased uptake of annual health checks, optimisation of medication in line with STOMP, identification and recording of reasonable adjustments and the patient engagement with community resources through social prescribing to maintain health and well-being.

	Barnet CCG JULY 2020		Practice			Practice Demographics			Quality							Workforce						Efficiency				Patient Experience				Finance	Patients Online						Extended Access		
	Practice Code	Practice Name	Co-commissioning model	Contract Type	Dispensing Practice	Practice Linked IMD 2019 (National Quintiles)	% Patients Aged 75+	% Patients Non-BME	CQC Rating - Overall	CQC - Caring	CQC - Effective	CQC - Responsive	CQC - Safe	CQC - Well led	Written complaints (Total) 2018/19	Written complaints (via NHSE) 2018/19	Practice Size (Based on FTE GPs)	% GPs aged 55 years and over	% Locum GPs	% Nurses aged 55 years and over	Number of patients per FTE GP	Number of patients per FTE Nurse	QOF Achievement 18/19 (%)	QOF Exception Rate 18/19	List size	Annual List Size Change Mar 19 - Mar 20	FFT: % likely to recommend GP service to friends & family (Feb 2020) (* = nos <5; no data = zero return)	GPPS - Good overall experience of GP practice	GPPS – Easy to get through by phone (~ = nos <10; * = < 0.5%)	GPPS - Satisfied with the type of appointment offered (~ = nos <10; * = < 0.5%)	Average payment per weighted patient 2018/19	Online Appointments Enabled	% Of Reg Pop with online appointment enabled	Total no. pt transactions using online appointments service (Mar 20)	Order Repeat Prescriptions Online Enabled	% Of Reg Pop with order repeat prescriptions online enabled	Total no. prescriptions ordered via online pt transaction service (Mar 20)	Category Full / Partial / No	No. of extended access days	Directed Enhanced Services (Extended Access payment)
1	E83003	Oakleigh Road Health Centre	Del	GMS	✗	4	7.4%	70%	●	●	●	●	●	●	11	0	Large	20%	0%	100%	1,388	6,721	96.5	3.5	9145	2.7%	93%	88%	92%	78%	£123	✓	22%	68	✓	21%	271	FULL	7	✓
2	E83005	Lichfield Grove Surgery	Del	PMS	✗	5 - Least Deprived	4.8%	64%	●	●	●	●	●	●	8	1	Small-medium	15%	1%	100%	2,373	19,838	98.9	7.6	6356	2.5%	no data	82%	71%	76%	£141	✓	55%	86	✓	54%	312	FULL	7	✓
3	E83006	Greenfield Medical Centre	Del	PMS	✗	3	5.6%	58%	●	●	●	●	●	●	5	0	Medium-large	17%	0%	58%	1,712	10,631	98.3	4.6	6771	-0.6%	no data	84%	66%	70%	£153	✓	39%	285	✓	39%	109	FULL	7	✓
4	E83007	Squires Lane Medical Practice	Del	GMS	✗	3	6.6%	59%	●	●	●	●	●	●	7	2	Single-handed	0%	100%		9,150	6,734	99.1	7.4	5856	1.0%	71%	64%	54%	62%	£130	✓	36%	83	✓	36%	257	FULL	7	✓
5	E83008	Heathfielde Medical Centre	Del	PMS	✗	5 - Least Deprived	7.6%	78%	●	●	●	●	●	●	9	0	Medium-large	50%	0%	15%	2,731	6,914	99.4	3.3	8672	5.1%	no data	89%	93%	77%	£150	✓	51%	80	✓	51%	510	FULL	7	✓
6	E83009	PHGH Doctors	Del	PMS	✗	5 - Least Deprived	8.4%	75%	●	●	●	●	●	●	24	2	Medium-large	25%	4%	100%	3,204	11,211	94.2	5.0	11204	1.4%	87%	75%	60%	64%	£151	✓	40%	39	✓	40%	772	FULL	7	✓
7	E83010	The Speedwell Practice	Del	PMS	✗	4	6.7%	63%	●	●	●	●	●	●	38	0	Medium-large	13%	0%	36%	2,475	4,824	95.6	4.8	11376	-1.2%	77%	67%	41%	66%	£176	✓	36%	333	✓	36%	550	FULL	7	
8	E83011	The Everglade Medical Practice	Del	GMS	✗	2	2.9%	42%	●	●	●	●	●	●	1	1	Medium-large	21%	1%	0%	1,562	8,898	98.4	7.9	8776	5.2%	74%	79%	65%	58%	£141	✓	15%	39	✓	15%	176	FULL	7	✓
9	E83012	The Old Courthouse Surgery	Del	GMS	✗	4	8.7%	77%	●	●	●	●	●	●	0	0	Medium-large	0%	0%	0%	1,758	8,715	99.1	6.5	8482	1.1%	85%	89%	73%	85%	£126	✓	27%	34	✓	27%	139	PARTIAL	6	✓
10	E83013	Cornwall House Surgery	Del	GMS	✗	5 - Least Deprived	8.2%	63%	●	●	●	●	●	●	0	0	Medium-large	33%	0%	0%	1,263	20,659	98.5	8.3	6056	-4.0%	86%	59%	35%	47%	£138	✓	26%	23	✓	25%	117	FULL	7	✓
11	E83016	Millway Medical Practice	Del	PMS	✗	4	7.3%	65%	●	●	●	●	●	●	64	0	Large	2%	5%	12%	1,625	5,825	98.7	4.1	18590	0.5%	no data	85%	40%	66%	£165	✓	96%	1071	✓	96%	1488	FULL	7	✓
12	E83017	Longrove Surgery	Del	PMS	✗	4	8.6%	79%	●	●	●	●	●	●	17	2	Large	29%	0%	53%	1,592	4,806	98.4	4.2	11435	1.1%	no data	85%	58%	55%	£146	✓	33%	55	✓	34%	788	FULL	7	✓
13	E83018	Watling Medical Centre	Del	GMS	✗	3	6.1%	51%	●	●	●	●	●	●	20	0	Large	7%	0%	0%	1,209	6,221	97.5	6.8	16498	1.2%	85%	79%	61%	68%	£125	✓	34%	389	✓	34%	1039	FULL	7	✓
14	E83020	St George's Medical Centre	Del	PMS	✗	4	5.9%	60%	●	●	●	●	●	●	1	1	Medium-large	0%	0%	0%	3,019	5,956	98.3	4.4	11823	4.6%	no data	82%	41%	63%	£146	✓	80%	451	✓	80%	786	FULL	7	✓
15	E83021	Torrington Park Group Practice	Del	PMS	✗	4	9.1%	63%	●	●	●	●	●	●	9	0	Medium-large	27%	0%	55%	2,130	10,503	96.9	8.4	12325	-2.0%	100%	82%	52%	74%	£158	✓	44%	228	✓	44%	535	FULL	7	✓
16	E83024	St Andrews Medical Practice	Del	PMS	✗	5 - Least Deprived	9.4%	72%	●	●	●	●	●	●	2	2	Large	15%	0%	48%	1,484	4,227	99.3	4.7	11158	2.0%	no data	90%	59%	63%	£165	✓	46%	189	✓	46%	516	FULL	7	✓
17	E83025	Pennine Drive Practice	Del	GMS	✗	3	5.8%	55%	●	●	●	●	●	●	9	2	Small-medium	24%	0%	0%	3,224	7,897	98.5	8.5	8950	-0.3%	no data	74%	61%	66%	£124	✓	11%	9	✓	11%	196	FULL	7	✓
18	E83026	Supreme Medical Centre	Del	GMS	✗	5 - Least Deprived	8.3%	65%	●	●	●	●	●	●	2	0	Small-medium	76%	0%	0%	2,136	5,483	95.2	4.2	4389	1.1%	no data	79%	59%	64%	£145	✓	34%	32	✓	34%	64	FULL	7	✓
19	E83027	The Practice @ 188	Del	PMS	✗	4	8.9%	69%	●	●	●	●	●	●	10	1	Small-medium	7%	22%	0%	4,241	8,312	99.8	10.0	8306	6.4%	no data	77%	71%	60%	£143	✓	23%	54	✓	23%	227	FULL	7	✓
20	E83028	Parkview Surgery	Del	PMS	✗	2	3.1%	47%	●	●	●	●	●	●	6	0	Small-medium	40%	25%	100%	2,478	11,067	96.5	4.6	6639	0.6%	no data	83%	68%	63%	£136	✓	18%	27	✓	18%	110	FULL	7	✓
21	E83030	Penshurst Gardens Surgery	Del	GMS	✗	4	9.9%	61%	●	●	●	●	●	●	33	0	Medium-large	0%	0%	0%	1,682	7,447	95.8	4.0	6751	0.8%	no data	68%	24%	53%	£151	✓	68%	158	✓	67%	736	no data	-	✓
22	E83031	The Village Surgery	Del	PMS	✗	4	8.9%	76%	●	●	●	●	●	●	1	0	Small-medium	42%	0%	100%	3,043	7,608	99.7	3.7	5278	1.0%	no data	94%	92%	91%	£138	✓	20%	35	✓	20%	226	FULL	7	
23	E83032	Oak Lodge Medical Centre	Del	GMS	✗	3	4.1%	43%	●	●	●	●	●	●	32	0	Large	0%	0%	11%	1,560	5,495	100.0	9.0	18099	-1.7%	no data	65%	36%	51%	£139	✓	51%	78	✓	51%	784	FULL	7	✓
24	E83034	Mulkis Hb-The Surgery	Del	GMS	✗	3	6.5%	69%	●	●	●	●	●	●	0	0	Single-handed	100%	0%	100%	5,356	7,439	96.7	5.0	5352	-0.2%	no data	80%	80%	78%	£121	✓	31%	22	✓	31%	293	FULL	7	✓
25	E83035	Wentworth Medical Practice	Del	PMS	✗	4	6.8%	59%	●	●	●	●	●	●	24	2	Medium-large		0%	0%	2,135	6,563	97.4	3.2	11899	3.4%	86%	77%	63%	73%	£162	✓	34%	150	✓	34%	381	FULL	7	✓
26	E83036	Vale Drive Medical Practice	Del	GMS	✗	3	6.5%	73%	●	●	●	●	●	●	7	0	Small-medium	100%	0%	0%	2,312	6,656	99.6	4.4	5916	5.2%	60%	75%	71%	69%	£136	✓	25%	25	✓	25%	125	FULL	7	✓
27	E83037	Derwent Crescent Medical Centre	Del	PMS	✗	5 - Least Deprived	8.6%	68%	●	●	●	●	●	●	4	0	Small-medium	41%	18%	52%	2,802	5,018	99.8	4.9	5591	0.9%	no data	89%	88%	71%	£168	✓	85%	63	✓	85%	393	FULL	7	✓
28	E83038	Jai Medical Centre	Del	GMS	✗	3	8.1%	50%	●	●	●	●	●	●	8	0	Small-medium	31%	0%	76%	4,800	6,290	97.9	4.9	8463	2.0%	no data	79%	73%	71%	£124	✓	18%	38	✓	18%	115	FULL	7	✓
29	E83039	Ravenscroft Medical Centre	Del	PMS	✗	4	4.4%	62%	●	●	●	●	●	●	2	0	Small-medium		0%	100%	3,005	5,052	98.1	4.1	6150	-14.4%	no data	79%	73%	69%	£161	✓	7%	27	✓	7%	31	FULL	7	✓
30	E83041	Wakeman's Hill Surgery	Del	GMS	✗	3	5.3%	40%	●	●	●	●	●	●	8	1	Small-medium	0%	22%	0%	2,507	7,520	98.1	6.2	4513	-1.8%	no data	71%	69%	65%	£124	✓	15%	14	✓	15%	36	FULL	7	✓
31	E83044	Addington Medical Centre	Del	GMS	✗	4	8.2%	76%	●	●	●	●	●	●	8	0	Medium-large	50%	0%	76%	1,598	7,220	97.9	5.5	9444	3.1%	90%	85%	75%	75%	£124	✓	32%	164	✓	32%	0	FULL	7	✓
32	E83045	Friern Barnet Medical Centre	Del	GMS	✗	4	6.0%	63%	●	●	●	●	●	●	2	2	Medium-large	42%	13%	100%	2,180	6,538	99.6	5.5	9502	4.0%	no data	79%	57%	66%	£126	✓	22%	78	✓	21%	225	PARTIAL	5	✓
33	E83046	Mulberry Medical Practice	Del	GMS	✗	3	5.2%	53%	●	●	●	●	●	●	31	1	Medium-large	23%	14%	26%	2,096	5,542	93.2	4.7	9651	-2.1%	no data	63%	47%	56%	£127	✓	26%	77	✓	25%	105	no data	-	✓
34	E83049	Langstone Way Surgery	Del	PMS	✗	4	5.4%	59%	●	●	●	●	●	●	48	2	Medium-large	30%	0%	34%	2,561	2,890	95.3	7.2	8402	4.3%	no data	79%	52%	66%	£169	✓	20%	37	✓	20%	240	FULL	7	✓
35	E83050	East Finchley Medical Centre	Del	GMS	✗	5 - Least Deprived	6.4%	77%	●	●	●	●	●	●	12	0	Medium-large	0%	0%	0%	2,589	9,386	77.7	3.4	8007	1.7%	no data	64%	55%	52%	£115	✓	21%	6	✓	23%	315	no data	-	✓
36	E83053	Lane End Medical Group	Del	GMS	✗	4	7.7%	60%	●	●	●	●	●	●	15	1	Large	18%	0%		1,377	9,341	98.1	7.8	13321	1.6%	93%	72%	44%	58%	£146	✓	49%	149	✓	41%	719	FULL	7	✓
37	E83600	Adler Js-The Surgery	Del	GMS	✗	4	4.4%	73%	●	●	●	●	●	●			Small-medium	50%	0%	0%	2,972	11,180	91.6	1.8	6259	6.5%	100%	94%	78%	83%	£133	✓	25%	3	✓	26%	328	FULL	7	✓
38	E83613	East Barnet Health Centre	Del	PMS	✗	4	7.5%	76%	●	●	●	●	●	●	6	0	Large		0%	40%	1,262	12,098	100.0	0.2	11610	2.0%	no data	96%	72%	83%	£143	✓	19%	168	✓	19%	285	FULL	7	✓
39	E83621	Brunswick Park Medical Centre	Del	GMS	✗	4	8.9%	68%	●	●	●	●	●	●	14	1	Large		0%	100%	1,239	4,325	99.2	3.0	8532	-0.1%	75%	82%	56%	60%	£125	✓	40%	111	✓	39%	613	FULL	7	✓
40	E83622	Temple Fortune Medical Group	Del	GMS	✗	5 - Least Deprived	7.6%	74%	●	●	●	●	●	●			Medium-large	51%	0%	55%	2,510	12,717	99.3	8.1	7653	3.5%	no data	83%	83%	71%	£121	✓	26%	11	✓	25%	327	no data	-	✓
41	E83637	Colindale Practice (Dr Lamba)	Del	PMS	✗	3	2.9%	41%	●	●	●	●	●	●	5	0	Medium-large	47%	0%	65%	3,130	7,119	98.6	3.8	9667	6.3%	80%	76%	67%	72%	£141	✓	29%	32	✓	29%	239	FULL	7	✓
42	E83638	The Mountfield Surgery	Del	PMS	✗	5 - Least Deprived	7.8%	66%	●	●	●	●	●	●	1	0	Small-medium	93%	0%	100%	2,127	4,254	98.0	2.8	5106	1.2%	80%	88%	90%	83%	£157	✓	14%	6	✓	14%	104	FULL	7	✓
43	E83639	Rosemary Surgery	Del	GMS	✗	4	3.5%	62%	●	●	●	●	●	●	0	0	Medium-large	15%	0%		1,352		98.3	5.1	5980	10.5%	99%	79%	72%	69%	£132	✓	46%	144	✓	46%	203	FULL	7	✓
44	E83649	The Hodford Road Surgery	Del	PMS	✗	4	5.4%	67%	●	●	●	●	●	●	1	0	Small-medium	100%	0%	0%	2,330	16,571	92.8	2.7	3976	6.9%	no data	82%	88%	75%	£147	✓	82%	54	✓	82%	198	FULL	7	✓
45	E83650	Gloucester Road Surgery	Del	GMS	✗	4	12.2%	75%	●	●	●	●	●	●	0	0	Single-handed	100%	0%	100%	2,009	4,738	92.0	3.8	1893	0.0%	no data	91%	93%	85%	£116	✓	26%	3	✓	26%	64	FULL	7	
46	E83653	The Phoenix Practice	Del	GMS	✗	4	6.1%	61%	●	●	●	●	●	●	11	1	Medium-large	13%	0%	42%	3,083	8,139	95.2	4.1	10308	2.1%	no data	87%	63%	76%	£130	✓	29%	61	✓	28%	396	FULL	7	✓
47	E83657	The Hillview Surgery	Del	GMS	✗	4	6.7%	62%	●	●	●	●	●	●	1	0	Small-medium	100%	0%	100%	1,840	7,771	94.6	10.8	1864	-0.7%	no data	92%	97%	88%	£154	✓	7%	0	✓	7%	14	NO	0	✓
48	E83668	Medical Centre (Deans Lane)	Del	GMS	✗	4	3.5%	52%	●	●	●	●	●	●	4	0	Single-handed	0%	0%	100%	4,563	7,986	98.5	4.0	4261	-0.7%	no data	84%	92%	71%	£129	✓	18%	1	✓	17%	60	FULL	7	✓
49	Y00316	Woodlands Medical Practice	Del	PMS	✗	4	6.1%	68%	●	●	●	●	●	●	14	0	Medium-large	0%	5%	0%	1,386	11,048	96.7	4.7	4422	0.7%	69%	61%	45%	53%	£142	✓	49%	30	✓	49%	187	FULL	7	✓
50	Y02986	Cricklewood Health Centre	Del	APMS	✗	2	0.5%	54%	●	●	●	●	●	●	8	3	Small-medium	0%	0%	100%	2,606	27,921	84.4	6.9	5204	4.5%	no data	78%	65%	67%	£130	✓	26%	85	✓	26%	125	no data	-	
51	Y03663	Hendon Way Surgery	Del	GMS	✗	3	3.3%	53%	●	●	●	●	●	●	4	4	Medium-large		0%		2,521	14,845	95.6	4.1	8909	2.4%	92%	61%	38%	52%	£127	✓	29%	37	✓	29%	179	no data	-	✓
52	Y03664	Dr Azim & Partners	Del	GMS	✗	4	3.7%	55%	●	●	●	●	●	●	28	2	Medium-large		0%		2,566	11,318	93.7	6.6	9205	0.5%	no data	60%	35%	54%	£128	✓	60%	70	✓	60%	233	FULL	7	✓

Comments:

No. 38 - E83613 East Barnet Health Centre list size increase reflects merger of Monkman (E83613), Weston (E83629) and Peskin (E83632) practices now under East Barnet Health Centre (E83613)

North Central London Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee Meeting
Thursday 23 July 2020

Report Title	Primary Care Workstream update	**Date of report**	9 July 2020	**Agenda Item**	2.3
Lead Director / Manager	Tony Hoolaghan / Paul Sinden	**Email / Tel**		t.hoolaghan@nhs.net p.sinden@nhs.net	
GB Member Sponsor	Dr Jo Sauvage, Chair, NCL CCG Dr Charlotte Benjamin, Vice-Chair, NCL CCG Tony Hoolaghan, Executive Managing Director Haringey and Islington Borough Directorates Paul Sinden, Executive Director, Performance and Planning				
Report Author	Sarah Mcilwaine, Adam Backhouse, Keziah Bowers	**Email / Tel**		sarah.mcilwaine@nhs.net adam.backhouse@nhs.net keziah.bowers@nhs.net	
Name of Authorising Finance Lead	*Not Applicable*	**Summary of Financial Implications** *Not Applicable*			
Report Summary	This report summarises the work to date of the primary care COVID-19 response workstream to date. It includes a brief description of each area of work, the actions taken in response to the COVID-19 pandemic, and key considerations for primary care recovery going forward. The same report was considered at the NCL CCG Covid Oversight Committee (July).				
Recommendation	To **NOTE** the work undertaken to date, and the key areas for further development as primary care recovery continues.				
Identified Risks and Risk Management Actions	See separate primary care risk log				
Conflicts of Interest	*Not Applicable*				
Resource Implications	There may be resource implications linked to development of GP model. These will need to be worked up in more detail.				
Engagement	Member practices have been engaged and consulted throughout the workstream through weekly webinars with Jo Sauvage for all practices, and through requests for feedback and input via the GP bulletin, targeted surveys and other communications channels.				

	Three GP-focused recovery groups were co-chaired by PCN clinical directors, and involved clinicians, including governing body members and primary care network clinical directors, and the LMC Patient engagement will be undertaken going forward through the GP access recovery group, and through the long term conditions steering group, and more broadly in NCL work.
Equality Impact Analysis	*Not Applicable* (however the appendix below summarises our work to date on covid-19 demographic risk assessments for primary care staff).
Report History and Key Decisions	*Not Applicable*
Next Steps	Ongoing monitoring / progression as part of GP recovery work
Appendices	Appendix 1 - Primary care workstream areas

Appendix: Primary care workstream areas

	Scope / Context	Covid Response	Key questions for recovery	Recovery work to date
Clinical Model	• Covid symptom sites, home visiting, infection control, phlebotomy, imaging, estates	• Primary care rapidly mobilised dedicated borough based sites / home visiting services for seeing patients with covid / suspected covid. • All other patients (with lower suspicion of covid) managed by own (host) practices. Model is developing through GP recovery work. • All patients remotely triaged prior to any face to face appointment being booked. In line with national GP standard operating procedures • Roll out of digital online consultation tools to support remote working. 99% of NCL practices now offering remote (virtual consultations) and all patients are triaged remotely • Priority given to essential treatment, and only GPs only ordering essential phlebotomy / diagnostics. •	• How do we prepare for second peak? • How do we support practices in restoring routine care – support for both staff and patients? E.g. remote management of children, other patient cohorts. • How do we care for much smaller numbers of patients with covid-19 symptoms? • How do practices return to routine work? Particularly management of vulnerable patients and those with LTCs – some of whom are still shielding (see below)? • How do we support practices to implement robust infection control procedures so staff and patients feel safe (especially given limitations of estates). • How do we share best practice on use of new digital / online tools? • What information do patients need to be able to access care (and know it is safe to do so)?	• Ongoing discussions with providers and clinical leads to iterate clinical model • Working with diagnostics team to align return of routine primary care work with return of routine diagnostics and referral pathways • Development of NCL practice survey to understand level of confidence / support required in restoring delivery of routine care • Developing practice self - assessment tool to support all practices in the delivery of safe care (for patients and staff)
Supporting Vulnerable People	• Shielding, HealtheIntent, work with LAs and VCSE, social, prescribing	• Primary care have moved to total triage model, home visiting and remote consultations where possible • NCL steering group comprising NHS, local authority and voluntary sector colleagues to share and agree best practice in supporting this cohort whilst reducing duplication of work • Promoted use of the “Good Sam” national volunteer responders service, as well as local	• How do shielding patients access General Practice safely and confidently? • What additional care needs have we identified for this cohort that need to be met through development of the primary care clinical model and the long term conditions steering group?	• Providing care to this cohort has been incorporated into planning for the primary care model, and the long term conditions steering group • A GP access task and finish group has been set up which will consider the long term patient access and experience of this group

	Scope / Context	Covid Response	Key questions for recovery	Recovery work to date
		voluntary sector offers to GPs to support referrals • Repurposing the social prescriber link worker role in General Practice to focus on proactively reaching out to this cohort to identify their needs • NCL shielding guidance written and disseminated to primary care to help identification and management of shielding patients (this has been continually updated in response to changing national guidance) • A healtheintent dashboard has been created to support practices in identifying as many of their shielding cohort as is possible using patient records	• How do we continue to work with our local authority and voluntary sector partners to support these patients without duplicating work?	
Long Term Condition (LTC) Management	• As we restart routine primary care services we must be aware of not only patients vulnerable to covid-19, but those who are at risk of deteriorating in the community without their routine LTC management. • Locally commissioned services (LCS) and community provision which supports LTC management have has also been paused and must be safely restarted • The emerging evidence has identified a group of patients with LTCs most at risk, and primary care must	• Primary care have moved to total triage model, home visiting and remote consultations where possible, however we acknowledge this will not be appropriate for routine LTC management • There has been an increased uptake of digital offers which help practices to support patients remotely. • A healtheintent dashboard has been created to identify and stratify vulnerable patients so practices can target the most at risk.	• How do commissioners support General Practice to restart care for at-risk patients with LTCs? • How do commissioners support practices to make the most of digital offers (both standardisation of available digital solutions, and • How do training hubs and other training providers ensure the primary care workforce have the skills and knowledge to support patients remotely and encourage self-management? • How do we take an outcomes-focused quality improvement approach to LTC management to incentivise and drive continuous improvement in LTC management?	• LTC steering group have made a set of short term recommendations to support practices with recovery (commissioning, training, digital and quality improvement). Plan to engage patients in co-designing future offers. • LTC steering group will also recommend to EMT the creation of an NCL LTC strategy which will set out our commissioning ambitions for locally commissioned services (LCS) and community contracts based on a common vision and principles for all boroughs. • A bid has been accepted by NHS England to fund a remote self-management project which will support patients with home blood pressure monitoring using virtual group consultations and peer coaching.

	Scope / Context	Covid Response	Key questions for recovery	Recovery work to date
	work differently to support these patients to manage their conditions – without intervention this patients remain at risk of deterioration and hospital admission			
Practice Resilience & Workforce	• PPE, testing, demographic risk assessments, practice resilience/funding	• Regular support and information provided to practice on PPE, patient and staff testing and on clinical priorities. • Shared range of available risk assessment and occupational health tools to support practices with staff risk assessments. • Financial funding package issued for Q1 which included access to funding for covid costs, and clarification of which services / activities could be stopped with no impact on practice income. • Roll out of digital / remote working kit to enable GPs and other practice staff to work from home. • Dedicated (national) webinar for all NCL practices on staff risk assessments (9/7)	• How do we ensure practices have relevant equipment, training, resources needed to support new ways of working, and up to date, timely information on which services are available where (particular reference to secondary care)? • How do we support our practices with assessing staff risks? • How do we ensure our practices continue to be financially sustainable? • How do we support our practices with managing new online routes of demand?	• Developing practice survey to understand what support they need going forward. • Series of webinars taking place in July looking at how to assess staff risks. • Q2 financial package in process of being agreed. • Working with digital team to look at how we can embed online routes of access in a way that is manageable e.g. via e-hubs.
Clinical Leadership & Communications	• Comms, webinars, GP bulletin	• Twice weekly bulletin to General Practice, and exceptional messages communicated via Primary care Contracting • Weekly Chair's briefing with GB clinicians and clinical leads • Weekly Chair's briefing with all NCL practices • Borough webinars / forums with practices and clinical directors on specific topics e.g. end of life, children and young people, developments in primary / secondary care interface issues e.g. phlebotomy • Working with Training Hubs to devlop support for practices	• How do we build primary care / general practice voice into ICS design (and governance) • How do we build a sustainable clinical leadership? I.e. distribution of work to avoid individual burnout?	• Letter sent to providers to ask for their views on building a primary care / general practice voice in our ICS.GP recovery group has CCG clinical leads and PCN clinical directors • 6 PCN clinical directors have co-chaired our GP recovery task and finish groups.

	Scope / Context	Covid Response	Key questions for recovery	Recovery work to date
		• Development of GP Provider Alliance, with PCN CDs, GP Federations and LMC • Weekly NCL meeting with LMC • Regular calls with GP federations and GP providers as part of development and provision of COVID model • Exploring live comms with NCL digital team – onto practice computers		

	Scope / Context	Covid Response	Key questions for recovery	Recovery work to date
Enhanced Health in Care Homes	• Care home residents at especially high risk from covid-19. • NCL -unequal distribution of care homes by borough & historic variation in level of commissioned support to care homes • The 2020-21 PCN contract introduced an Enhanced Health in Care Homes (EHCH) specification, detailed primary and community care input required into care homes. • National decision to delay implementation until 1/10/20; interim letter detailing expectations in supporting care homes published on 1/5/20	• A Barnet care homes locally commissioned service has been introduce to provide an interim service until the EHCH service launches in October • A digital care home workstream has been set up to support care homes to make use of remote consultations and shared records • In response to the May 1st letter, all NCL care homes now have clinical leads who are tasked with ensuring patients in care homes are regularly reviewed and have care and support plans in place	• How do we support General Practice to transition from the interim covid-specific provision to delivery of the EHCH specification? • How do we embed digital solutions and new technology to deliver the multi-agency decision making and care planning the EHCH specification requires? • What contractual arrangements need to be made with other health and care partners once we are able to resume this work? • How will funding and resource be commissioned to support practices to do this? • How do we allocate care homes to PCNs to avoid significantly uneven distribution	• An EHCH steering group has been setup to support primary care with the transition from covid-specific arrangements to implementation of the full the EHCH specification • The steering group is currently focusing on ensuring all care homes are allocated to a primary care network, have a named GP lead, and that there is a clear process for re-registering patients to a nearby GP practice, and clarity on clinical lead role • Discussions have begun about provision of LCS after October and about the commissioned resource required, and these will continue once a senior responsible officer (SRO) for NCL care homes is appointed

Covid 19 Response Oversight Committee Risk Register -
22 June 2020

ID	Risk Owner	Risk Manager	Objective	Risk	Consequence (Initial)	Likelihood (Initial)	Rating (Initial)	Controls in place	Evidence of Controls	Overall Strength of Controls in place	Consequence (Current)	Likelihood (Current)	Rating (Current)	Controls Needed	Actions	Action Deadline	Update on Actions	Consequence (Target)	Likelihood (Target)	Rating (Target)	Committee	Strategic Update for Committee	Date of Last Update	Status
Covid 1	Ian Porter, Executive Director of Corporate Services		To support the CCGs leadership team to identify and address capacity gaps in line with the resource and skills required to deliver COVID-19 priorities and facilitate business continuity	**Loss of Workforce Capacity (Threat)** Cause: If there is a significant loss of workforce capacity due to illness during the Covid 19 pandemic Effect: There is a risk that there will be an insufficient number of staff to undertake the CCG's response to the Covid 19 pandemic and the CCG's critical business Impact: This may result in delays and disruption to the pandemic response across North Central London resulting in an increased risk of reduced CCG support to the system and local response.	4	3	12	C1. Recording and monitoring of COVID related absence on workforce system; C2. HR status report showing COVID related absence shared with Directors and EMT on a weekly basis to identify issues/trends; C3. HR team to work with Directors to address and reduce levels of sickness absence; C4. Provision of support for staff on COVID related absence to facilitate return to work as early as possible; C5. Workforce capacity audit will help identify areas that are under/over resourced to support redeployment of staff internally, if required; C6. Development and implementation of demographic responsive staff risk assessment framework to ensure appropriate risk management and mitigation to support those communities that have been identified as being disproportionately affected by COVID-19 pandemic; C7. HR status report to each Covid 19 Response Oversight Committee meeting.	C1. Fortnightly and monthly HR reports to the Board/Committee showing absence rates C2. HR Reports, notes of meetings C3. HR Reports, communications C4. HR Reports, Factsheets, Guidance, Information and support on Intranet C5. Reports, Logs, Meeting papers, notes and plans C6. Framework, Guidance, staff and managers communications, audit log, staff briefings, information on intranet, meeting papers and notes, Issues log C7. Reports, Meeting papers and notes	Strong	4	3	12	CN1. Outcome of Risk Assessments to be sent to HR to ensure support and adjustments put in place for staff identified as being high risk	A1. Actions: Continue to prompt/ encourage regular line manager/Directors 'check-ins' with staff via 1:1s and team meetings; A2. Monitoring of sickness absence reporting on the workforce system and flagging under-reporting with Directors; A3. HR support for Directors and managers to support staff to return to work following sickness absence; A4. Risk assessments to be undertaken to be undertaken in accordance with the Demographic Responsive Staff Risk Assessment Framework	A1. 31.08.20 A2. 31.08.20 A3. 31.08.20 A4. 31.08.20	A1. Ongoing during COVID pandemic A2. Ongoing during COVID pandemic A3. Ongoing during COVID pandemic A4. Demographic Risk Assessment Framework has been published and managers and staff are undertaking risk assessments	3	3	9	Covid 19 Response Oversight Committee	The response to this risk is to support the CCGs leadership team to identify and address capacity gaps in line with the resource and skills required to deliver COVID-19 priorities and facilitate business continuity. The current Controls in place adequately mitigate the risk and are monitored , however, further controls will be identified where necessary.	19/06/2020	Open
Covid 2	Ian Porter, Executive Director of Corporate Services		To ensure the CCG workforce is engaged and motivated during the pandemic with the remote working arrangements	**Workforce Motivation and Alignment to Priorities (Threat)** Cause: If the CCG does not effectively manage the change in working arrangements to support staff working remotely from home Effect: There is a risk that productivity of staff may be negatively affected Impact: This may result in a negative impact on the delivery of key CCG activities/ services and affect business continuity	3	3	9	C1. Provision of staff support in accordance with national NHS People Support offer; C2. HR status report showing COVID related absence shared with Directors and EMT on a weekly basis to identify issues/trends and HR team will support Directors address any absence issues; C3. Managers/Directors to continue regular team/1:1 meetings/briefings to check-in with staff; C4. Mini survey to obtain staff views and feedback on working arrangements, communication and health and wellbeing support in place and address any areas for improvement/gaps accordingly; C5. Workforce capacity audit will help identify areas that are under/over resourced to support redeployment of staff internally, if required to address capacity issues; C6. Clarity of roles, responsibilities regarding redeployment roles/change of priorities; C7. Fortnightly staff side meetings continuing to take place to address any concerns raised by members and escalate as required.	C1. HR Updates, Factsheets, Information on intranet, newsletters, staff briefings C2. HR Reports, communications C3. Correspondence, meetings records C4. Survey, Correspondence, HR updates, newsletters, Reports C5. Audit papers, meeting papers, notes, plans C6, Redeployment Request forms, logs, placement agreements, meeting papers, notes C7. Meeting dates, papers, notes, communications/correspondence	Strong	3	2	6	CN1. Action plan to be developed to address areas of improvement required	A1. Continue to prompt / encourage Directors/line managers to regularly engage with teams and for staff via team meetings/1:1s to raise any issues / concerns etc; A2. CCG undertaking a short supporting survey for staff; A3. Weekly HR updates and factsheets on provision of support available from NHSE/I.	A1. Ongoing during COVID pandemic A2. Draft action plan to be developed by 31 May 2020 A3. Ongoing during COVID pandemic	A1. Ongoing during COVID pandemic A2. Supporting staff survey closed and results have been analysed. Draft action plan currently being developed A3. Ongoing during COVID pandemic	3	2	6	Covid 19 Response Oversight Committee	During this pandemic, the CCG has continued to deliver both essential and statutory BAU activities and COVID related priorities as determined by the outcome of the recent workforce capacity planning audit. In addition, the findings of the recent supporting staff survey identified that the majority of staff provided positive views on existing support in place during this time with regard to the change in working arrangements, mental, health and wellbeing support; contact and support from managers, communication, workstation and technology facilities. Areas of improvement that have been identified to include additional line management support, further informal virtual forums for staff across the CCG to interact and some staff require further support with remote working. Following the analysis of the information received, HR have developed a robust action plan to support the areas for improvement identified and further support and engage staff during this period of remote working.	19/06/2020	Open

Covid 3	Ian Porter, Executive Director of Corporate Services			**Lack of Public Engagement (Threat)** Cause: If the CCG does not effectively engage the public as part of its core business during the Covid 19 pandemic Effect: There is a risk that the CCG does not meet its statutory duties and makes decisions without insights from the public Impact: This may cause the CCG to commission services which do not meet the needs of the public it serves and sustain damage to its reputation and its relationships.	3	2	6	C1. Public can submit questions to the Governing Body electronically in advance of Governing Body meetings with responses to be published on the CCG's website; C2. Governing Body meeting minutes will be expedited and published on the CCG's website within two weeks of the meeting; C3. Lay Member for Patient and Public Engagement sits as a member of the Covid 19 Response Oversight Committee; C4. Communications & Engagement teams are in place and working collaboratively to support the Covid response and other business critical work requiring comms and engagement support; C5. Non-critical CCG commissioning activity suspended. Related PPE activity will resume at the appropriate time.	C1. Dedicated email address promoted on NCL CCG website and social media channels. C2. Minutes made available on NCL CCG website following meeting. C3. Terms of Reference C4. Comms leads on each of the Covid workstreams to oversee input, output and engagement opportunities. C5. Online options to replace face-to-face meeting reviewed and tested.	Average	3	2	6	CN1. Technological solution as temporary workaround to restrictions on face-to-face meetings that will be inclusive to the population at large, and could increase reach of interaction and engagement.	A1. Keep under review the need for any necessary public & patient updates on the CCG website regarding CCG commissioning activity; A2. Planning meetings for CCG next steps on patient and public engagement.	A1. 31.08.20 A2. 31.08.20	A1. Planning and implementation for Phase 2 NCL CCG website development will focus on improving engagement with our stakeholders and making relevant information available. A2. Work underway, however, key take away lessons from alternative meeting arrangements and times are noted and evolving.	3	2	6	Covid 19 Response Oversight Committee	The controls in place continue to mitigate the risks identified and further actions will be identified and undertaken as necessary. An NCL Covid communications and engagement framework has been developed to ensure the CCG engages with residents on Covid restart / ICS activity, and work is underway to develop an NCL deliberative engagement model. Borough level engagement activity is continuing, via digital channels, focused on CCG Covid priorities	19/06/2020	Open

Covid 4	Ian Porter, Executive Director of Corporate Services		Develop and implement a new operating model to support a single CCG	**Pausing of Wave 2 and 3 Staffing Restructure (Threat)** Cause: The CCG has taken the decision to pause the reorganisation and consultation process for functions in scope of waves 2 and 3 staffing restructure Impact: This may result in a delay in implementing an operating model that effectively utilises our workforce to support a single CCG. Effect: This may result in a delay in optimising the CCG's resources to support the single CCG and its core business	3	3	9	C1. Regular communications to staff from EMT; C2. EMT keeping the staffing arrangements under review and considering optimum timing and when wave 2 will commence; C3. Wave 2 and wave 3 to be undertaken together- so addresses any confusion and/or concern generated from doing them separately; C4. Clear communications to staff to explain the rationale for pausing the consultations; C5. EMT are holding and have logged the feedback from Wave 2 prior to it being suspended. C6. Fortnightly meetings with local staff side representatives and monthly meeting with regional representatives	C1. Staff briefings, communications, updates, FAQs C2. Meeting papers, notes C3. Meeting papers, notes, communication to staff, FAQs C4, communication from AO, staff briefings, FAQs C5, Feedback log, Meeting notes, written feedback and responses C6. Meeting papers, notes	Strong	3	3	9	CN1. Keep staff updated with any future timescales when consultation may commence	A1. EMT to review revised staff consultation timeline when appropriate; A2. EMT to provide updates to staff when appropriate.	A1. TBC A2. Ongoing during COVID pandemic	A1. To be determined A2. Ongoing and updates as required	3	3	9	Covid 19 Response Oversight Committee	Given that the decision has been made to pause wave 2, this will provide an opportunity to align the wave 2 and wave 3 consultation processes in the future. A date to resume the process is yet to be confirmed, however, we are committed to keeping communications and engagement open and to responding to staff concerns.	19/06/2020	Open
Covid 5	Kay Matthews, Executive Director of Clinical Quality			**Service Quality (Threat)** Cause: If the level of focus on the Covid 19 response is to the exclusion of all else Effect: There is a risk that there is a critical reduction in the quality of services in key non-Covid 19 areas Impact: This may result in high risk patients being missed or not receiving appropriate care.	5	5	25	C1. Establishment of an NCL-wide Clinical Advisory Group (CAG) to oversee service suspension/changes made by providers; C2 . Development of a clinical decision log to provide a record of service changes; C3. Establishment of a clinical quality work stream to monitor/manage significant risks/issues.	C. 1 Action logs from meetings C.2 Clinical decision log C.3 Weekly EMT update reports, Covid committee reports and GB reports	Average	4	4	16	CN1. Ensure all key information is appropriately reported and considered in a timely and robust way within the CCG.	A1. Continue to hold NCL CAG meetings; A2. Continue to use clinical decision log; A3. Continue with work streams.	A.1 31.08.20 A.2 31.08.20 A.3 31.08.20	A.1 NCL CAG meetings continue to be held 3 times per week A.2 The clinical decision log is updated following every CAG meeting A.3 The clinical quality work stream continues to meet 3 times per week	4	3	12	Covid 19 Response Oversight Committee	The CCG is working with providers to ensure that, where services have been suspended/altered or due to be reinstated, the impact to patient safety is fully considered. The NCL CAG feeds into the London CAG.	17/06/2020	Open
Covid 6	Simon Goodwin, Chief Finance Officer			**Risk of Significant Overspend (Threat)** Cause: If the level of expenditure required to effectively respond to the Covid 19 pandemic is far greater than the CCG's income Effect: There is a risk of a significant overspend of the CCG's budget Impact: This may result in the CCG not being able to deliver the MTFS and having to implement greater cost reductions to do so.	4	4	16	C1. Monitoring arrangements in place for Covid 19 expenditure and total expenditure; C2. SFIs in place with appropriate delegation limits. C3. Make payments in accordance to COVID financial guidance C4: CCG Finance Committee	C1. Reports C2. Standing Financial Instructions C3. Financial Guidance and instructions C4. Reports, Minutes, and Meeting notes	Average	4	4	16	CN1. Guidance from NHSE regarding post July 2020. CN2. Development of financial recovery plan.	A1: Finalise and circulate updated COVID financial governance arrangements (with regular updates for national guidance and rules for COVID allowable costs for reimbursement); A2: Regular logging / monitoring of COVID spend decisions and feedback to EMT; A3: Understanding and sharing the implications of national COVID finance guidance including CCG central top-up allocations when announced; A4: Regular reporting, tracking the direct and indirect implications of the COVID response and guidance compared to pre-COVID budget.	A1. 30.04.20 A2. 30.04.20 A3. 30.04.20 A4. 31.05.20	A1. Finance Governance approved by GB in April 20 and circulated to CCG. A2. Cost reimbursement process implemented in line with NHSE guidance A3. Financial Reporting process embedded. NHSE guidance received to confirm, subject to confirmation of allocation top-up for reasonable costs, expectation that the CCG will breakeven for the four period April to July 20. A4. Financial Reporting process implemented. Including reporting to EMT, covid-19 Oversight Committee and Update to Finance Committee	4	4	16	Covid 19 Response Oversight Committee	Robust financial monitoring and reporting for Covid-19 expenditure has been implemented. Guidance has been received from NHSE that indicates that the CCG will breakeven for the first four months of the year (April to July). This will be dependent on the CCG receiving full reimbursement for reasonable costs claimed during this time. To date there is no guidance post this date and there remains a risk to the CCG financial position	19/06/2020	Open
Covid 7	Simon Goodwin, Chief Finance Officer			**Non-Delivery of 2020-21 QIPP Programme (Threat)** Cause: If focus and capacity to deliver the QIPP programme is redirected to support the Covid 19 response. Effect: There is a risk of non-delivery of the 2020-21 QIPP Programme Impact: This may result in a significant overspend of the CCG's budget and a worsening of the CCG's deficit.	3	5	15	C1. 20/21 budget setting includes QIPP programme assumptions C2. QIPP programme review (subject to availability of staff).	C1. 202/21 Budget C2. Review documentation	Average	3	5	15	CN1. High-level review of Covid 19 QIPP impact. CN2. In-year Financial recovery plan. CN3. Ongoing scrutiny of CCG performance against measures.	A1: Review 20/21 CCG Efficiency programme and project likely impact of COVID A2. Ongoing financial impact on QIPP to continue to be monitored and reported to Finance Committee A3. Stretch on Transformation schemes where appropriate to be maximised A4. Development of an in-year Financial Recovery Plan to support mitigating SEP slippage risk	A1. 30.05.20 A2. 31.03.21 A3. 31.03.21 A4. 31.03.21	A1. High-level analysis undertaken and presented to Finance Committee May 20 A2. Report to Finance Committee May 2020 A3. Report to Finance Committee May 2020 A4. Ongoing work as Covid situation develops.	3	5	15	Covid 19 Response Oversight Committee	There is a significant financial risk to the CCG SEP plan. This is being monitored through the Finance Committee. Opportunism to maximise SEP underway. The CCG is in the process of developing an in-year Financial Recovery Plan This risk is monitored through Covid 1 Workforce capacity risk and FIN2 SEP risk, scrutinised by Finance Committee.	19/06/2020	Closed

Covid 8	Simon Goodwin, Chief Finance Officer			**Increased Risk of Fraud During Covid 19 Pandemic (Threat)** Cause: If there is a lack of awareness and systems in place to successfully identify and counter new methods of fraud emerging during the Covid 19 pandemic Effect: There is a risk that the CCG will be the victim of fraud Impact: This may result in financial loss to the CCG	4	3	12	C1. Covid 19 Fraud Response Plan in place; C2. Budget holder training; C3. Finance Directorates, CSU finance processor workforce, Local Counter-Fraud specialist (LCFS) teams in place C4. Multi-layered processing systems to minimise human error and susceptibility including SBS and LCFS systems C5. Inter-Partner co-operation and communication C6. NCL CCG Conflict of Interest and Counter-Fraud and Bribery policies C7. Pan-System workforce cyber risk training and awareness C8. Communications team sharing of intelligence.	C1. Response plan C2. Meeting notes and presentations C3. Contracts of employment, Job Descriptions, and alternative contractual arrangements documented. C4. SBS process, policy and procedures, standardised forms and processing C5. Email, correspondence and telephone notes C6. Policies on Internet and Intranet C7. Mandatory and additional training records C8. Communications team publications	Average	4	3	12	CN1. Additional fraud guidance included in CCG Financial Governance Framework	A1. To explore with LCFS communications with staff to raise their awareness of fraud during the pandemic. A2. Additional financial governance implemented including independent verification of agreement of all Covid-19 financial decisions made	A1. 30.04.20 A2. 31.08.20	A1. Covid fraud guidance included in the Financial Framework A2. Additional finance resources identified and focussed on financial governance approval and assurance.	2	3	6	Covid 19 Response Oversight Committee	The CCG has implemented additional steps to ensure Financial Governance compliance including additional resource to review and maintain a central record off financial approvals. The CCG continues to work with Counter Fraud to ensure good practice. This is monitored by the Finance Committee through FIN5 Fraud risk. Therefore this risk is closed	19/06/2020	Closed
Covid 9	Simon Goodwin, Chief Finance Officer			**Risk of Inappropriate Spend and Ultra Vires Decision Making (Threat)** Cause: If the CCG does not have the proper systems and processes in place for clear and effective decision making during the Covid 19 pandemic Effect: There is a risk that staff members may incur inappropriate expenditure and/or expenditure they are not authorised to agree Impact: This may result in CCG resources being used inappropriately, increased risk of legal challenge, increased challenge-ability of decisions and increased risk of fraud.	4	3	12	C1. Covid 19 Response Oversight Committee established for effective decision making; C2. SFIs and Scheme of Reservation and Delegation in place; C3. Key governance documents agreed by Chair's Action; C4. Terms of Reference for committees in place to allow for decision making where appropriate; C5. Virtual decision making protocol in place.	C1. Reports, Minutes and meeting notes C2. SFIs and SoRD C3. Minutes C4. Terms of Reference (ToRs) C5. Protocol documentation	Average	4	3	12	CN1. Pan-NCL Decision-making guidance, and follow-up support, training and resources.	A1: Finalise and circulate updated COVID financial governance arrangements (with regular updates for national guidance and rules for COVID allowable costs for reimbursement); A2: Regular logging / monitoring of COVID spend decisions and feedback to EMT.	A1. 31.04.20 A2. 31.08.20	A1. Completed A2. Recording and feedback system in place.	3	3	9	Covid 19 Response Oversight Committee	Covid-19 financial governance as approved by Governing Body has been fully implemented	19/06/2020	Open
Covid 10	Sarah Mansuralli, Executive Director of Strategic Commissioning	Eileen Fiori / Elizabeth Ogunoye		**Critical Non-Covid 19 Commissioning Activity (Threat)** Cause: If there is insufficient focus and attention on the CCG's critical non-Covid 19 commissioning activity (including new commissioning areas) Effect: There is a risk that this critical activity will be missed or not given sufficient attention (e.g. Adult Orthopaedics public consultation) Impact: This may result in significant delay to the commissioning of key services, increased risk of legal challenge and of patients not receiving the best care within the resources available.	3	3	9	C1. Utilisation and dissemination by NCL CCG of national guidance and directives about transitioning from emergency response into recovery phase; C2. Working with all sectors (acute, community, mental health, primary care) to identify priorities for reset and recovery phase in partnership with local authorities; C3. Log of service changes to inform exit strategy from sustained state of emergency; C4. Business as usual critical commissioning and contracting activities being maintained during pandemic period. C5. Recovery transformation priorities overlap with previous commissioning plans so not all commissioning plans adversely impacted.	C1. NHSE/I national guidance and directives utilised and disseminated; C2. Initial restart and recovery plans being developed by each sector in partnership with system colleagues; C3. NCL Clinical Advisory Group established to oversee and document service changes; C4. CSU and CCG staff required to undertake business critical commissioning and contracting activities have been identified and progressing with support from finance. C5. CCG/Borough level review of restart and recovery priorities aligning with previous commissioning plans and objectives.	Average	3	3	9	CN1. Critical delivery list for the CCG beyond the Covid response.	A1. CCG critical delivery priority list post COVID in development. Local boroughs reviewing planned commissioning activities for 20/21 to understand prioritisation in alignment with system plans for restart and recovery. A2. Implementation and delivery plans to be developed to accelerate pace and recover delay where possible.	A1. 30.06.20 A2. 30.06.20	A1. Work ongoing to finalise priority list. A2. Newly added action. Further update will be available as work progresses.	3	3	9	Covid 19 Response Oversight Committee	Although there was a pause to focus on COVID preparation and response in the crisis phase, there is active and collaborative planning between providers and commissioners to reset, recovery and reimagine service delivery. The latter stage of reimagine enables transformational priorities to be embedded into the work programme for the second phase response to the pandemic. Implementation plans to accelerate pace and progress will be developed to support delivery to mitigate this risk further.	17/06/2020	Open
Covid 11	Tony Hoolaghan, Executive Managing Director		To ensure that there are transparent and effective communications between general practice and the NCL Governing Body leadership	**Trust and Confidence of Member Practices (Threat)** Cause: If the CCG's member practice do not feel the CCG has properly engaged and supported them through the Covid 19 pandemic Effect: There is a risk that the member practices lose trust and confidence in the leadership of the Governing Body and directors Impact: This may result in member practices become disengaged, less co-operative and a potential challenge to the CCG's leadership.	4	2	8	C1. The Governing Body Chair holds regular webinars with key representatives from member practices to support them through the Covid 19 pandemic; C2. Regular bulletins are sent to member practices; C3. Regular updates through the GP website.	C1. Weekly webinar is recorded C2. GP bulletin is circulated weekly C3. GP website updated weekly by comms team	Average	4	2	8	CN1. Mechanism in place to gauge any changes in opinion	A1. Continue bi-weekly GP leadership webinars by Jo Sauvage; A2. Continue to send bi-weekly GP bulletins and publish on the GP microsite.	A1. 31.08.20 A2. 31.08.20	A1. Work is ongoing and steps have met needs A2. Work is ongoing and steps have met needs	3	2	6	Covid 19 Response Oversight Committee	A number of communication channels are put n place led by CCG chair to keep practices informed in response to the covid pandemic and to take feedback from practices	17/06/2020	Open

Covid 12	Tony Hoolaghan, Executive Managing Director	Sarah McIlwaine, Director of Transformation, Haringey Directorate	To ensure that there is sufficient capacity in general practice to manage demand	**Capacity in General Practice (Threat)** Cause: If GP practices experience an increase in the number of staff who are unwell or are self-isolating with suspected covid-19 Effect: There is a risk that practices will be forced to close Impact: This may result in greater pressure being put onto practices which remain open, which may also be short-staffed, to manage increased demand.	4	4	16	C1. Increasing availability of staff testing for General Practice; C2. GP practices moving to "telephone first" model where majority of consultations will be carried out on the phone. GP Federations leading on providing GPs with equipment and remote access to EMIS to allow them to work remotely to provide these consultations; C3. Returning staff to General Practice; C4. Creation of "hot sites" and home visiting services in each borough to ensure that covid-19 positive patients who need to see a GP in person can be diverted to specifically setup sites / seen at home, to reduce number of General Practice staff who will be in contact with this group; C5. Practice 'buddying' arrangements via their Primary Care Networks; C6. Primary care site reps to support early warning system; C7. Hot sites/home visiting are now live in each borough.	C1. Primary care COVID action plan C2. Primary care COVID action plan C3. Primary care COVID action plan C4. Primary care COVID action plan C5. Primary care COVID action plan C6. Primary care COVID action plan C7. Primary care COVID action plan	Average	4	3	12	CN1. Bi-weekly calls with Primary Care Covid Leads and clinician and associated action plan will identify the need to plan further controls	A1. Hot sites / home visiting to go live in each borough. Action completed- now live; A2. Confirm practice PCN buddying arrangements. A3. Develop new model for general practice through the NCL general practice recovery group.	A1. 30.04.20 A2 31.08.20 A3. 31.08.20	A1 - Completed A2 Complete. Buddying arrangements in place A3 ●Reviewed service models based on activity and needs of practices for phase 3), which will be in place from 1st June. ●Focus on upskilling of general practice to deal with the range of covid presentations. as a stepping stone to the longer-term sustainable model for managing covid symptom levels;	4	3	12	Covid 19 Response Oversight Committee	All NCL practices have opened during the covid 19 pandemic including at Easter and bank holidays. Extended access hubs remain open at weekends and bank holidays. Additional capacity has been secured from LCW/111 Practices are now undertaking total remote triage (phone/on-line) to ensure minimal face to face contact.	17/06/2020	Open
Covid 13	Tony Hoolaghan, Executive Managing Director	Alex Faulkes - Programme Director Urgent and Emergency Care	To ensure that LCW has sufficient capacity to able to deliver 111 services during periods of increased demand	**Demand for General Practice (Threat)** Cause: If LCW/111 becomes overwhelmed and is unable to support NCL patients with advice over the phone. Effect: There is a risk patients will instead contact their local GP practice Impact: This may result in an increased burden on those General Practices.	3	2	6	C1. Expanded hub capacity to support London Central and West Unscheduled Care Collaborative ('LCW'); C2. LCW able to send calls and patients to extended access hubs; C3. Allowing CCG offices in NCL to be used for additional LCW call handlers to work to deal with capacity; completed C4. Texts from NCL GPs reminding patients to use 111 on line before using 11 phone line.	C1. Twice weekly calls to discuss demand and capacity and associated notes C2. Twice weekly calls to discuss demand and capacity and associated notes C3 Twice weekly calls to discuss demand and capacity and associated notes C4. Twice weekly calls to discuss demand and capacity and associated notes	Average	3	2	6	CN1. Contract review meetings to take place looking at capacity vs demand and service development. E.G. NHS 111 "Help us help you" programme	A1. Confirm communication to agree content of any NCL texts - alignment with national messaging; A2. Continue to hold regular discussions re capacity/ demand between LCW and extended access hubs.	A1. 31.08.20 A2. 31.08.20	A1. Twice weekly meeting with LCW taking place A2. Constant review of capacity between LCW/111 and NCL practices	3	2	6	Covid 19 Response Oversight Committee	Daily monitoring of demand and capacity between LCW/11 and NCL practices. Beginning contract reviews to consider demand capacity and introducing the national NHS111 Programme "Help us Help you".	17/06/2020	Open
Covid 14	Tony Hoolaghan, Executive Managing Director	Alex Smith - Director of Transformation, Islington Directorate	To ensure that there is sufficient PPE available in general practice so that staff can see patients safely	**Personal Protective Equipment (Threat)** Cause: If adequate supplies of PPE are not made available to General Practice Effect: There is a risk that staff will not be able to safely see patients in person, without putting their own health at risk Impact: This may result in an increase in staff becoming infected and reducing capacity in general practice.	4	4	16	C1. Dedicated PPE support for NCL GP practices from NCL CCG staff - named staff member; C2. Streamlining ordering and giving practice clear information on ordering; C3. Promotion of mutual aid; C4. Delivering PPE to sites that have run out/low stick; C5. Plugging practices into the NCL PPE work programme; C6. Cascading PPE new guidance to all NCL GP practices.	C1. Supply and demand model for primary care in place C2 Supply and demand model for primary care in place C3. Supply and demand model for primary care in place C4. Regular records of urgent practice requests logged C5. Regular weekly meeting in place between Primary Care Federation representatives leading on PPE C6. Primary Care representatives on weekly NCL Procurement Hub PPE calls	Average	4	3	12	C1. National Clipper Solution for Primary Care to access	A1. Continue to hold regular discussions re capacity/ demand between LCW and extended access hubs.	A1. 31.08.20	A1. Regular weekly discussions in place.	5	2	10	Covid 19 Response Oversight Committee	A number of actions have been put in place that enable primary care to have access to PPE supplies that meet national guidance including through mutual aid when there are urgent availability challenges through the business as usual supply route.	17/06/2020	Open
Covid 15	Kay Matthews, Executive Director of Clinical Quality		To ensure vulnerable adults and children are safe	**Child and Adult Safeguarding (Threat)** Cause: If Children and vulnerable adults are not accessing health services in the normal way Effect: there is a risk that abuse, neglect, fraud, mental health etc. is not identified/treated Impact: leading to increase in numbers and severity of injuries and an increase in cases presenting to health services once social distancing measures have been lifted.	5	5	25	C.1 Establishment of a safegarding work stream; C.2 All CCG safeguarding designated and named professionals excluded from redeployment to maintain safeguarding BAU; C.3 Working with safeguarding partnerships to identify key risks/issues; C.4. Development of a strategic safeguarding risk register in addition to the Borough safeguarding risk registers; C.5 Implementation of a seven day cover for CCG Child Designate and adult professional lead for advice and guidance. However, as there have not been any recent calls for advice agreement has been given to stand down the on call. Handover to existing out of hours cover which is advertised on the NCL website. Review on-call requirements regularly and prior to any anticipated increase in demand e.g. Children returning to school. C.6 Comms out to GP practices with guidance on how to manage safeguarding concerns during Covid; C.7 NCL CCG membership of the London Covid-19 Safeguarding sub cell; C.8 Safeguarding BAU to continue; C.9 Weekly calls with Safeguarding Lead professionals across providers; C.10 Multi agency risk conference is being held as a weekly virtual meeting during this period. Attended by the CCG Safeguarding Adult Lead; C.11 Established a rapid communications process for GP practice safeguarding leads across NCL; C.12 All 'known' vulnerable children have been reviewed by Local Authority; C13. Obtained additional resource to develop and	C.1 Action log from safeguarding work stream C.2. No safeguarding designated professionals were redeployed C3. Every safeguarding partnership Board Chair was contacted and their concerns were fed into the safeguarding ris register C.4 Risk register C5. Safeguarding 7 day working rota C.6 email communications C.7 Attendance record of virtual meetings C.8 minutes from BAU safeguarding meetings C.9 Attendance record of virtual meetings C.10 Attendance record of virtual meetings C.11 Managed by the safeguarding PA - evidence will be email communications to GPs C.12 Performance reporting at partnership boards C.13 Facilitator in place C.14 Elearning package/link sent to GPs C.15 comms plan. Comms work stream in place; C16. Telephone and visit notes.	Average	5	4	20	CN1. Need an almagemated risk register within work stream CN2. Assurance that Provider BCPs are aprropriate and effective	A1. Continue to cascade relevant advice/guidance to appropriate stakeholders; A2. Further review of provider BCPs to ensure that it is still relevant and appropriate and captures requirements for the next phase of Covid. Progressed through weekly meetings with providers. Letter sent wc 18 May 2020 to providers formally requesting BCP for return 29 May. A3. Establishment of task and finish groups to manage safeguarding risks actions. Strategy, risk review, training and communications groups commenced. A4. Identifying hidden domestic abuse and violence – additional training/ webinar planned for all NCL GPs in assessing for DV virtually, early June; promotion of national materials for accessing help for DV through NCL comms channels, highlighting national advice to GPs and other providers. A5. Reviewing recovery plans with partners. .	A1. 31.08.20 A2. 20.06.20 A3. 31.08.20 A4. 10.06.20 A5. 20.06.20	A1. All relvant national and local guidance is sent to appropriate stakeholders A2. This is underway A3. In place A4. on track A5. Underway	4	3	12	Covid 19 Response Oversight Committee	This risk is likely to remain high until the Covid-19 lockdown eases and vulnerable children and adults start accessing health services more frequently. At that point we will be better sighted on the 'unknown' harms.	17/06/2020	Open

								implement a short term and medium term plan for managing safeguarding both during and immediately after Covid impact. C14. GP focused training, for example NCL domestic abuse virtual training session, in partnership with Domestic Abuse services and virtual Level 3 training with a focus on hidden harm; C15. Communication and engagement - to support the response to hidden harm by developing a local communication plan to deliver national and local safeguarding messages and campaigns; C16. Working with safeguarding partnership to identify new/different ways of working to reach vulnerable adults and children during Covid-19. Local Authority have contacted all 'at risk' children and continue to visit 'at risk' groups where possible and virtually where face to face visits are not possible C17. London-wide safeguarding AAR completed and incorporated into NCL plans.																					
Covdi 16 NEW RISK	Sarah McDonnell-Davies, Executive Managing Director - Camden, Sarah Mansuralli, Executive Director of Strategic Commissioning	Meena Mahil Richard Elphick		**Unsustainable Model of Care for Care Homes (Threat)** Cause: If primary care and community services return to pre-Covid19 levels of activity or experience a second peak Effect: There is a risk that the additional resources (primary and community support, IPC and testing) drawn upon to put the model of care in place for care homes would need to be withdrawn Impact: This may lead to the early implementation of elements of the EHCH framework becoming unsustainable, particularly for Barnet who had a significantly different starting position to other boroughs.	5	5	25	C1. The importance of maintained support to care homes is being highighted wirth providers during Primary care and community recovery planning. Recovery plans will be reviewed and endorsed at a system-level to identify any system-wide impacts & ensure these are addressed. C2. CCG COVID Response Oversight Committee agreed the need for a joint(CCG & LA) care homes work programme over the next 12 months. C3. An interim programme management team across CCG and Local Authorities is in place to support a care home work programme. They are working with clinical leads and providers (incl care homes) to identify which of the elements of the model can be retained outside Covid19 peaks. C4. The Enhanced Health in Care Homes Steering Group has been established to ensure clinical support arrangements to care homes. C5. After Action Review has been established to learn from providers what has worked well and what hasn't with the Covid19 emergency response, and to consider which elements we may wish to retain in the long-term. C6. Barnet LCS has received funding until October, after which the EHCH DES will be implemented.	C1. COVID Oversight Committee minutes C2. PP&R PMO reports C3. Non-Acute Gold minutes C4. National assurance reports	Average	4	3	12	CN1. Identifying the ongoing clinical support required in MH/LD settings. CN2. National guidance on restoration of adult services provided by NHSE/I needs to be aligned with local priorities around care homes CN3. Dedicated SRO from CCG. CN4. Final programme of work and associated governance structure across the council and the CCG. CN4. Commissioning plan and business case for the medium to longer term model of care.	A1. Confirm future arrangements of SRO within CCG. A2. Boroughs to update on current arrangements for MH/LD settings to EHCH Steering Group and PP&R Silver	A1. 01.07.20; A2. 01.07.20.	A1. In progress. A2. In progress	3	3	9	Covid 19 Response Oversight Committee	The care home programme management team are currently working with partners to scope out the development of an After Action Review that will specifically look to address the issues identified (primary and community support, IPC and testing). The outputs of this work will be brought back to Oversight Committee for review and input.	16/06/2020	Open
Covid 17 NEW RISK	Will Huxter, Director of Strategy	Richard Dale, Director of Strategic Programmes Tendai Wileman, Director of Programme Delivery	Improve quality	**Recovery - Returning to Old Ways of Working Following COVID (Threat)** Cause: If actions are not taken to learn lessons and identify opportunities arising from the NCL COVID-19 response Effect: There is a risk that 'recovery' merely involves returning to old ways of working, rather than embedding a more collaborative, system-focussed approach Impact: This may result in a setback to the development and implementation of an Integrated Care System in North Central London, and ultimately to inefficient and poorer quality care for our residents	4	4	16	C1. Recovery planning by each COVID workstream	C1. COVID workstream recovery plans	Average	4	3	12	CN1. Stocktake / review of opportunities and lessons arising from the COVID19 response.	A1) Undertake an after action review to identify opportunities and lessons from COVID-19 response A2) Ensure that opportunities and lessons are factored into ICS priorities and programmes A3) Establish revised transformation portfolio in a standard way and ensure outputs are widely communicated and jointly developed	A1. 30.06.20; A2. 31 .07.20; A3. 30.08.20.	A1. After action reviews have been held with the SROs of all STP workstreams and Gold Cells to discuss opportunities and lessons learned, including those from COVID; A2. Reset proposals are in the process of being drafted.	4	2	8	Covid 19 Response Oversight Committee	Director of strategy is in the process of undertaking a review of ICS priorities and programmes. Interviews have been held with the SROs of all STP workstreams and Gold Cells. We are in the process of drafting a set of proposals on how to reset our priorities to ensure we learn lessons from COVID and take advantage of opportunities that have been identified.	19/06/2020	Open
Covid 18 NEW RISK	Will Huxter, Director of Strategy	Richard Dale, Director of Strategue Programmes Tendai Wileman, Director of Programme Delivery	Improve quality and financial sustainability	**Recovery - Financial and Capacity Challenges Associated with Recovery (Threat)** Cause: If we do not identify, prioritise and allocate sufficient financial and capacity support to COVID-19 recovery work Effect: There is a risk that our recovery plans will not be properly implemented Impact: This may result in our not being able to meet the care provision and financial challenges before us	4	4	16	C1. Recovery planning by each COVID workstream	C1. COVID workstream recovery plans	Average	4	3	12	CN1. Baseline financial position; CN2. Financial Recovery target in year and over time; CN3. Robust programme and financial plans.	A1. Finance to confirm baseline financial position; A2. Established programmes of work with deliverable objectives and benefits; A3. Adequate resourcing arrangements at all levels to suppport delivery	A1. 31 .07.20;; A2. 30.08.20; A3. 30.08.20.	A1, A2 and A3. Financial arrangements for Q1 being worked through which will inform the baseline financial position. Strategy directorate reviewing all programmes and establishing a revised portfio with support and input from across the system. Resourcing requirements being worked through.	4	2	8	Covid 19 Response Oversight Committee	This is a new risk with a Current Risk Score of 12. Financial arrangements for Q1 are being worked through which will inform the baseline financial position. The Strategy Directorate is reviewing all programmes and establishing a revised portfolio with support and input from across the system. Resourcing requirements are also being worked through.	19/06/2020	Open

North Central London CCG
Primary Care Commissioning Committee Meeting
Thursday 23 July 2020

Report Title	Commissioning Decisions on PMS Agreement Changes	**Date of report**	11 July 2020	**Agenda Item**	3.1
Lead Director / Manager	Paul Sinden, NCL Director of Performance, Planning and Primary Care	**Email / Tel**		p.sinden@nhs.net	
GB Member Sponsor	*Not Applicable*				
Report Author	NLPHC GP Commissioning	**Email / Tel**		0203 688 1993 england.lon-nc-pcc@nhs.net	
Name of Authorising Finance Lead	*Not Applicable*	**Summary of Financial Implications** *Not Applicable*			
Report Summary	Detail of the request to vary PMS Agreements and any conditions to be applied				
Recommendation	**APPROVAL** of the proposed changes outlined below and any conditions				
Identified Risks and Risk Management Actions	Not maintaining the stability of the agreement. The risk can be mitigated by approving the variations with appropriate conditions.				
Conflicts of Interest	*Not Applicable*				
Resource Implications	*Not Applicable*				
Engagement	*Not Applicable*				
Equality Impact Analysis	*Not Applicable*				
Report History and Key Decisions	*Not Applicable*				
Next Steps	Issue appropriate variations with conditions where applicable				
Appendices	*Not Applicable*				

Contents

1 Executive summary

The below table summarises the Agreement Changes requested by PMS Practices in NCL. The corresponding CCG is asked to make determination for the PMS Agreement Changes in their area.

2 Background

PMS practices are required to submit agreement change requests with 28 days' notice to allow the commissioner to consider the appropriateness of the request. The Commissioner should be satisfied that the arrangements for continuity of service provision to the registered population covered within the agreement are robust and may wish to seek written assurances of the post-variation individuals ability and capacity to fulfil the obligations of the agreement and their proposals for the future of the service.

3 Appointment benchmarking

As a part of the due diligence undertaken when assessing PMS Practices' requests to vary the PMS Agreement, the number of GP appointments offered by the Practice is assessed. All weekly GP appointments (face to face, telephone, home visit) are totalled and compared to the benchmark of 72 appointments per 1000 patients per week. This figure is a requirement in all new Standard London APMS contracts and is described in the BMA document Safe working in general practice[1] as developed by NHS England via McKinsey but widely accepted.

Where Practices do not meet the 72 GP appointments per 1000 patients Commissioners will seek to work with the provider to increase access.

[1] https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/negotiating%20for%20the%20profession/general%20practitioners/20160684-gp-safe%20working-and-locality-hubs.pdf

4 Table of requested PMS Agreement Changes

Practice	Borough location	List Size 1/10/19	PCN membership	Agreement Change	Comment Recommended guide based on: 72 GP appointments per 1000 patients Apps x 10 min (app) / 180 (3 hour session)	Recommendation to committee
F85071 Fernlea	Haringey	10401	Practice is a member of Haringey – Welbourne PCN, comprising: • 6 Practices • 50467 patients at 01/04/2020	Addition of Dr Priya Amin	Fernlea Surgery currently has 3 contractors and wishes to add a contractor to the PMS Agreement to take effect from a retrospective date of 01/04/20. The recommendation could not be brought to earlier PCCC as commissioners required more assurance on practice's clinical capacity. Hence retrospective effective date of 01/04/20. **Clinical sessions/Appointments provided** • 793 GP appointments per week • 40 GP sessions per week • 339 nurse appointments per week • 11 nurse sessions per week **Recommended Guide** • 749 GP appointments per week • 40 GP sessions per week • 333 nurse appointments per week • 18 nurse sessions per week	To approve a retrospective variation to take effect on 01/04/20
F85071 Fernlea	Haringey	10401	Practice is a member of Haringey – Welbourne PCN, comprising: • 6 Practices	Approve Dr Caplan taking 24-hour retirement on 06/05/20, returning 07/05/20	Subject to the approval of the addition of Dr Amin to the PMS Agreement, Drs Raindi, Mehta and Amin will remain on the PMS Agreement whilst Dr Caplan takes 24 hour retirement. The Practice is, and will continue to offer following Dr Caplan's 24-	To approve a variation to take effect on 06/05/20

Practice	Borough location	List Size 1/10/19	PCN membership	Agreement Change	Comment Recommended guide based on: 72 GP appointments per 1000 patients Apps x 10 min (app) / 180 (3 hour session)	Recommendation to committee
			• 50467 patients at 01/04/2020		hour retirement, the following session/appointment provision: • 793 GP appointments per week • 40 GP sessions per week • 339 nurse appointments per week • 11 nurse sessions per week **Recommended Guide** • 749 GP appointments per week • 40 GP sessions per week • 333 nurse appointments per week • 18 nurse sessions per week During COVID response it is not necessary for those taking 24hr retirement to reduce their hours to 16 per week for 28 days: The Coronavirus bill sets out that there is a suspension of certain rules that apply in the NHS Pension Scheme in England and Wales so that healthcare professionals who have recently retired can return to work and those who have already returned can increase their hours without there being a negative impact on their pension entitlements.	
F85058 Nightingale House Surgery	Enfield	6716	Practice is a member of Enfield Unity PCN, comprising:	Removal of Dr Chimere Aka	Application for Dr Aka to be removed from the PMS Agreement with effect from 30/04/20. This will leave 2 remaining	To approve

Practice	Borough location	List Size 1/10/19	PCN membership	Agreement Change	Comment Recommended guide based on: 72 GP appointments per 1000 patients Apps x 10 min (app) / 180 (3 hour session)	Recommendation to committee
			• 23 Practices • 159116 patients at 01/04/2020		partners to the Agreement supported by a salaried GP. **Clinical sessions/Appointments provided** • 700 GP appointments per week • 19 GP sessions per week • 130 nurse appointments per week • 13 nurse sessions per week **Recommended Guide** • 484 GP appointments per week • 26 GP sessions per week • 222 nurse appointments per week • 12 nurse sessions per week Although there is no shortfall of the number of appointments being offered there is a shortfall of the number of expected GP sessions: 7 GP sessions There is a shortfall of 92 nurse appointments per week. Practice have detailed: • The leaving partner provided 7 sessions per week • They will aim to recruit a salaried GP with possible progression to partnership as soon as possible.	

Practice	Borough location	List Size 1/10/19	PCN membership	Agreement Change	Comment Recommended guide based on: 72 GP appointments per 1000 patients Apps x 10 min (app) / 180 (3 hour session)	Recommendation to committee
					• The practice will employ locum GPs to provide clinical appointments whilst they recruit a permanent GP • Remaining partners to work additional sessions where required until replacement is in position. • Additional clinical sessions will be provided by nurse returning from maternity leave.	
Y00316 Woodlands Practice	Barnet	4422	Practice is a member of Barnet PCN 3, comprising: • 16 Practices • 118,015 patients at 01/04/2020	Removal of Dr Singh Addition of Dr Fernandes	Application of the removal of Dr Singh and addition of Dr Fernandes to take effect from 01/06/2020, thereby resulting in no effective change from the number of partners (currently 2). **Clinical sessions/Appointments provided** • 330 GP appointments per week • 17 GP sessions per week • 63 nurse appointments per week • 3 nurse sessions per week **Recommended Guide** • 319 GP appointments per week • 17 GP sessions per week • 141 nurse appointments per week • 8 nurse sessions per week	To Approve

Practice	Borough location	List Size 1/10/19	PCN membership	Agreement Change	Comment Recommended guide based on: 72 GP appointments per 1000 patients Apps x 10 min (app) / 180 (3 hour session)	Recommendation to committee
					There is also a shortfall of nurse appointments offered each week (78) and sessions pw (5) The practice have advised that they had begun a recruitment drive for nursing staff shortly prior to the COVID-19 pandemic and hope to recommence this work to meet the demand for nursing appointments/sessions.	
1. Forest Road Group Practice (MHP) 2. Riley House Surgery (MHP) 3. Freezywater PCC (MHP) 4. Southbury Surgery (MHP) 5. Green Street Surgery (MHP) 6. Lincoln Road Medical Practice (MHP) 7. Enfield Island Surgery (MHP)	Enfield	Total of 15 MHP GMS/PMS Practices – 91,595 patients as 1/4/20 List size at Dean House Surgery- 2,186 patients Currently 36 signatories including 1 non- clinical.	Practice is a member of Enfield Unity PCN Primary Care Network, comprising: • 23 Practices 159,116 patients as at 1/04/20	24 Hours Retirement of Dr Sajida Choudhry from Medicus Health Partners (MHP)	Commissioners have received an application from Dr S Choudhry who wishes to take 24 hour retirement. Dr Choudhry is an individual on 9 PMS agreements, which form part the Medicus Health Partners (MHP) (made up of 6 GMS & 9 PMS practices). There will be 35 individuals remaining on the contract, during the 24 hour retirement. Dr Choudhry wished to take a 24 hour break from NHS work from 12 June 2020. During the COVID response, from 25th March 2020, it is not necessary for those taking 24hr retirement to reduce their hours to 16 per week for 28 days. The guidance provided by NHS Business Services Authority advises there has been a temporary suspension to 16-hour rule.	To approve

Practice	Borough location	List Size 1/10/19	PCN membership	Agreement Change	Comment Recommended guide based on: 72 GP appointments per 1000 patients Apps x 10 min (app) / 180 (3 hour session)	Recommendation to committee
8. Dean House Surgery (MHP) 9. Bush Hill Trinity (MHP)					In the past, the rule has prevented GPs who wish to return to work after taking 24 hour retirement from working more than 16 hours per week in the first calendar month after retirement. Suspension of this rule also allows GPs to return immediately to work after taking a minimum 24-hour retirement and continue their existing working commitments, or increase them, whilst they are in receipt of their full pension benefits. Dr Choudhury will return to her normal sessions from 22nd June 2020. **Clinical sessions/Appointments provided by the Dean House Surgery:** • 230 GP appointments per week. • 10 GP sessions per week + extended hours • 44 nurse appointments per week • 4 nurse sessions per week **Recommended Guide:** • 158 GP appointments per week • 9 GP sessions per week • 70 nurse appointments per week • 4 nurse sessions per week	

Practice	Borough location	List Size 1/10/19	PCN membership	Agreement Change	Comment Recommended guide based on: 72 GP appointments per 1000 patients Apps x 10 min (app) / 180 (3 hour session)	Recommendation to committee
					There is a shortfall of 26 nurse appointments. The practice have confirmed from 18th May 2020 the practice will be offering 70 more nurse appointments and can offer access to more nurse appointments at other MHP sites.	
Lawrence House Surgery F85007	Haringey	16500	Practice is a member of Haringey – Welbourne PCN, comprising: • 6 Practices 50467 patients at 01/04/2020	Approve Dr John Rohan taking 24-hour retirement on 02/09/20, returning 04/09/20	The Practice is, and will continue to offer following Dr Rohan 24 hour retirement, the following session/appointments provision : • 1217 GP appointments per week • 68 GP sessions per week • 626 nurse appointments per week • 35 nurse sessions per week Recommended Guide • 1118 GP appointments per week • 66 GP sessions per week • 545 nurse appointments per week • 31 nurse sessions per week Recommended Guide During COVID response it is not necessary for those taking 24hr retirement to reduce their hours to 16 per week for 28 days, the Coronavirus Bill stipulates that those returning to work after retirement may increase their hours without there being a negative impact on their pension entitlements.	To approve a variation to take effect on 02/09/20

Practice	Borough location	List Size 1/10/19	PCN membership	Agreement Change	Comment Recommended guide based on: 72 GP appointments per 1000 patients Apps x 10 min (app) / 180 (3 hour session)	Recommendation to committee
Lawrence House Surgery F85007	Haringey	16500	Practice is a member of Haringey – Welbourne PCN, comprising: • 6 Practices 50467 patients at 01/04/2020	Addition of Dr Uchenwoke	Application to add Dr Uchenwoke to the Lawrence House Surgery PMS agreement effective from 01 August 2020. Currently there are 5 GPs and 1 non clinician on the agreement. Clinical sessions/Appointments provided • 1217 GP appointments per week • 68 GP sessions per week • 626 nurse appointments per week • 35 nurse sessions per week Recommended Guide • 1118 GP appointments per week • 66 GP sessions per week • 545 nurse appointments per week • 31 nurse sessions per week The practice currently offer above the recommended amount of both GP and nurse sessions/appointments.	To approve
F85033 Winchmore Hill Practice	Enfield	17108 (as at 01/04/20)	Practice is a member of West Enfield Collaborative PCN comprising of 4 Practices	Addition of Dr Hetul Shah	Application to add Dr Hetul Shah as a signatory to the Winchmore Hill Practice Agreement to take effect from a retrospective date of 01/05/20. This variation will increase the number of signatories to four.	To approve retrospective variation to take from effect 01/05/20

Practice	Borough location	List Size 1/10/19	PCN membership	Agreement Change	Comment Recommended guide based on: 72 GP appointments per 1000 patients Apps x 10 min (app) / 180 (3 hour session)	Recommendation to committee
			40,259 patients (as at 1/04/20)		Clinical sessions/Appointments provided • 1334 GP appointments per week • 64 GP sessions per week • 492 nurse appointments per week • The practice provide a mixture of 10 minute and 15 minute appointments, have yet to confirm the number of sessions per week Recommended Guide • 1232 GP appointments per week • 65 GP sessions per week • 548 nurse appointments per week • 29 nurse sessions per week There is a shortfall of 1 GP session and 56 nurse appointments per week.	
James Wigg Practice F83023	Camden	21905 as of April 2020	Practice is a member of Kentish Town South PCN compromising of 2 practices with a list size of 29182 as of 01/04/2020	Removal of Dr Natasha Smeaton	Application to remove Dr Natasha Smeaton from the James Wigg Practice PMS agreement effective from 02 July 2020 leaving 4 signatories. Clinical sessions/Appointments provided • 1850 GP appointments per week • 122 GP sessions per week • 420 nurse appointments per week • 28 nurse sessions per week Recommended Guide • 1578 GP appointments per week • 88 GP sessions per week	To approve

Practice	Borough location	List Size 1/10/19	PCN membership	Agreement Change	Comment Recommended guide based on: 72 GP appointments per 1000 patients Apps x 10 min (app) / 180 (3 hour session)	Recommendation to committee
					• 723 nurse appointments per week • 41 nurse sessions per week There will be no reduction in service as a salaried GP has been employed to cover the sessions of Dr Smeaton. The Practice has been advised of shortfall of nursing appointments and NCL Commissioning Team will monitor, providing advice if necessary.	
West Hampstead Medical Centre F83055	Camden	17358 at April 2020	Practice is a member of West Camden PCN compromising of 4 practices with a list size of 47196 as of April 2020	Removal of Dr Jonathan Michael Barnett	Application to remove Dr Jonathan Barnett from the West Hampstead Medical Centre PMS agreement effective from 01 August 2020 leaving 3 signatories. Clinical sessions/Appointments provided • 1335 GP appointments per week • 89 GP sessions per week • 270 nurse appointments per week • 18 nurse sessions per week Recommended Guide • 1263 GP appointments per week • 71 GP sessions per week • 579 nurse appointments per week • 33 nurse sessions per week There is a shortfall of 309 nurse appointments and 15 sessions.	To approve

Practice	Borough location	List Size 1/10/19	PCN membership	Agreement Change	Comment Recommended guide based on: 72 GP appointments per 1000 patients Apps x 10 min (app) / 180 (3 hour session)	Recommendation to committee
					The Practice has been advised of shortfall of nursing appointments and NCL Commissioning Team will monitor, providing advice if necessary.	

North Central London CCG
Primary Care Commissioning Committee Meeting
Thursday 23 July 2020

Report Title	Longrove Surgery Co-location with Vale Drive Practice	**Date of report**	14 July 2020	**Agenda Item**	3.2
Lead Director / Manager	Colette Wood, Director of Primary Care Transformation, Barnet	**Email / Tel**		Colette.wood1@nhs.net	
GB Member Sponsor					
Report Author	Vanessa Piper	**Email / Tel**		Vanessa.piper@nhs.net	
Name of Authorising Finance Lead		**Summary of Financial Implications** There will be a higher increase in the rent following the relocation but due to the void cost liability, this increase is reduced.			
Report Summary	This paper is being presented to request committee members to consider the case to co-locate Longrove Surgery with Vale Drive Practice. The trigger for the request is following the partners for Longrove Surgery and Vale Drive Surgery wish to merge and to operate from the same building. Vale Drive Practice contract is held by a single hander and they have expressed a wish to no longer operate as a sole contract holder. The practice operates from a purpose built primary care centre shared with the community provider services and Community Health Partnerships (CHP) are the landlord. Longrove Surgery currently operates from a commercial building which had been converted into a practice. The internal environment of the building is a purpose built health facility, but requires some compliance improvement works, and the room sizes do not meet the current Health Building Note (HBN) 11-01 guidance. The building has a private landlord and the lease is due to expire in September 2020, which provided the partners the opportunity to not renew the lease and request a relocation into a compliant purpose built primary care centre. The contract holders for each practice plan to relocate before 18 September 2020 with a view to merge shortly after. Both practices have commenced the due diligence stage of planning for the merger, i.e. reviewing the budgets, accounts, staffing, policies etc. Therefore a further application for the merger will be submitted in a future committee meeting.				

	Change in rent Committee members should first be aware that there will be an increase in rent of £176,802 (54% increase) following the relocation. The existing combined rent for both practices is £152,719 and the new rent will increase to £329,521. This increase in rent is predominantly related to the, (1) increase in square metre from the relocation of Longrove Surgery, (2) increase specifically related to the shared space required in the building and (3) the factors included by CHP in the lease plus rent payment. The existing combined square meters for both practices is 466.72m2 and this will increase to 722.07m2 (35% increase). The increase in the space is not related to the clinical rooms requested by the practice. The practices combined, currently have 14 clinical rooms. In the new space this will increase to 15 rooms, therefore the increase in square metres is predominately related to the shared space and larger size of the rooms to meet premises standards. Another factor related to the increase in rent is because for LIFT buildings the rental charge is termed a Lease Plus payment, which includes a lifecycle cost for Facilities Management costs. The Facilities Management and lifecycle costs cover internal repairs, planned replacement, painting and maintenance of the building etc. Whereas for Current Market Rent (CMR) payments this includes external repairs and building insurance, therefore both reimbursements are not comparable, specifically for the lower rent reimbursed for Longrove surgery. The Lease plus payment used for CHP buildings is a different model used for LIFT buildings and is a financial model agreed by the Department of Health (DH) and CHP. Committee members should note that there was not a case to relocate both practices to the Longrove Surgery premises. The practice currently operates out of 9 clinical rooms. The combined list for both practices is 17,354 which provides a room to patient ratio of 1 room : 1,928 patients, which significantly exceeds the Department Health Building notes estimation of 1 room : 1,157, for 15 rooms of which the practices have requested. The total void cost liability to the CCG and NHSEI is £301,000 per annum. Therefore with the rent increase and reimbursable cost to the CCG of £329,521, taking into consideration the void liability the actual increase in cost is £28,521. The distance between the practices is 0.7 miles. Patients at Longrove Surgery have been engaged with and they were in favour of the relocation.
Recommendation	Committee members are asked to **APPROVE** the; 1. Relocation and co-location of Longrove Surgery with Vale Drive Practice 2. The change and increase in rent for both practices which is; a. New rent £329,521 b. Current rent £152,719 c. Increase of £176,802

	3. Due to the significant increase in rent committee members are asked to take into consideration when making the decision the current void cost liability of £301,000 per annum which will be saved after the relocation, therefore the actual liability will increase to £28,521 per annum
Identified Risks and Risk Management Actions	
Conflicts of Interest	*Not Applicable*
Resource Implications	Increase in rent reimbursement
Engagement	Patients at Longrove Surgery have been engaged with and they were in favour for the relocation.
Equality Impact Analysis	An equality impact assessment has not been carried out. The practices are 0.7 miles apart therefore commissioners deem this to be a low impact. There will also be no change in the service provision. The practices are asked to engage with patients and specifically vulnerable groups to seek their views prior to the relocation.
Report History and Key Decisions	*Not Applicable*
Next Steps	If the case is approved by PCCC members, commissioners will meet with both practices to plan the relocation and wider engagement with patients. The practices will be required to sign Heads of Terms with the landlord price to relocating. A further paper will be referred to the committee regarding the merger.
Appendices	*Non Applicable*

Background

Longrove Surgery and Vale Drive Practice have requested to merge and co-locate into the same building.

Longrove Surgery's lease expires on 18 September 2020, and the partner's preference was not to renew the lease as the building would not support both practices operating in the premises.

Longrove Surgery currently has 9 clinical rooms in the existing site and the combined list for both practices will be 17,354 which provides a room to patient ratio of 1 room : 1,928 patients. Therefore the practice has requested to relocate and co-locate with Vale Drive Surgery.

Current space

Longrove Surgery currently operates from 291.73 m2, with an annual rent reimbursement of £71,165.

Vale Drive Practice currently operates from 174.99m2, with an annual rent reimbursement of £81,554.

The total current combined space and rent for both practices are;

- Current square metre – 466.72m2 (inclusive of 14 clinical rooms)
- Current rent reimbursed - £152,719

New space

Barnet Borough premises lead has worked with CHP to review and calculate the new space required by the merged practice. This equated to the following;

- New square metre – 722,07m2 (inclusive of 15 clinical rooms)
- New rent reimbursed – £329,521

The increase in the change of space and rent is predominantly related to the shared areas in the building.

The practices are requesting 15 clinical rooms and this provides a ratio of 1 room : 1,157 patients, which is comparable to the Department of Health (DH) Health Building Notes estimator (HBN), which calculates practice space requirements including the need for growth and a higher number of contacts / patient attendances.

For the combined practices list size of 17,354, the DH HBN calculator estimates 15 clinical rooms (11 consulting and 4 treatment) at 96 GP appointments / 1000 per week, which is higher than the BMA guidance of 72 appointments. Nursing appointments per week also take into consideration a higher rate of attendances at 36 appointments per 1000 / week. These calculations are based on an 80% utilisation rate, 6 contacts per annum per patient and 15 minute appointments.

A second factor relating to the increase in the rent is related to the Lease plus payment (rent) which includes, Facilities Management and lifecycle costs to cover internal repairs, planned replacement, painting and maintenance of the building etc. The Lease plus payment used for CHP buildings is a different model used for LIFT buildings and is a financial model agreed by the Department of Health (DH) and CHP.

Current Market Rent (CMR) payments includes external repairs and building insurance, therefore both reimbursements are not comparable, specifically for the lower rent reimbursed for Longrove surgery.

Strategic case for the relocation

The total void cost liability to the CCG and NHSEI is £301k per annum. Therefore with the rent increase and reimbursable cost to the CCG of £329,521 following the relocation, taking into account the void liability the actual increase in cost is £28,521.

The contract holder for Vale Drive Surgery has been operating as a single hander therefore by co-locating Longrove and the merger of the two contracts will provide more resilience for both practices.

Longrove Surgery's lease was due to expire in September 2020 and the size of the building was restrictive in terms of further growth of the practice and prohibited a merger and co-location on this site with Vale Drive Surgery. Therefore the co-location will facilitate the merger and ensure both practices are operating from fit for purpose buildings.

North Central London CCG
Primary Care Commissioning Committee Meeting
23 July 2020

Report Title	Parkview Surgery Request to approve (i) Closure of branch Surgery (ii) increase in Rent	**Date of report**	June 2020	**Agenda Item**	3.3
Considered at	**Part 1**☒ Part 2 ☐ Urgent decision ☐				
Lead Director / Manager	Colette Wood, Director of Primary Care Transformation, Barnet	**Email / Tel**		Colette.wood1@nhs.net	
GB Member Sponsor					
Report Author	Su Nayee	**Email / Tel**		Su.nayee@nhs.net	
Name of Authorising Finance Lead	*Not Applicable*	**Summary of Financial Implications** **The partners are currently reimbursed the following;** - Total rent reimbursement £31,065 - Main surgery £27,067 - Branch surgery £3,997 New total CMR will be 37,400 ext VAT, therefore there will be an increase of £6,335.			

Report Summary

1. <u>Relocation of Branch</u>

Parkview Surgery provides GP services across two sites. The main practice is based at Cressingham Road Health Centre and the branch site is based at Grahame Park Health Centre. There are 2 GP partners and 3 Salaried GPs providing services to 6639 patients.

The Grahame Park Health Centre site is planned to be demolished in 2024 and redeveloped as part of the wider Colindale regeneration project, where there is an anticipated increase in population of 11,950 by 2027. The branch site is co-located with another GP practice, The Everglade Surgery.

Parkview Surgery has two rooms in the main surgery which were leased by the community dental surgery. The dental service is no longer being provided from the site and the dental rooms are now available; the partners would like to refurbish these rooms to consolidate the list onto one site. The two clinical rooms will be a like for like replacement of the two clinical rooms currently in use at the Graham Park Health Centre. Barnet Borough Teams have secured capital

	through the ETTF programme to refurbish the dental rooms in order to accommodate the list at Cressingham Road. The move will also provide the flexibility at Grahame Park Health Centre to increase clinical space for the remaining practice to absorb the initial population growth. Access to GP services at the branch site is limited, with availability of appointments on 4 mornings and 2 afternoons per week and a nurse is only available on a Monday morning. Patients are directed to use the main site at other times and days. Patients accessing services at the branch site, will continue to be able to access services at the main site. The main Surgery premises are based approximately 1 mile from the branch site, where the practice opens from 8:00 am – 6:30 pm and the practice nurse works throughout the week. The practice at the main site offers a wider range of services, including access to a clinical pharmacist. Parkview currently has 5 clinical rooms across the two practice premises (3 main and 2 at the branch). The raw list as at 1 April was 6639. This provides a ratio of 1 room to 1,328 patients. The existing room to patient ratio is in line with the Department of Health Building (HBN) Note calculator, which provides an indication of the number of clinical rooms required by general practice. The DH HBN estimator calculated for Parkview surgery, at 6 contacts per annum at 70% utilisation the practice requires 6 rooms. At 80% utilisation the practice requires 7 rooms. The DH HBN calculator also takes into consideration the number of attendances. At 70% utilisation the attendances are 796 per week for GP and nursing which is greater than the guide of 72 GP and 33 nursing which provides 699 per week. Committee members should note that the practice is not proposing to increase the number of clinical rooms, only to have a like for like replacement at the main site. If the committee members approve the relocation, the practice will commence engagement with patients. Refurbishment of the rooms is likely to take approximately 8 – 10 weeks. **2. <u>Increase in Revenue</u>** The estimated increase to the current CMR to the delegated budget will be by £6,335. The contract holders are currently reimbursed the following; - Main surgery £27,067 - Branch surgery £3,997 - Total rent reimbursement £31,065 The DV valuation has been carried out to include the two refurbished rooms, the new valuation has indicated the CMR will be £37,400 excl. VAT, and therefore there will be an increase in rent of £6,335 per annum. The contract holders are requesting an increase in CMR to include the two new clinical room once converted.

	Committee members are asked to note the practice did not have a lease in place previously, however as part of the improvements, the landlord – CHCL, have offered the contract holders a 5 year lease. **Capital Costs** The partners are not requesting any capital to covert the room, this is being funded by ETTF Funding which has already been secured by Barnet borough colleagues and includes refurbishment of the rooms to meet current premises standards. **GPIT** The practice will require IT equipment for these clinical rooms and approval will need to be sought through the CCGs GPIT budget
Recommendation	• Commissioners are requesting committee members to **APPROVE**: • The consolidation of the branch surgery onto the main surgery • Estimated increase in CMR of £6,335 to allow the conversion of the two rooms • The contract holders will highlight the risk associated with the short term in the lease of 5 years.
Identified Risks and Risk Management Actions	• Financial • Patients' perception of the practice is closing – this will be mitigated by engagement with patients.
Conflicts of Interest	*Not Applicable*
Resource Implications	• Increase to the delegated Budget • The improvement work is being funded by an ETTF grant. The costs of the works is estimated to be approx. £37,334 excl. VAT.
Engagement	• If the relocation of the list is approved, the contract holders will commence wider engagement with patients of the consolidation of the two sites.
Equality Impact Analysis	*Not Applicable*.
Report History and Key Decisions	• The practice's PID was approved in 2016, as part of the ETTF application process • ETTF PMO took the Business Case through the LEPCCP approval process. • This scheme has been identified as STP priority scheme.
Next Steps	• Commissioners will convene a project group to manage the relocation process. • The two clinical rooms at Cressingham room will be refurbished within 8-10 weeks to allow the relocation of the list onto one site •
Appendices	• Practice Catchment area and distances

1.0 Recommendation

The Committee members are asked to approve a contract holder's request

1: To relocate their Branch surgery from Grahame Park Medical Centre to their main surgery site at Cressingham Road which is a purpose built premises, a distance of approximately 1 mile or 19 minutes' walking distance.

2: To approve increase in CMR of £6,335.

Approval is subject to the following conditions:

- The contract holders will be highlighted to the risk of the short term lease arrangements that the practice will have and the risk to the patient list if they are unable to secure a longer term lease beyond the 5 year period.

2.0 Background

The Parkview Surgery Contract holder provides GP services across two sites. A main site is based at Cressingham Road Health centre, Edgware and the branch site is based at Grahame Park Health Centre in Colindale. The PMS practice has 2 GP partners, 3 Salaried GPs providing services to 6639 patients. The main surgery premises are based approximately 1 mile from the branch site. Where the practice opens from 8:00 am – 6:30 pm and the practice nurse works throughout the week. The practice at the main site offers a wider range of services, including access to a clinical pharmacist

The distance between the two sites is approximately 1 mile, 19 minutes' walking distance. Appendix 1 provides location of where patients reside and the location of both practices.

Access to services at the branch site is limited, with availability of appointments on 4 mornings and two afternoons per week and a nurse is only available on a Monday morning. Patients are directed to use the main site on other days if they wish to be seen. Patients accessing services at the branch site, will continue to be able to access services at the main site.

The Grahame Park Health Centre site is planned to be demolished in 2024 and redeveloped as part of the wider Colindale regeneration project. There is an anticipated increase in population of 11,950 by 2027. The branch site is co-located with another GP practice, The Everglade Practice. Both practices will be required to relocate as part of the regeneration work. Relocating the Parkview Surgery's branch site will be the first phase of this.

Parkview Surgery, has two rooms in the main surgery which were being used by the community dental service. The dental service is no longer being provided from the site and the clinical space has become available. The partners would like to refurbish these rooms to consolidate the list onto one site. The two clinical rooms will be a like for like replacement of the two clinical rooms currently in use at the Graham Park Health Centre. The move will also provide the flexibility at Grahame Park Health Centre to increase clinical space for the remaining practice to absorb the initial population. The capital required for the refurbishment has been secured through the EFFT programme.

Across these two premises the practice has a total of 5 clinical rooms (3 - main and 2 - branch).

On reviewing the patient to clinical room ratio, based on the current list size of 6639 (1st April 2020). This provides a ratio of 1 room to 900 patients.

The existing room to patient is in line with the Department of Health Building (HBN) Note calculator, which provides an indication of the number of clinical rooms required by general practice.

The Department of Health Building Note (DHHBN) estimator calculates for Parkview Surgery, at 6 contacts per annum at 70% utilisation the practice requires 6 rooms. At 80% utilisation the practice requires 7 rooms.

The DH HBN calculator also takes into consideration the number of attendances. At 70% utilisation the attendances are 796 per week for GP and nursing which is greater than the guide of 72 GP and 32 nursing which provides 699 per week.

Committee members should note that the practice is not proposing to increase the number of clinical rooms, only to have a like for like replacement at the main site.

3. Increase in Revenue

The estimated increase to the current CMR to the delegated budget will be by £6,335.

The contract holders are currently reimbursed the following;

- Total rent reimbursement £31,065
- Main surgery £27,067
- Branch surgery £3,997

The DV were instructed to carry out an assessment of the premises to include the two refurbished rooms, the new valuation has indicated a new CMR will be £37,400 excl. VAT, and therefore there will be an increase in rent of £6,335 per annum.

The contract holders are therefore requesting an increase in CMR to include the two new room once converted.

Committee members are asked to note that the practice did not have a lease in place previously, however, as part of the improvements, the landlord – CHCL, have offered the contract holder a 5 year lease.

If approval to the increase in CMR is given, the contract holders will be highlighted to the risk associated with the short term in the lease of 5 years.

Capital Costs

The partners are not requesting any capital to refurbish the two rooms, this will be funded by ETTF Funding.

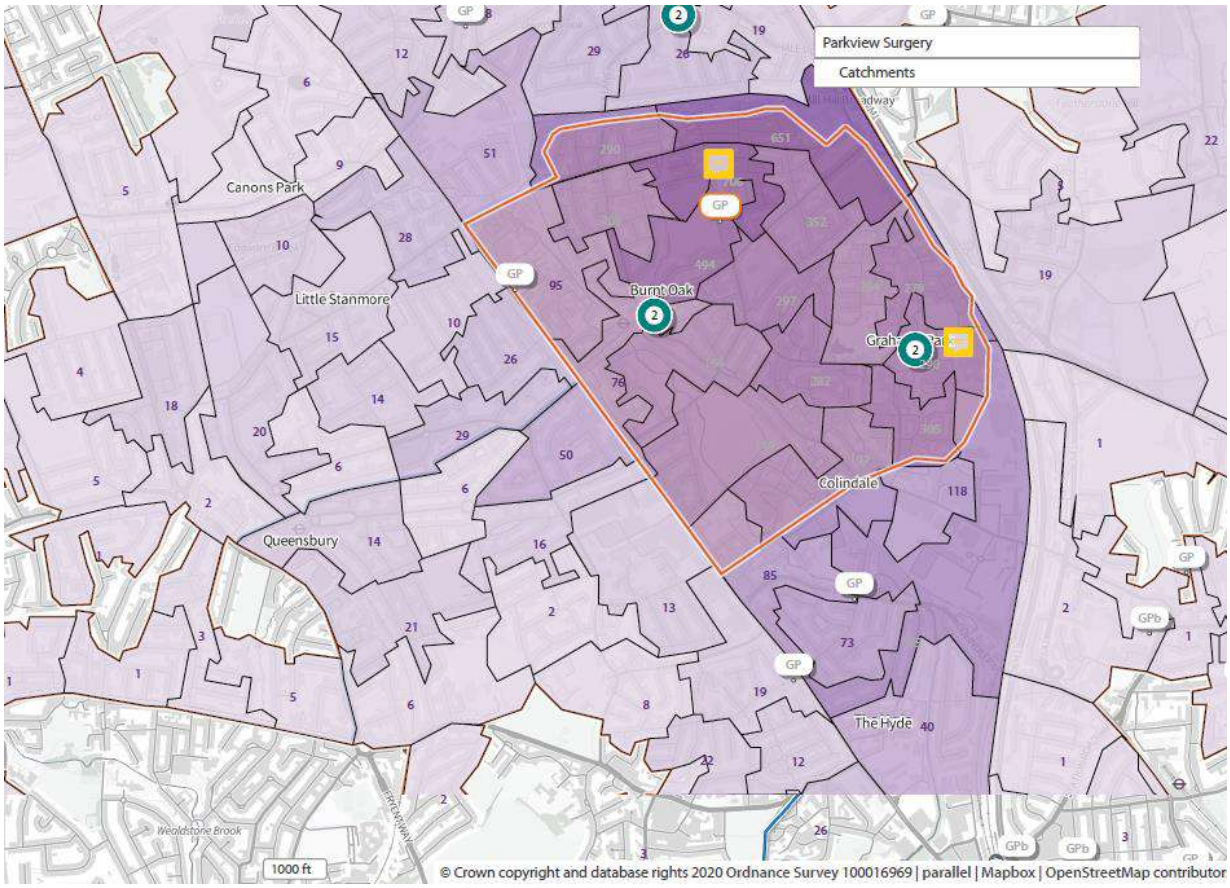
Next Steps

The contract holders will commence engagement with their patients if approval for the relocation is given. It is anticipated the refurbishment will take 8 – 10 weeks.

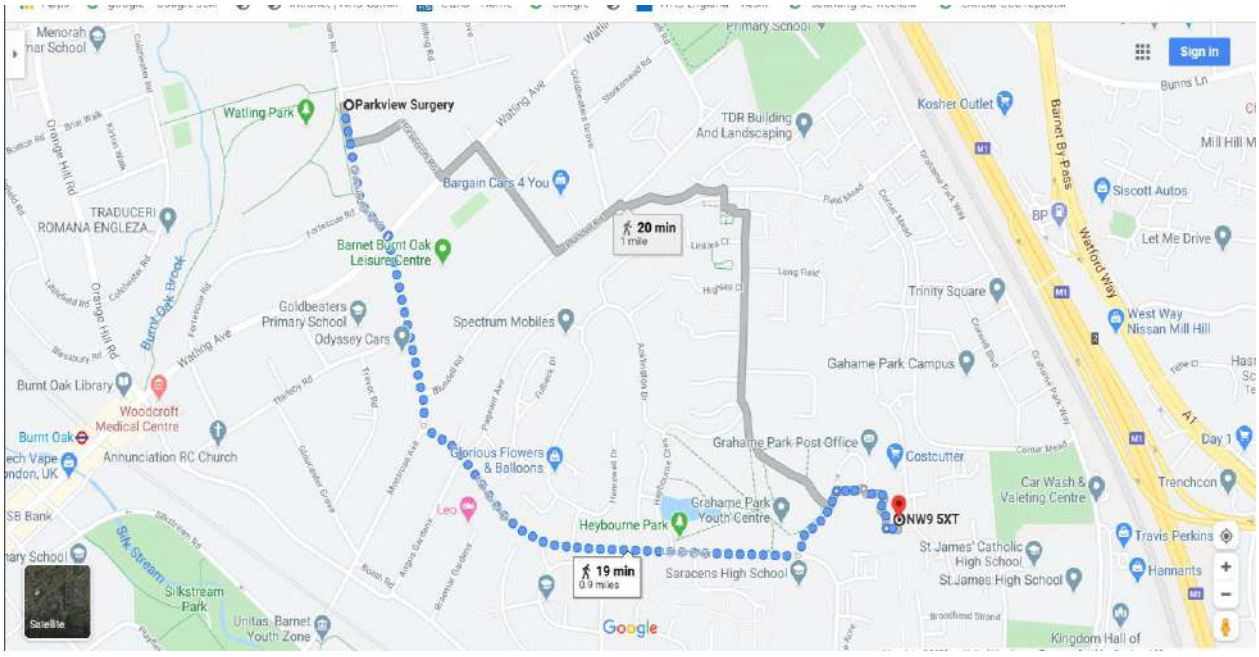
If committee members approve the relocation, commissioners will meet with the practices to convene a project group to complete actions and ensure that the conditions outlined above are met

Appendix 1 – Parkview Surgery Catchment Area and Distances between the two practices

Practice Catchment Area and the location of the two sites



Distance between the two sites



North Central London CCG
Primary Care Commissioning Committee Meeting
Thursday 23 July 2020

Report Title	Derwent Practice Relocation	**Date of report**	13 July 2020	**Agenda Item**	3.4
Lead Director / Manager	Colette Wood, Director of Primary Care Transformation , Barnet	**Email / Tel**		colette.wood1@nhs.net	
GB Member Sponsor					
Report Author	Vanessa Piper	**Email / Tel**		Vanessa.piper@nhs.net	
Name of Authorising Finance Lead		**Summary of Financial Implications** Increase in current market rent of £2,215 per annum			
Report Summary	This paper is being presented for committee members to consider the request to relocate Derwent Medical Practice to Torrington Park Health Centre, which is a ½ mile apart. The trigger for the relocation is the contract holders for Derwent Park Medical Practice and Torrington Park Group Practice had requested the following; 1. Variation of both PMS contracts so each contract holder is listed under both contracts, then form a partnership from 1 April 2020 2. Derwent Medical Practice to co-locate with Torrington Park Health Centre in 2020 3. Merger of the PMS contracts on 1 April 2021 The premises for Derwent Medical Practice is also a converted house which is not compliant with primary care premises standards. Torrington Park Health Centre is a purpose built primary care centre which is shared with the Community Health Provider. The landlord of the building is NHS Property Services. Committee members approved the variation of both PMS contracts in February 2020, and we are now asking committee members to approve the terms of the relocation. **Change to the Current Market Rent (CMR)** The new CMR will be £40,365, this is inclusive of 7.5% of a full repair and insuring lease, this means the contract holders will be responsible for reinvesting the 7.5% per annum for the upkeep of the internal areas they lease. The existing rent for Derwent Practice is £38,150, therefore the total increase in CMR will be £2,215 per annum.				

	Change in space Derwent Medical practice has requested a total of 8 rooms in the new building, 5 consulting rooms, waiting area and 2 multi-use rooms, which will be shared with Torrington Park Health Practice. With 5 consulting rooms this provides a room to patient ratio of 1 room: 1118 patients, for Derwent Medical Practice. There was not a case to relocate Derwent Medical Practice into the existing 12 consulting rooms Torrington Park Group Practice occupies. The combined list of both practices is 17,917 (April 2020), therefore would result in 1 room: 1, 493 patients. This ratio does not take into consideration any growth in the list. It is also greater than the Department Health (DH) Health Building notes (HBN) space estimator of 1 room : 1194 patients. The multi-use rooms will be for GPs to free up consulting rooms to do clinical administration, triage and telephone consultations. The second multi use room will be a shared admin staff room for both practices, which will free up space in the reception area, to enable Derwent Medical Practice staff to share the space. **Patient engagement** Derwent Medical Practice is ½ mile from Torrington Park Group Practice, therefore commissioners deem the impact of the relocation to be low, but the contract holders were requested to engage with patients to seek their views. Engagement has commenced with a small sub-set of patients at Derwent Medical Practice who are in favour of the relocation. If committee members approve the decision to relocate, we have asked the contract holders to carry out a wider engagement with patients to take in their views on any service changes or improvements prior to the relocation. **Capital funding** The practice advice that some of the rooms requested require some reconfiguration, IT cabling and compliant sinks. Therefore a separate capital bid for funding will be submitted to NHS England and Improvement. Commissioners do not deem these works will prevent the practice from planning and relocating, whilst they wait for the outcome of the capital funding. **Conditions to the relocation** The DV has valued the current market rent on the basis of a 15 year lease with 3 yearly rent reviews, therefore the contract holders will be asked to negotiate a lease on this basis, with appropriate breaks clauses. Head of Terms for the lease will also need to be signed prior to the relocation.
Recommendation	Committee members are asked to **APPROVE:** 1. Relocation of Derwent Medical Practice 2. Increase in Current Market Rent to £40,365 per annum 3. the approval to relocate is on the basis that the practice negotiates and signs Head of Terms for a lease, with a full lease being signed shortly after

Identified Risks and Risk Management Actions	*Not applicable*
Conflicts of Interest	*Not applicable*
Resource Implications	There will be an increase in CMR of £2,215
Engagement	A small group of patients have been engaged who are in favour of the relocation. A wider engagement will commence once the outcome of the committee decision is known.
Equality Impact Analysis	An Equality impact assessment was not required in this case. The distance of the relocation is ½ mile, commissioners deem the impact to patients to be low. There will also be no service change or reduction in service as part of the relocation. The contract holders are asked to engage and notify patients, specifically vulnerable groups, regarding the plans to relocate.
Report History and Key Decisions	Committee members in February 2020 approved a variation to the PMS contracts for Derwent Medical Practice and Torrington Group Practice, so the contracts holders are listed under each contract from 1 April 2020.
Next Steps	The merger of the PMS contracts will be brought to a future committee meeting.
Appendices	*Not applicable*

Background

Derwent Medical Practice has a current list size of 5,592 patients (April 2020). The practice has requested to relocate and co-locate with Torrington Park Health Centre whose list size is 12,325 (April 2020).

This is following a variation to the PMS contracts for both practices to enable the contract holders to be listed under each contract. Committee approved the variation in February 2020, and the change came into effect on 1 April 2020.

The partners have now requested the relocation of Derwent Medical Practice to be approved. The practices will initially operate with 2 clinical system in the co-located space and the final stage will be a merger of the contracts in 2021.

Current premises and space

Derwent Park Medical Practice operates out a converted house which does not meet premises standards. The practice has 6 clinical rooms, with a list size of 5,592 patients which provides a room to patient ratio of 1 room : 932 patients.

Torrington Park Group Practice operates from a purpose built primary care centre, which is shared with the Community Provider. The practice has 12 clinical rooms for a list size of 12,325 (April 2020) which provides a room to patient ratio of 1 room : 1027 patients.

Commissioners deem there is not a case to relocate Derwent Park Medical Practice into the existing space that Torrington Park Group Practice occupies. The combined list of both practices is 17,917 (April 2020) therefore if we co-locate both practices within the existing 12 clinical rooms, this provides a room to patient ratio of 1 room : 1493.

This room to patient ratio does not take into consideration any list size growth and is higher than the Department of Health (DH) Health Building Notes (HBN) estimator, which calculates 15 rooms at 80% utilisation, 6 contacts per annum and equates to a ratio of 1 room: 1194 patients.

The DH HBN calculator for the combined list size, estimates 96 GP appointments per week which is higher than the BMA guide of 72 GP appointments per week. Therefore takes into account any additional space requirements related to a wider workforce and partially supports the recent infection prevention and control space requirements relating to the pandemic.

Change in rent

Commissioners deem there is a case to approve the 8 rooms requested by the practice which consists of 5 consulting rooms, 2 multi-use rooms and 1 waiting area.

This is on the basis that the total increase in current market rent (CMR) will be £2,215 per annum following the relocation.

The current reimbursement for Derwent Medical Practice is £38,150 for 205.18m2, which includes 6 clinical rooms. The valuation has been based on the space requirements within a converted house therefore the metre square requirements cannot be a like for like comparison. c

The new space requested and valued by the District valuer is for 133.28m2, including 5 clinical rooms with an annual current market rent (CMR) of £40,365.

Capital funding

The practices have requested capital funding for IT cabling, reconfiguration of the multi-use rooms and compliant sinks.

Commissioners will be submitting a separate request for capital funding to NHS England and Improvement. We deem these works should not prevent the practices from planning and relocating.

Conditions to the approval

The contract holders will be notified that approval is on the grounds that a Head Lease is negotiated and signed prior to the relocation, with the full lease being signed shortly after.

The DV has assessed the CMR on the basis of a 15 year lease with 3 yearly rent reviews, therefore commissioners will advise the contracts that the term should be no shorter, with appropriate break clauses.

North Central London CCG
Primary Care Commissioning Committee Meeting
23 July 2020

Report Title	Barnet Directorate – Care Home LCS	**Date of report**	12 May 2020	**Agenda Item**	4.1
Lead Director / Manager	Colette Wood	**Email / Tel**		colette.wood1@nhs.net	
GB Member Sponsor	*Not Applicable*				
Report Author	Daniel Glasgow	**Email / Tel**		daniel.glasgow@nhs.net	
Report Summary	This Locally Commissioned Service (LCS – appendix 1) will help support general practice to deliver the ask for nursing and residential care homes patients as detailed in Dr Kanani's letter dated 1 May 2020 (see appendix 2), as well as the ability to respond to the additional pressure Covid-19 has placed on the care of patients in this cohort. This LCS is also intended to support practices to work with their PCNs to ensure that they are in prime position to be able to deliver the Network DES service specification for care homes when it formally launches in October 2020. This LCS is in addition to the work that is ongoing around the development of an 'In-reach' and multi-disciplinary team model for care homes in Barnet. This is deemed essential to bridge the gap between the ask of Dr Kanani's letter and formal launch of the Network DES service. A virtual meeting was held by colleagues of PCCC on 13 May 2020 as an urgent decision required for sign off of this LCS. **The Committee APPROVED the launch of the Locally Commissioned Service (LCS) for supporting Care Homes within the Barnet Directorate.**				
Recommendation	To **NOTE** the launch of the Locally Commissioned Service (LCS) for supporting Care Homes within the Barnet Directorate.				
Identified Risks and Risk Management Actions	There is a financial risk of transition from this short-term Locally Commissioned Service to the new primary care DES - as this is funded at a higher level than the national DES. This however is a NCL wide risk and isn't isolated to Barnet. From a Barnet perspective, this will be mitigated by clearly communicating this to the GPs from the outset, to manage expectations. Minor risk pertaining to practices not signing up to the Locally Commissioned Service but this will be mitigated by offering practices the option of signing up to the DES at a Primary Care Network (PCN) Level, as an alternative				

Conflicts of Interest	*Not known.*
Resource Implications	There are no resource implications beyond the identified funding limit of £562k.
Engagement	• Task and Finish Group with directorate clinical leads, PCN Directors, LMC and Training Hub • Barnet Directorate Senior Management Team • Executive Management Team
Equality Impact Analysis	All care homes beds will be covered through this Locally Commissioned Service
Report History and Key Decisions	*Not Applicable*
Next Steps	Following the virtual approval of the Committee: • The scheme was launched on 14th May 2020 • Contract variations have been agreed for all participating practices. • All appendix documents to LCS have been developed and shared with participating practices. • The LCS will continue to be managed and monitored by the Primary Care team.
Appendices	• Appendix 1 – Barnet Care Home LCS • Appendix 2 – Dr N Kanani Letter, 1st May 2020

North Central London
Clinical Commissioning Group

Service	**Locally Commissioned Service Specification for Nursing & Residential Care Homes**
Commissioning lead	**Primary Care: Barnet borough** **Kelly Poole/Carol Kumar** **Asst. Director of Primary Care transformation (job share)** **carol.kumar@nhs.net** **kelly.poole@nhs.net**
Provider lead	**General Practice**
Period	**1 May 2020- 31 October 2020**
Version	**V0.9**

This Locally Commissioned Service (LCS) will help support general practice to deliver the ask for nursing and residential care homes patients as detailed in Dr. Kanani's letter dated 1 May 2020 (see appendix 1), as well as the ability to respond to the additional pressure Covid-19 has placed on the care of patients in this cohort.

This LCS is also intended to support practices to work with their PCNs to ensure that they are in prime position to be able to deliver the Network DES service specification for care homes when it formally launches in October 2020.

This LCS is in addition to the work that is ongoing around the development of an 'In-reach' model for care homes in Barnet.

We would strongly encourage all practices who have patients registered in one of the homes detailed on the list in appendix 2 to sign up to this LCS, and will be required to provide the services as set out in section 3 of this service specification. If a practice chooses not to sign up, the CCG will seek to work with that practice's PCN to provide a solution in order to ensure equity of provision for all patients residing in the homes detailed in appendix 2.

1. National/local context

Primary care and community health services nationwide are under increasing pressure to provide an enhanced level of care to patients in care homes and this has been further exacerbated by the COVID-19 crisis. Care home residents are particularly vulnerable to COVID-19 as a consequence of their complex medical problems and advanced frailty.

Barnet has almost 50% of the care home bed capacity in NCL, with no NHS support to in-reach and support care home staff, unlike the other 4 CCG areas who have in place a locally commissioned service or community in-reach service. We therefore do not have a strong foundation from which to build in the new service requirements. We are working at pace whilst responding to COVID-19 to ensure that these expectations can be met.

In Barnet, we can only achieve this via an LCS, to pump-prime primary care so that they are in a position to meet the ask of the 1 May letter and to be able to fully and wholly

deliver the DES requirements in October. In addition to this, the work to launch an in-reach model for care homes is ongoing.

2. Outcomes

This local incentive scheme will ensure that practices can offer:

- *timely access to clinical advice for care home staff and residents*
- *proactive support for people living in care homes, including through personalised care and support planning as appropriate*
- *care home residents with suspected or confirmed COVID-19 are supported through remote monitoring – and face-to-face assessment where clinically appropriate – by a multidisciplinary team (MDT) where practically possible (including those for whom monitoring is needed following discharge from either an acute or step-down bed) and*
- *sensitive and collaborative decisions around hospital admissions for care home residents if they are likely to benefit.*

3. Scope and Service Delivery

This LCS should be delivered for all care homes. To confirm, a 'care home' is defined as a CQC-registered care home service, with or without nursing. A full list of registered CQC care homes can be found on the application form and practice contract variation document in appendix 2.

- Practice should have a named lead and deputy GP to ensure that the specification is met.
- The practice should hold an up to date register of care home patients
- Practice should ensure they have a named administrative person to manage the LCS
- Delivery of a consistent, weekly (virtual) 'ward round', to review patients identified as a clinical priority for assessment and care. Practices commissioned to provide this LCS should use the funding to ensure that they are able to free up GP capacity to support the requirements of the LCS.
- The weekly ward round should:
    - *Be delivered by the practice designated GP.*
    - *Where practically possible, primarily and remotely wherever appropriate and practically possible, be supported by an MDT.*
    - *This MDT should draw on general practice and community services staff and expertise, including advanced nurse practitioners, clinical pharmacists, social prescribing link workers, dental care, and wider specialist services (e.g. geriatrician and dementia services).*
    - *Review patients identified as a clinical priority for assessment, including but not limited to those with suspected or confirmed COVID-19 symptoms, in line with the protocols established in the primary care standard operating procedures and the community services standard operating procedures.*
    - *Support the provision of care for those patients identified as a clinical priority*
    - *Include appropriate and consistent medical oversight and input from a lead practice GP (with the frequency and form of that input determined by clinical judgement)*
    - *Support the introduction and use of remote monitoring of COVID-19 patients using pulse oximeters and other equipment (which may be supplied directly to care homes or eligible for practice reimbursement), and prescription and supply of oxygen to care homes for treatment, where clinically indicated.*

- *Practices must confirm they are able to use the digital links via the iPads that have been issued to support care homes. Any issues concerning iPad and/or communications with the care home must be reported to the Primary Care team.*

- Care Home and Residents Support shall include:
  - *Provision of timely access to clinical advice for care home staff and residents.*
  - *Complete initial assessments for new patients on admission to the home within 7 days. Care plan to include information on consultation frequency, based on previous medical records.*
  - *In preparation for visits to the home, the Practice lead clinician or deputy shall have appropriate records and details of the patients available and liaise with appropriate staff from the care home to highlight concerns and actions. Where notes are not available, the Practice should ensure that a full and comprehensive history is obtained.*
- The Practice must provide care to all patients admitted to the home, regardless of the patient's length of stay.
- Development and delivery of personalised care and support plans for care home residents. A process needs to be established to:
  - *Support development of personalised and individually agreed treatment escalation plans for care home residents with care home teams, including mental health care plans and end of life care plans and preferences where appropriate. Ideally the care plan should be record on 'Co-ordinate my Care' (CMC), and practices can also draw on other available guidance and templates. Where time and resources are limited the advance care planning process should not be rushed and appropriate time found as soon as reasonable to complete the task with care and compassion. Practices are advised to use the NHS England Advanced Care Planning guide, which is attached in appendix 3.*
  - Where possible, primary care clinicians should share information on the level of frailty of residents (mild, moderate, severe frailty) with care homes, and use the Clinical Frailty Scale to help inform urgent triage decisions.
  - Out-of-Hours (OOH) cover is provided by the Borough OOH provider. Practices providing the service must ensure that they keep the Coordinate my Care (CMC) register up to date after any major review, so that the relevant other providers (such as OOH community nursing and the Specialist Palliative Care team) have access to the most up to date details for patients
- Provision of pharmacy and medication support to care homes. CCGs, PCNs and practices should co-ordinate pharmacy teams (including CCG employed pharmacists and pharmacists working as part of the Medicines Optimisation in Care Homes (MOCH) programme) to provide support to care home residents and staff (see appendix four for NHS England guidance on managing medicines in a care home overview and running a medicine reuse scheme in a care home or hospice setting). This support should include:
  - *Facilitating medication supply to care homes, including end of life medication where required*
  - *Work towards delivering structured medication reviews within one month of their admission to the care home and a care plan to be put in place as applicable.*
  - *Supporting reviews of new residents or those recently discharged from hospital within 7 days.*

    - *Supporting care homes with medication queries, and facilitating their medicines needs with the wider healthcare system (e.g. through medicines ordering).*
- Ensure appropriate infection prevention and control:
    - *All eligible patients shall be offered the relevant vaccinations (e.g. influenza, pneumococcal and shingles vaccinations), in line with national immunisation programme and the GMS contract.*
    - *The practice shall support and help adherence to Public Health England (PHE) protocols for the management of infection outbreaks in care homes.*
- The Practice also agrees to:
    - *Agree the weekly virtual 'ward round' timetable with the home so that a mechanism can be established for concerns and issues raised by staff and relatives to be addressed*
    - *Respond to urgent visit requests the same day they are requested;*
    - *Offer access to community palliative care*
    - *Try to ensure that routine visits are not made during patient meal times;*
    - *Ensure that adequate contingency arrangements are in place to provide full cover for the LCS, should planned or unplanned changes in service arise;*
    - *Give reasonable notice of any planned or unplanned changes to ward round timings to allow home staff to inform relatives who may have made an appointment;*
    - *Ensure care home have contact details for a single point of access/lead GP.*
    - *Ensure care homes are aware of how to access out of hours services .*
    - *Ensure care homes are aware of opening hours and location of out of hour pharmacies local to them (Practices can seek advice from the CCG Barnet directorate if they are unsure of this information).*
    - *Ensure care homes are aware of how to access palliative care support and end of life medication during out of hours.*
    - *Issue routine repeat prescriptions within 48 hours of the request;*
    - *Support Care Home Nursing staff to contribute to the management of complex cases;*
    - Ensure that the resuscitation status of a resident is established, documented and reviewed on a regular basis;
    - Discuss and share management of the care plan with the patient, the patient's relatives, home staff and other professionals as appropriate.
    - Meet the Quality & Outcomes Framework (QOF) standards (if appropriate, avoid unnecessary tests in very elderly or patients with dementia);
    - Provide a medical report, if requested, when a client is presented to a complex care panel or community care panel;
    - Serious Untoward Incidents (SUIs) are reported and managed appropriately, as per section 4 of this specification.
- Practices should also utilise funding under this LCS to prepare for the launch of the Nursing Homes service specification when it is launched in October 2020. This will include a full plan detailing how care will move to PCNs and assignment of homes accordingly. Plans will also detail arrangements for MDT review at PCN level (supported by the launch of an 'In-reach' model), moving away from practice level arrangements and for implementation by the DES deadline. An action plan template is provided for this in appendix five.

COVID-19 Response: LCS requirements

- Care home residents with suspected or confirmed COVID-19 are supported through remote monitoring – and face-to-face assessment where clinically appropriate – by a multidisciplinary team (MDT) where practically possible (including those for whom monitoring is needed following discharge from either an acute or step-down bed) and sensitive and collaborative decisions around hospital admissions for care home residents if they are likely to benefit.
- Support the introduction and use of remote monitoring of COVID-19 patients (As detailed above)
- A need for new GP patient reviews should residents test positive or return back to the home following a COVID-19 related inpatient stay.
- Support around EOLC planning, in addition to regular EOLC planning and acknowledging the increase in work required because of the COVID-19 crisis

4. Applicable quality requirements

- The practice is registered with the Care Quality Commission (CQC).
- All staff working with care home residents should recognise that COVID-19 may present atypically in this group. It will be necessary to use barrier precautions for residents with atypical symptoms following discussion with General Practitioners or other primary healthcare professionals.
- There are some situations in which supportive treatments such as care home based oxygen therapy, antibiotics and subcutaneous fluids should be supported as part of the local responses to COVID-19. The harms and benefits of such treatments must be considered carefully and they should not be used in place of good palliative care.
- Advance Care Plans must be recorded in a way that is useful for healthcare professionals called in an emergency situation. A paper copy should be filed in the care home records and, where the facility already exists, an electronic version used which can be shared with relevant services.
- All professionals should consider setting up multiprofessional local or regional WhatsApp groups, or other similar fora, to provide support to care home staff who may feel isolated and worried by the pandemic.
- Practices shall report all patient safety incidents (including near misses) to the National Reporting and Learning System (NRLS) using the GP-eform, as soon as they are identified and prior to the investigation commencing (whether they result in harm or not).
- Practices shall email complaints from the Care Home and patient feedback relating to this LCS service to the Primary Care Commissioning Team (barccg.barnetccgprimarycare@nhs.net) and Quality & Safety Team (barccg.quality@nhs.net).

5. Payment schedule

Each practice commissioned to provide the LCS will be reimbursed on the rates below:

- £450 per bed, per year (as this is a 6 month LCS, practices will be paid £225 per bed for this period). To be paid quarterly, up front.
- Based on 2501 CQC registered beds, across 83 homes (not including four cross-border homes), this represents an investment of £562, 725 over 6 months in Barnet General Practice (see appendix two for a list of homes).
- Practices who look after patients in the cross-border care homes named in appendix two are eligible to apply for reimbursement under this LCS as they are registered with a Barnet GP.

6. Training

- All care homes should have access to a pulse oximeter, thermometer and blood pressure machine to support remote assessments and monitoring. If there is an

identified learning need, in that the home is unable to utilise this equipment, the GP practice should signpost the home to appropriate training (which can be resourced via the NCL training hub)
- The named lead clinician responsible for the care homes should be capable of recording care plans on CMC. Training should be undertaken if necessary to achieve this.
- Pharmacists working in care homes as part of this LCS need to be skilled at managing poly-pharmacy and de-prescribing, including utilising tools such as the STOPP START tool. Practices should ensure pharmacists are supported in accessing this training and supported in developing the necessary knowledge and skills
- MDT working is less well developed in primary care and practices may need to upskill to ensure the multi-disciplinary team is utilised to maximum effect
- Where practice nurses have a role in supporting advanced care planning in care homes, practices should support their nursing staff in accessing appropriate training
- Practice clinical leads need to have a working knowledge of geriatric assessments, dementia assessments, advanced care planning and managing multi-morbidity & polypharmacy. Each lead needs to ensure appropriate training is undertaken as necessary.
- If new templates are introduced appropriate training will be provided and practices need to ensure this training is accessed in a timely fashion and the templates utilised appropriately so that data is coded correctly and can be collected to inform better management of care home residents.

7. Performance/Monitoring

Commissioned practices will be required to complete an audit template at the end of month 3. Further information will follow on this and will be added as appendix 6.

8. Exit and Suspension arrangements

The Contractor can terminate the scheme by providing one month's written notice to the CCG Primary Care Team. The CCG may terminate the scheme within 28 days if, following suspension of payments, the contractor fails to re-establish services according to the service specification or take appropriate action to address deficiencies within eligibility criteria. Before issuing an exit notice, the parties will meet to discuss the reason for termination. If after this meeting the reason for terminating is not resolved then the relevant partly will issue an exit notice.

Either primary care providers or the CCG can exit this agreement by providing a minimum of 28 days' written notice.

Either party can appeal against a suspension or termination notice to Barnet Directorate's Director of Primary Care Transformation.

Payments under the scheme will be suspended if at any time the practice is unable to provide services in line with the service specification or fail to meet contractor eligibility criteria. Before any suspension the practice and Barnet directorate, NCL CCG will meet discuss the reason for the suspension identifying any possible resolution. If the matter is not resolved the CCG will issue a suspension notice to the practice within seven days.

Appendices

Appendix 1: Letter from Dr Kanani, 1 May 2020	*Attached*
Appendix 2: Application form and contract variation	TO BE ADDED ON 13 MAY
Appendix 3: NHS England Advanced Care Planning Guidance	Attached

Appendix 4: NHS England guidance on managing medicines in a care home overview and running a medicine reuse scheme in a care home or hospice setting	Attached
Appendix 5: DES Service Specification action plan template	TO BE ADDED BY END OF MAY
Appendix 6: Audit template	TO BE ADDED BY END OF MAY

Publications approval reference: 001559

To:
GP practices and primary care networks
CEOs of community health providers
Regional directors of primary care
CCG accountable officers

NHS England and NHS Improvement
Skipton House
London Road
London
SE1 6LH

1 May 2020

Dear Colleagues,

COVID-19 response: Primary care and community health support care home residents

Thank you for all your continued extraordinary efforts to transform your services and ways of working to support the effective NHS management of the COVID-19 pandemic.

As you may know, care homes are reporting that the COVID-19 pandemic is posing a significant challenge. This calls for continued and further immediate assistance through Local Resilience Forums, and as highlighted in Simon Stevens' and Amanda Pritchard's 29 April letter to NHS leaders about the Second Phase of NHS Response to COVID-19.

So, alongside (i) continued NHS testing of all patients prior to discharge to care homes, (ii) clinical commissioning groups (CCG) directors of nursing assisting local authorities with training in infection prevention and control, (iii) supporting different staff groups to take up opportunities in care homes, we are (iv) **requesting primary care and community health services help, building on what practices are already doing, to support care homes.**

The model described in this letter has already been established – and is in the process of being implemented – in much of England. Where local arrangements go beyond the service model set out, and are working well for care homes, these should not be disrupted. The healthcare needs of care home residents – combined with the impact of the COVID-19 pandemic – means that the task of completing the job of implementation across the country is more urgent than before. Where this service does not exist, it therefore needs to be established as part of the COVID-19 response by CCGs, working with general practice, community services providers,

care homes, local medical and pharmacy committees and wider partners in their area.

The guidance set out below draws on key elements of existing evidence-based guidance and good practice, and updates this in order to bring it in line with the needs of care home residents during the current COVID-19 situation.

Practices and community providers will want to ensure:

- timely access to clinical advice for care home staff and residents
- proactive support for people living in care homes, including through personalised care and support planning as appropriate
- care home residents with suspected or confirmed COVID-19 are supported through remote monitoring – and face-to-face assessment where clinically appropriate – by a multidisciplinary team (MDT) where practically possible (including those for whom monitoring is needed following discharge from either an acute or step-down bed) and
- sensitive and collaborative decisions around hospital admissions for care home residents if they are likely to benefit.

We are looking for all practices to take part, not just Primary Care Networks (PCNs). However, it will be less burdensome for general practice, easier for community partners and better for care homes for this to be delivered at a PCN level as the default. The intention is that from 1st October, the model will be adapted to support the service specification already set out in the Network Contract Directed Enhanced Service.

COVID-19 care home support

Clinical service model

1. CCGs – working with general practices, community health services providers and engaging LMCs – should take immediate steps to implement the following support for care home residents:

    a) **Delivery of a consistent, weekly 'check in', to review patients identified as a clinical priority for assessment and care.** The weekly check in should:

        i. be delivered – primarily remotely wherever appropriate – by an MDT where practically possible, drawing on general practice and community services staff and expertise, including advanced nurse practitioners, clinical pharmacy, social prescribing link workers, dental care, and wider specialist services (eg geriatrician and dementia services) where appropriate

ii. review patients identified as a clinical priority for assessment, including but not limited to those with suspected or confirmed COVID-19 symptoms, in line with the protocols established in the primary care standard operating procedures and the community services standard operating procedures

iii. support the provision of care for those patients identified as a clinical priority

iv. include appropriate and consistent medical oversight and input from a GP and/or geriatrician (with the frequency and form of that input determined by clinical judgement)

v. support the introduction and use of remote monitoring of COVID-19 patients using pulse oximeters and other equipment (which may be supplied directly to care homes or eligible for practice reimbursement), and prescription and supply of oxygen to care homes for treatment, where clinically indicated and

vi. be supplemented by more frequent contact with the care home where further needs are identified.

b) **Development and delivery of personalised care and support plans for care home residents.** A process needs to be established to:

i. Support development of personalised and individually agreed treatment escalation plans for care home residents with care home teams, including end of life care plans and preferences where appropriate and drawing on available guidance and templates (including from the Royal College of General Practitioners and the joint statement from the British Medical Association, Care Provider Alliance, Care Quality Commission, and Royal College of General Practitioners). Where time and resources are limited the advance care planning process should not be rushed and appropriate time found as soon as reasonable to complete the task with care and compassion.

c) **Provision of pharmacy and medication support to care homes.** CCGs, PCNs and practices should co-ordinate pharmacy teams (including CCG employed pharmacists and pharmacists working as part of the Medicines Optimisation in Care Homes (MOCH) programme) to provide support to care home residents and staff. This support should include:

i. facilitating medication supply to care homes, including end of life medication

ii. delivering structured medication reviews – via video or telephone consultation where appropriate - to care home residents

iii. supporting reviews of new residents or those recently discharged from hospital

iv. supporting care homes with medication queries, and facilitating their medicines needs with the wider healthcare system (eg through medicines ordering).

Service enablers

2. **To deliver this support, CCGs should take immediate steps to support individual practices and community health services teams to organise themselves according to their local areas or networks**. Existing PCN arrangements should be the default. A network approach to delivery – backed by appropriate information sharing arrangements – will ensure that individual care homes have a single point of access for the majority of their residents and should reduce the infection control risks associated with multiple teams visiting individual care homes. As part of this process, networks should identify a named clinical lead for each care home.

3. **CCGs must ensure that clear and consistent out of hours provision is in place for each care home.** Out of hours provision to care homes may be provided via out of hours providers and community health services and should include arrangements for the supply and availability of medication through community pharmacy or other routes. This support must be clearly signposted to care homes.

4. **Secondary care providers should accept referrals and admissions from care home residents where clinically appropriate**, considering individuals' care and support plans and the benefits and risks of escalation to hospital-based care.

5. Wider guidance to support care homes and the Government's action plan for adult social care provide wider information for care homes (including on management of COVID-19 cases within care homes, testing for care home staff and residents, the provision of remote consultation support to care homes, and personal protective equipment) and should be read alongside this document.

Scope and timescales

6. **This support should be delivered for all care homes.** A 'care home' is defined as a CQC-registered care home service, with or without nursing.

7. **This model should be established as soon as possible, and within a fortnight at the latest in order to support residents as quickly as possible.**

8. **NHS England and NHS Improvement will collect regular 'sitrep' data from CCGs, starting next week, to understand the support being provided to care homes and the coverage achieved across the country.** This will provide information on whether there are local issues which need to be addressed and whether regulatory provisions are required. We will also look to collect information from care homes on the impact this service is having.

9. **We will also run dedicated webinars, to share examples of good practice and practical implementation challenges and offer regional and system level support where needed.**

10. **Additional costs for general practices and community health services providers – which cannot be met from their existing resources – may be eligible for reimbursement.** A reimbursement mechanism for general practice will be established to help practices meet the additional costs of COVID-19 related activity which cannot be met from existing practice resources. Reimbursement will be managed through CCGs, on the basis of national guidance. Community services providers should consult the letter of 17 March.

Further queries

11. Those seeking further information should contact their NHS England and NHS Improvement Regional Team in the first instance. Contact details are available here.

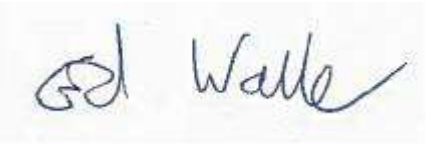
12. **Thank you again for your responsiveness and renewed commitment to supporting care homes, their staff and their residents, during the COVID incident,** in the context of a very fast-moving and difficult situation for everyone in the NHS and social care. We will do our best to provide as much support as we can nationally, regionally and locally to facilitate this.

Dr Nikki Kanani
Medical Director for Primary Care
NHS England and NHS Improvement

Matthew Winn

Director of Community Health

NHS England and NHS Improvement



Ed Waller
Director for Primary Care Strategy
and NHS Contracts
NHS England and NHS Improvement

Publications approval reference: 001559

My COVID-19 Advance Care Plan

Updated 11 May 2020

Guidance and template in the context of coronavirus (COVID-19)

This guidance is correct at the time of publishing. However, as it is subject to updates, please use any hyperlinks to confirm the information you are disseminating to the public is accurate.

Guidance notes for completing 'My COVID-19 Advance Care Plan'

What is a 'COVID-19 Advance Care Plan'?

It is a page of information written by you, with your family or friends (or somebody else if you need help). It is a place to write down quickly and in one place, the thoughts and wishes you have on the care and support you would like if you develop severe COVID-19 symptoms.

This does not replace any advance care plan or care and support plan you may already have. You may wish to use some of the information in your existing advance care plan to complete this one.

The information you write here can be used when talking with the medical team supporting you and provide information the team might otherwise not be aware of. In the event of you being unable to say your wishes, the information you provide could be useful in helping clinicians to consider your views when making clinical decisions about your ongoing care. To help this happen, you may choose to keep a copy with you and ask those supporting you (such as your GP) to keep a copy in your notes or on your file.

Any emergency contacts listed will be for the medical team to use if they need to speak to someone. The people you list will not be able to make decisions (even if they are your next of kin) unless they already have a legal position to do that, such as a lasting power of attorney (for health and welfare). For more information on creating a lasting power of attorney or the Mental Capacity Act, please visit the GOV.UK website.

COVID-19 Advance Care Plan is **not** an advance decision (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) to refuse a specific type of treatment at some time in the future. If you feel strongly about specific future treatments, you should discuss this with a doctor or nurse who knows you well. They will help you to understand how to make sure this is recorded properly and legally.

More information on this, Advance Decisions to Refuse Treatment, and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) can be found on the NHS website here.

Advance Care Plan guidance

To help you complete your COVID-19 Advance Care Plan, we have explained what you might like to include in each of the boxes.

My name; NHS number; I like to be known as	Basic information about your name, NHS number, and what you like to be known as.
Summary of my health conditions	Briefly list any underlying health conditions you have.
Who am I?	Let us know a few things about you as a person.
Three important things I want you to know	Write any particular wishes and preferences you have here. You might also like to state here if you have DNACPR, Advance Decision to Refuse Treatment, or lasting power of attorney – and where a copy is kept.
Medication I take	A list of your medication, the doses and frequency.
How my medication is administered	How you take your medication, eg orally, through a PEG, etc.
How I communicate	It may be that you don't usually use words to speak; or English isn't your first language, and a family member interprets for you. It might be useful to know how you would indicate distress or discomfort if you are unable to speak.
My emergency contacts	List the names and numbers of people you would like us to contact in an emergency, to keep them informed of your condition.

Planning my care during COVID-19

My name:	NHS number:
I like to be known as:	
Summary of my health condition(s) …	
Who am I? Something about me as a person …	
Three important things I want you to know …	
1.	
2.	
3.	
Medication I take …	
How my medication is administered…	
How I communicate …	
My emergency contacts	
Who has a copy of this?	
1 Name:	2 Name:
Relationship to me:	Relationship to me:
Telephone number:	Telephone number:

Publications approval reference: 001559

Version 1, 23 April 2020

Department of Health & Social Care

NHS

Novel coronavirus (COVID-19) standard operating procedure

Running a medicines re-use scheme in a care home or hospice setting

This guidance is correct at the time of publishing. However, it is subject to updates so please use the hyperlinks to confirm you are accessing the most up-to-date information.

Contents

1. Purpose

This standard operating procedure (SOP) supports timely access to essential prescribed medicines during the COVID-19 pandemic for patients who are being cared for in a care home[1] or hospice setting.[2] In England, care homes can offer nursing and personal care or personal care only. The latter may not employ any registered nurses. This guidance is applicable in England and for use during the COVID-19 pandemic only.[3]

Care homes and hospices in Northern Ireland, Scotland and Wales should refer to guidance and SOPs produced by the governing bodies and regulators in their devolved administration.

2. Background

COVID-19

Public Health England has issued guidance on managing COVID-19 in a residential care setting.

Managing medicines

NICE has issued good practice for managing medicines in care homes. The guidance promotes safe and effective use of medicines in care homes by advising on processes for prescribing (including remote prescribing), handling and administering medicines. It also recommends how medicines (including controlled drugs) should be received, stored and disposed of within a care home setting. That guidance includes a recommendation that care home providers must ensure that medicines prescribed for a resident are not used by another resident.

Although this remains good practice, this new Standard Operating Procedure is designed to help providers manage situations where, during the COVID-19 pandemic, the best interest of patients mean that it is not appropriate to follow this recommendation.

Recycling/re-use of unused medicines

The Human Medicines Regulations 2012[4] are the legislation that underpins the dispensing and supply of medicines, supplemented in the case of controlled drugs by the

[1] The Care Standards Act 2000 defines a 'care home' as accommodation that provides nursing or personal care.
[2] Hospice care aims to improve the quality of life and wellbeing of adults and children with a life-limiting or terminal condition. It helps people live as fully and as well as they can to the end of their lives, however long that may be.
[3] The up-to-date status of the COVID 19 pandemic is confirmed at https://www.gov.uk/coronavirus
[4] http://www.legislation.gov.uk/uksi/2012/1916/contents/made

Misuse of Drugs Regulations 2001. Part 12 of the Human Medicines Regulations 2012 limits the supply of prescription-only medicines (POMs) to supply in accordance with a prescription of an authorised prescriber, subject to various exceptions including supply under a patient group direction (PGD).

Provided that a supply is, in fact, in accordance with the prescription, for the specific purposes of Part 12 of the Human Medicines Regulations 2012, it will generally not be relevant how that medicine is sourced.

Accordingly, if at each stage of the supply chain the legal requirements relevant to that stage have been adhered to, the possibility exists that providers may have in their possession medicines that they are lawfully entitled to have in their possession for one purpose which they may be able to use for another purpose. This new guidance is to support making appropriate use of that recognised possibility in care homes and hospices.

When a patient is prescribed a medicine, once the final supply of the medicine is completed and it is in the patient's safe keeping, it is their property (although not their exclusive responsibility). If the medicine is still in the safe custody of the care home or hospice care provider, whether or not the final supply to the patient has been completed is the subject of differing legal views. Some would say that it becomes the patient's property as early as when it leaves the pharmacy.

This guidance does not seek to resolve these complex legal issues. Rather, it presents an agreed line through them, in the current very unusual circumstances, and that agreed line is strictly for the limited purposes which the guidance addresses.

Under usual circumstances, the re-use or recycling of another patient's medicine is not recommended by the Department of Health and Social Care (DHSC) as the quality of any medicine that has left the pharmacy cannot be guaranteed. Any unused medicines would normally be disposed of by returning them to a contracted external company or community pharmacy.

However, there are increasing concerns about the pressure that could be placed on the medicines supply chain during the peak of the COVID-19 pandemic. A medicines re-use scheme for care homes and hospices could potentially ease some of that pressure in the coming weeks.

Medicines re-use schemes already operate successfully in NHS hospitals across the UK. In addition, hospices and care homes generally have good procedures in place to store

medicines in an appropriate way. We can therefore be more confident of the quality of any unused medicines in these settings.

Due to the current unprecedented impact of COVID-19, DHSC and NHS England and NHS improvement are recommending a relaxation of previous recommendations and the NICE recommended good practice guidance to accommodate re-use of medicines, under very specific circumstances and only in a crisis situation as outlined.

First and foremost, the quality, integrity and safety of medicines are paramount and the best way to assure this is for pharmacies to supply medicines obtained through the regulated supply chain, appropriately labelled for individual patients.

However, in the unprecedented COVID-19 situation, DHSC and NHS England and NHS Improvement recognises that the re-use of medicines may be appropriate in certain circumstances. It is recommended that medicines should only be re-used in accordance with a medicines re-use scheme, set out in a SOP.

This SOP has been developed to support care home and hospice providers. It offers a framework to run a safe and effective medicines re-use scheme that is in the best interest of patients.

3. Medicines re-use scheme SOP for care homes and hospices

When would this apply?

This is time limited and would only apply during this period of emergency. i.e. during the COVID-19 pandemic.

What might constitute a crisis?

Each individual care home or hospice must carry out a risk assessment on an individual medicine basis.

Three key indicators should inform the risk assessment and the subsequent decision:

- No other stocks of the medicine are available in an appropriate timeframe (as informed by the supplying pharmacy) and there is an immediate patient need for the medicine.
- No suitable alternatives for an individual patient are available in a timely manner i.e. a new prescription cannot be issued, and the medicine(s) supplied against it in the conventional manner quickly enough.
- The benefits of using a medicine that is no longer needed by the person for whom it was originally prescribed or bought, outweigh any risks for an individual patient receiving that unused medicine.

Is a medicine suitable for re-use?

The medicine must be checked against the criteria in Tables 1 to 3 (see below) by a registered healthcare professional.[5]

Where no registered healthcare professional is on site (eg in a care home that only offers personal care and has no registered nurses on site), registered healthcare professionals (eg pharmacists, pharmacy technicians, general practitioners, community nurses) from other local organisations, such as clinical commissioning groups, general practices or community settings, can perform that check (this may be done virtually) and confirm that the medicine is suitable for re-use.

All medicines no longer needed by the person for whom they were originally prescribed and intended for re-use must be under the supervision of a registered healthcare

[5] A healthcare professional should be registered with one of the UK's professional regulatory bodies regulated by the Professional Standards Authority.

professional and appropriate records should be kept, including details of the registered healthcare professional who performed the check on suitability for reuse.

If the medicine suitable for re-use is a controlled drug, then it must remain in the control (possession) of an organisation authorised to do so. Further information from the Home Office can be found here. Appropriate records (e.g. controlled drugs register) **must** be maintained in respect of controlled drugs.

This SOP applies to medicines that have been supplied to patients while in a care home or a hospice, have not been removed from that setting (other than for short periods e.g. an outpatient appointment) and have been stored in accordance with good practice guidance on storing medicines in a managed setting. It applies to all medicines, including liquid medicines, injections (analgesics, insulin), creams and inhalers, that are in sealed or blister packs and when the criteria in Table 1 are met.

Providers should also consider, in the case of medicines that they have had difficulty accessing, whether the normal assumption of allowing patients to keep their own supplies of medicines for self-administration is appropriate, or whether other storage arrangements would better facilitate their re-use, if that patient no longer needs them.

Re-use should only be within a single care home/hospice setting; medicines identified for re-use should not be transferred to another care home or hospice, even those within the same parent organisation.

Tables 1 to 3 below provide supporting prompts to assist the registered healthcare professional with their decision making. It is advised that medicines for re-use are pro-actively assessed prior to them being needed in an emergency situation.

Table 1: Criteria to be considered before the medicine can be reused

	Yes	No	Notes
Is the medicine in an unopened pack or blister that has not been tampered with?			In an unopened, unadulterated and sealed pack (including sub-pack) or blister strip. If any doses have already been used, the remainder of that blister strip should be destroyed. If the contents (including blister strips and sealed individual units such as ampoules) are completely intact, then as long as they match the description on the packaging

			they were retrieved from (including check of batch numbers) they can be considered for re-use.
Is it in date?			Medicines should be in date. If expired, they will need to be returned to a pharmacy to be safely destroyed.
Has it been stored in line with the manufacturer's instructions, including any need for refrigeration?			Any medication that requires refrigeration, or that has a reduced shelf-life once removed from refrigerated storage, should be destroyed if it has not stored appropriately. Medicines left in unsuitable conditions (eg direct sunlight, near radiators) or where appropriate storage cannot be confirmed, should be destroyed.
Is the medicine a licensed medicine that has either been prescribed by a registered healthcare professional with prescribing rights or bought 'over the counter'?			For some medicines, 'homely remedies' are an option in care homes and should be considered in line with guidance: https://www.sps.nhs.uk/articles/rmoc-guidance-homely-remedies/

If the answer to all of the above questions is **yes,** then the risk of reuse may be judged to be minimal. If the answer to **any question** is **no** then the medicine should not be re-used. If doubt remains, discuss with appropriate registered healthcare professionals and local networks to get a wider perspective on the decision.

Table 2: Minimise risk of cross-contamination

	Yes	No	Notes
Is the medicine from a patient with a diagnosis of COVID-19 or showing symptoms of COVID-19?			Ensure that adequate infection prevention and control precautions have been taken. Medicine that has been retrieved from a patient infected with COVID-19 should be sealed (double bagged) and quarantined for three days. A do not process before date should be fixed to the bag before the bag is stored safely and away from any other medicines.

Table 3: Ensuring permission is obtained and patients, families and/or carers are fully involved

	Yes	No	Notes
If a medicine is thought to be suitable for re-use, permission should, if possible, be obtained for re-use from the patient for whom it was prescribed or (if the patient lacks capacity) from a person with power of attorney, or (if the patient has died) from their next of kin.			If the patient has become responsible for the safe keeping of the medicine, it is the property of the patient (although not their exclusive responsibility), but if the medicine is still in the safe custody of the care home or hospice care provider, whether the final supply to the patient has been completed is the subject of differing legal views. Reflecting this uncertainty, if possible, ensure the patient or their next of kin agrees for the medicine to be reused. **See Annex B.**

To ensure re-use of medicines is an option that can be used as flexibly as possible we suggest that care homes and hospices proactively seek written permission from all patients for:

- their medicines (if no longer needed) to be made available for other patients and/or
- them to receive a re-used medicine, provided they are deemed safe for re-use.

Further information to inform discussions is available in Annex B.

Once a decision has been made to re-use a medicine, then the following processes (summarised in the flow chart in Section 4 of this SOP) should be followed:

All medicines

1. A log should be maintained of re-used stock. The log should include the generic drug name, batch number, strength, formulation, expiry date quantity and details of the registered healthcare professional who assessed the medicine, as a minimum. When the stock is re-used, the quantity used should be entered. An example log returns sheet is given in Annex B.

2. Any medicines that might be re-used should be placed in a sealed container and marked as 'patient returns', to make it clear that the stock should only be re-used when stock cannot be obtained from the legitimate supply chain. The additional obligations in respect of storage of controlled drugs must be adhered to.
3. Once a medicine has been assessed as being suitable for re-use, the usual processes and governance, as recommended by NICE guideline SC1: Managing medicines in care homes, apply.

4. Any re-used medicine would need to be administered according to the direction of a relevant prescriber[6] and recorded by care home or hospice staff in the relevant administration chart.

5. Unless the product is being supplied under a PGD or a patient specific direction, a new prescription must be obtained prior to supply to the new patient. If it is for a controlled drug, the extra requirements in relation to controlled drugs prescriptions must be satisfied. New remote prescriptions should be scanned and emailed before the first dose is given, and a copy of the prescription kept with the patient's records in line with current processes.

6. The administration chart (paper or electronic) should be updated by the care home or hospice, in line with the direction from the prescriber (in most cases this would be the prescription). The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used. The prescriber does not need to sign the MAR chart.

Controlled drugs

7. Any stock of medication Schedule 2 or 3 controlled drugs should only be retained if it can be stored securely with controlled and limited access (in line with safe

[6] This can be a verbal direction initially with a written prescription to follow either by email or hard copy

storage requirements for controlled drugs). Lawful possession of such drugs is generally predicated on a prescription or direction being in place, so continuity of prescriptions is important for these particular products, having regard to the normal timeframes for safe disposal of these products where they are no longer needed.

8. Any Schedule 2 controlled drugs must be entered into a separate section of the controlled drugs register and then an entry made when they are re-used, as is usual practice.

Records

9. All records (CD register entries and returned medicines stock, risk assessments) must be kept in line with legislation.

Prescribers

10. When medicines are out of stock and there is an immediate need for them, an alternative preparation should be prescribed and dispensed, as is usual practice where possible.

11. Where stock is not available, the supplying pharmacy will contact the care home or hospice to establish whether a medicines re-use scheme is in place and stock of the required medicine is available in the home.

12. Re-used medicines may be administered to residents in a care home or hospice under the direction of a prescriber, and in line with this SOP, where an appropriate medicines re-use scheme is in operation.

13. In this situation, the direction would normally be in the form of a prescription. If a prescription is issued remotely, it should be scanned and emailed to the care home by the prescriber (for known medicines shortages) or the community pharmacy as appropriate in each individual case.

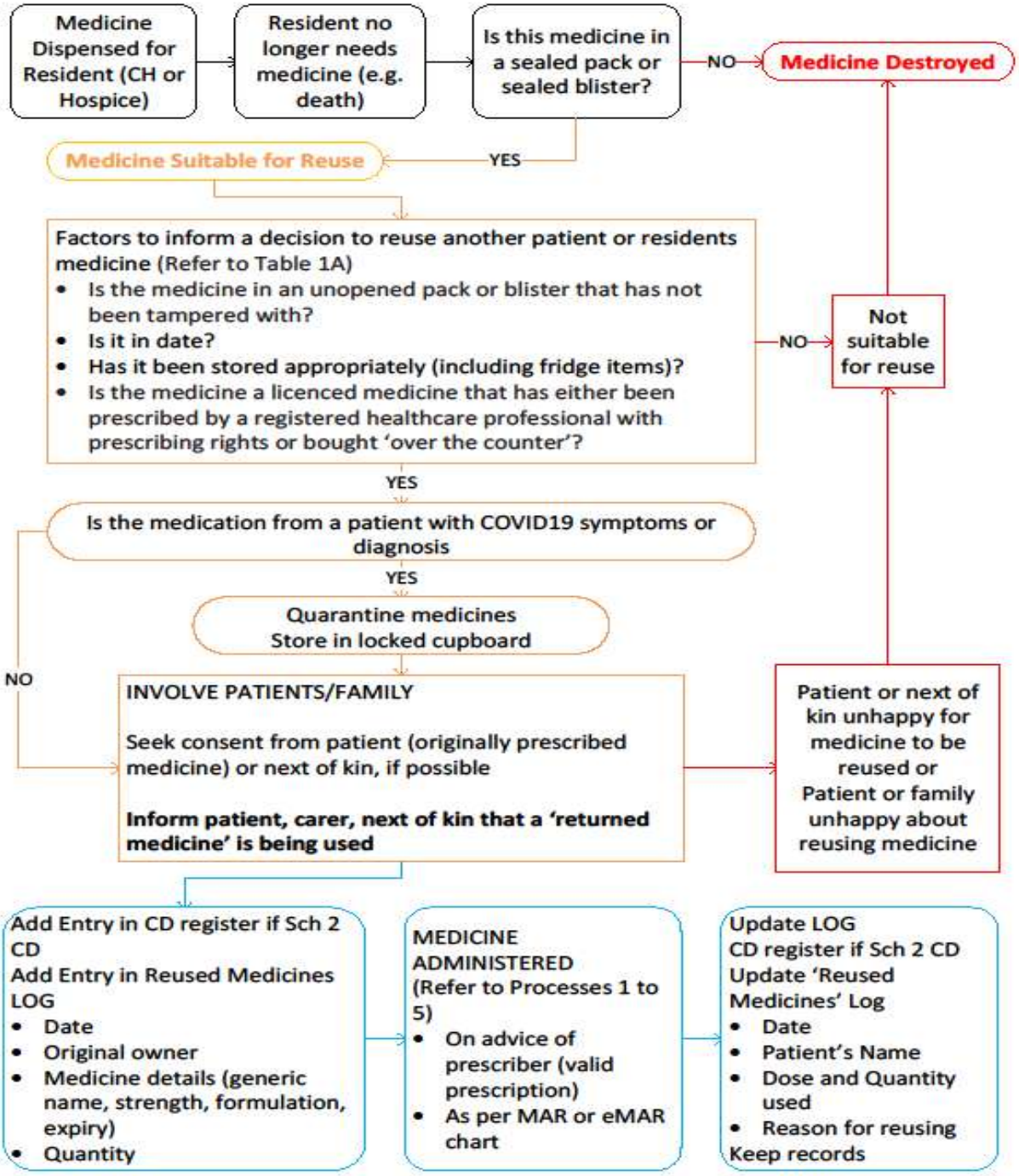
Community pharmacy

14. When medicines are out of stock and there is an immediate need for them, an alternative preparation should be prescribed and dispensed, as is usual practice where possible.

15. Where there is no suitable alternative or a prescription cannot be written for the alternative medicine (eg out of hours), the community pharmacy team should ask the care home or hospice whether they run a medicines re-use scheme and whether they have any stock of the required medicine.

16. If stock of a re-used medicine is available in the care home or hospice, the community pharmacy team must share a copy of the prescription for that medicine with the home and update the corresponding MAR chart as necessary. The supply of the medicine by the care home or hospice will need to be in accordance with that prescription. They cannot rely on a report of its contents.

4. Medicines re-use pathway



Pharmacovigilence
- Report all adverse events and problems to CCG, COVID19 Trimverate
- Report clinical adverse via Yellow Card Scheme (note that medicine was reused)
- Log all errors via NRLS or equivalent

North Central London CCG
Primary Care Commissioning Committee Meeting 23 July 2020

Report Title	Rosslyn Hill Surgery merger with Hampstead Group Practice Urgent Decision to note	**Date of report**	7 July 2020	**Agenda Item**	4.2
Considered at	**Part 1** ☒ Part 2☐ **Urgent decision** ☐				
Lead Director / Manager	Simon Wheatley	**Email / Tel**			
GB Member Sponsor	Simon Wheatley				
Report Author	Anthony Marks	Email / Tel		anthony.marks@nhs.net	
Name of Authorising Finance Lead	Not Applicable	Not applicable			
Report Summary	Commissioners are requesting committee members to note the Urgent Decision made to approve the merger of Hampstead Group Practice and Rosslyn Hill Practice. The paper sets out the case for the committee to agree commissioners' recommendations to approve the merger of two PMS contracts: Hampstead Group Practice (list size 15,943) with Rosslyn Hill Practice (1,800). Committee approved the co-location of the practices in October 2019. The merger took place on the same day as co-location, 1July 2020, when the Rosslyn Hill site closed. The sites are 0.4 miles apart or 8 minutes walk. The full Urgent Decision paper follows.				
Recommendation	Members of the Committee are asked to note the Urgent Decision made				
Identified Risks and Risk Management Actions	If no action is taken the potential to fully integrate the two practice on one site would be lost with the possibility of a two tier service for the patients of the different practices. Risk: the landlord will evict Rosslyn Hill practice and the list may be dispersed. Mitigation: merger with Hampstead Group Practice Risk: Stakeholder perception the practice is closing Mitigation: engagement with stakeholders, confirmation that the relocation will allow the practice to remain open				
Conflicts of Interest	Not Applicable				
Resource Implications	Not Applicable				

Engagement	The Patient Participation Groups (PPG) at both practices have been engaged and are supportive of the relocation. Wider patient and stakeholder engagement has followed on the proposal to merge
Equality Impact Analysis	Not Applicable
Report History and Key Decisions	**PCCC October 2019** Approval of the relocation of Rosslyn Hill into Hampstead Group Practice site.
Next Steps	Continue the project group to conclude the relocation and merger process
Appendices	Not Applicable

North Central London Primary Care Committee – April 2020				
Report Title	Rosslyn Hill Surgery merger with Hampstead Group Practice		**Date of report**	**Agenda Item**
Considered at	**Part 1☐ Part 2 ☐ Urgent decision ☒**		**April 2020**	
Lead Director / Manager	Simon Wheatley	Tel/Email		
GB Member Sponsor	Simon Wheatley			
Report Author	Anthony Marks	Tel/Email	anthony.marks@nhs.net	
Report Summary	This paper sets out the case for the committee to agree commissioners' recommendations to approve the merger of two PMS contracts: Hampstead Group Practice (list size 15,943) with Rosslyn Hill Practice (1,800). Committee approved the co-location of the practices in October 2019. The merger will take place on the same day as co-location, 1July 2020, when the Rosslyn Hill site will close. The sites are 0.4 miles apart or 8 minutes' walk. The Rosslyn Hill Surgery landlord is seeking the return of the building when the lease expires in July 2020.			
Recommendation	Members of the Committee are asked to approve the merger subject to the conditions: • There will be no increase in the rental revenue costs to the CCG as a result of the merger/re-location • Full patient engagement on the merger will be undertaken with feedback used to inform possible service improvements			
Identified Risks and Risk Management Actions	Risk: the landlord will evict Rosslyn Hill practice and the list may be dispersed. Mitigation: merger with Hampstead Group Practice Risk: Stakeholder perception the practice is closing Mitigation: engagement with stakeholders, confirmation that the relocation will allow the practice to remain open			
Conflicts of Interest	**Not Applicable**			
Resource Implications	Re-location costs for IT equipment. Saving of rent and rates reimbursement (£60K) for the Commissioners			

Engagement	The Patient Participation Groups (PPG) at both practices have been engaged and are supportive of the relocation. Wider patient and stakeholder engagement will follow on the proposal to merge
Equality Impact Analysis	**Not Applicable**
Report History and Key Decisions	**PCCC October 2019** Approval of the relocation of Rosslyn Hill into Hampstead Group Practice site.
Next Steps	Continue the project group to manage the relocation and merger process
Appendices	Not Applicable

1.0 Recommendation

Committee members approved the relocation of Rosslyn Hill Practice onto the Hampstead Group Practice (HGP) site in October 2019. This was to stabilise the Rosslyn Hill Surgery patient list as there had been a number of months of uncertainty following the landlord's intention to take back the surgery building. The relocation will allow the surgery to remain open and patients be seen in a purpose built health centre. The Commissioners will save the current Rosslyn Hill rent and rates reimbursement of approximately £60,000 per annum.

Both practices have since agreed to merge on the same date. This will allow a single service for patients in the building and remove the perception of a two tier service. Approval is subject to the following conditions:

- There will be no increase in the rental revenue costs to the CCG as a result of the re-location
- Full patient engagement on the merger will be undertaken with feedback used to inform possible service improvements

2.0 Background

The Rosslyn Hill Surgery contract holder has informed Commissioners that the current lease expires July 2020 and the landlord requires the building at the earliest opportunity. PMS services are currently provided from a converted house.

Hampstead Group Practice has assessed the feasibility of accommodating the Rosslyn Hill Surgery practice and staff. In order to do this effectively some reconfiguration of space and the digitisation and removal of paper records from site is required. The practices have secured funding for the cost of these works from alternative funding streams and confirm that the CCG will not resource this.

Both practices now wish to merge which will provide a better patient experience as there will be a single service, appointment system and telephone number.

Impact on patients

The distance between the two sites is approximately 0.4 miles, 8 minutes walking distance. The location where Rosslyn Hill Surgery patients reside is included in Figure 1 and Figure 2 below.

Figure 1

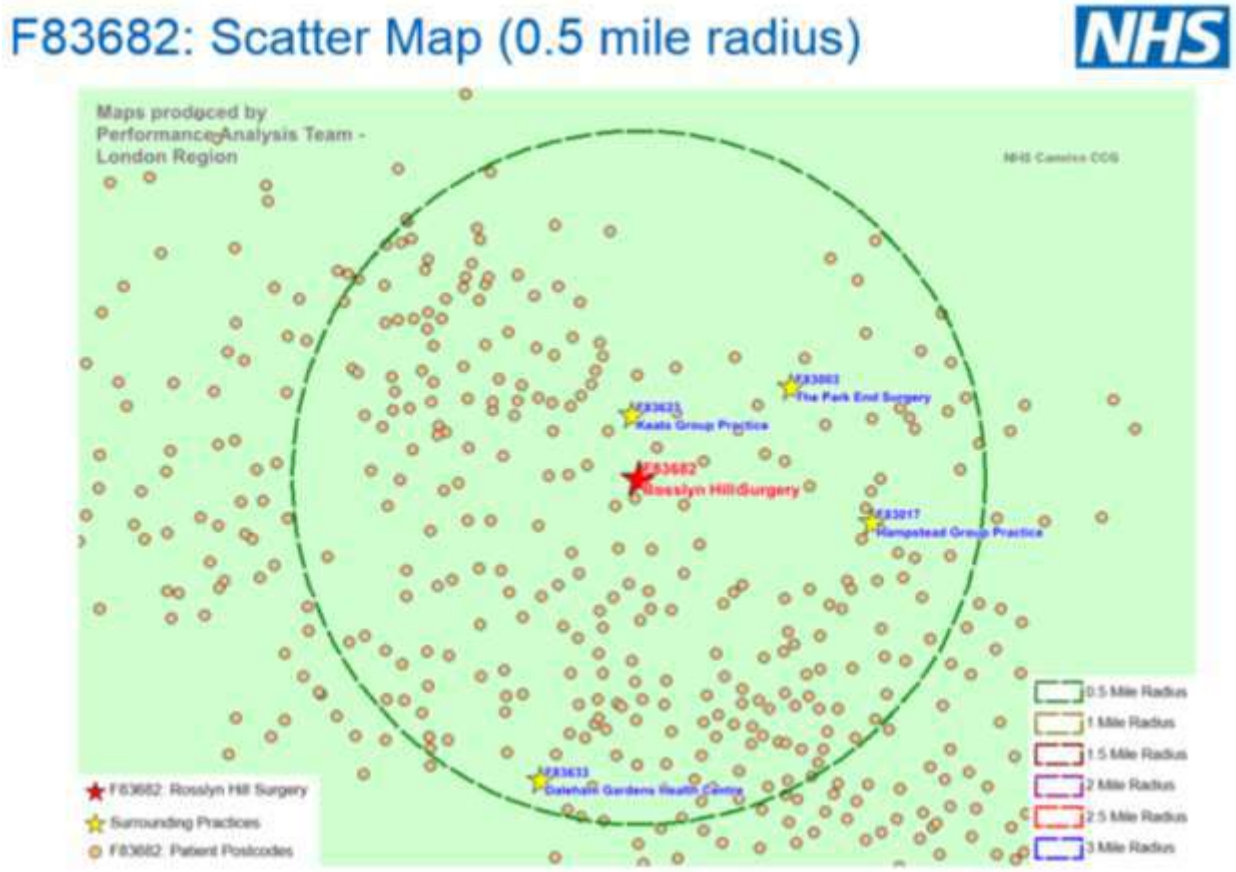
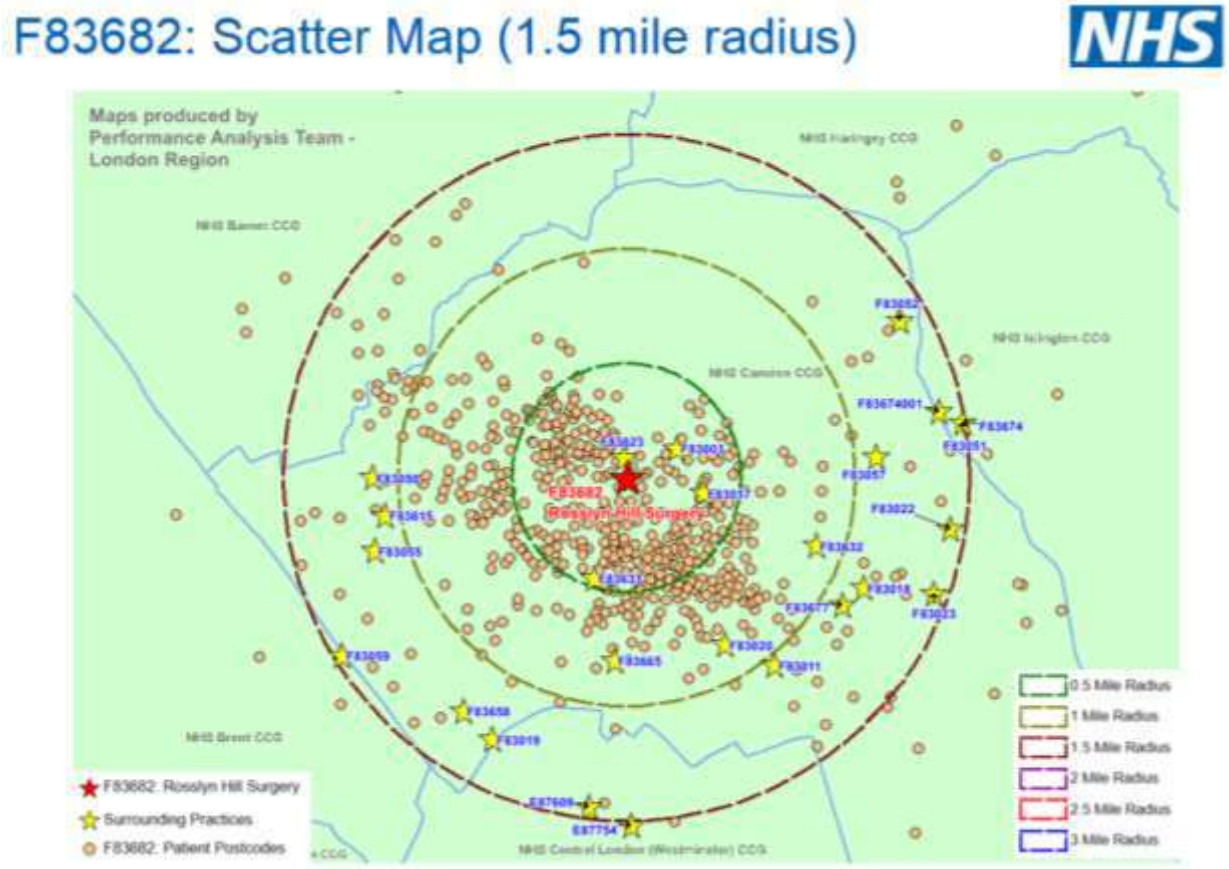


Figure 2



Stakeholder engagement

The PPGs at both practices have been engaged and are supportive of the relocation and the merger. Wider engagement with all patients will be undertaken by the practices.

Local stakeholders will be engaged prior to the merger.

Benefits

The practices which are a part of the same Primary Care Network (PCN). There will be no decrease in access for patients.

The surgeries will be able to share good practice. Patients will transfer to the new building and merged practice without the need to re-register providing continuity of care. Rosslyn Hill patients will have easier access to additional PCN services as they develop as some will likely be delivered from the new location.

Financial Impact

As a result of the relocation, the premises at Rosslyn Hill Surgery can be returned to the landlord and will release a surplus of £60,000 (rent and rates reimbursement).

3.0 Patient and Stakeholder Engagement

The practices have already informally consulted with their PPGs and intend to consult further with them and the broader patient list formally if approval from PCCC is agreed. The GP federation and the PCN are aware of the plans.

4.0 Next Steps

If committee members approve the merger, commissioners will meet virtually with the practices to convene a project group to complete actions and ensure that the conditions outlined above are met.

North Central London CCG
Primary Care Commissioning Committee Meeting
Thursday 23 July 2020

Report Title	PCCC Terms of Reference	**Date of report**	2nd July 2020	**Agenda Item**	5.1
Lead Director / Manager	Paul Sinden, Executive Director of Performance and Assurance	**Email / Tel**		p.sinden@nhs.net	
GB Member Sponsor	*Not Applicable*				
Report Author	Andrew Spicer, Head of Governance and Risk	**Email / Tel**		andrew.spicer1@nhs.net	
Name of Authorising Finance Lead	*Not Applicable*	**Summary of Financial Implications** The Committee's Terms of Reference sets out its operating structure and therefore how the Committee makes financial decisions.			
Report Summary	The Committee's Terms of Reference were approved at the Governing Body meeting on 18th June 2020 and are presented to the Committee for noting.				
Recommendation	The Committee is requested to: • **NOTE** the Terms of Reference.				
Identified Risks and Risk Management Actions	The Committee will provide oversight and scrutiny of the CCG's key risks within the area of its remit.				
Conflicts of Interest	This report was written in accordance with the CCG's Conflicts of Interest Policy.				
Resource Implications	This report supports the CCG by providing oversight and scrutiny of delegated primary care commissioning and in making effective and efficient use of its resources.				
Engagement	The Committee includes Lay Members and clinicians. Patient Representatives are also invited to Committee meetings as Standing Attendees.				
Equality Impact Analysis	The report was written in accordance with the provisions of the Equality Act 2010.				
Report History and Key Decisions	The Terms of Reference were approved at the Governing Body meeting on 23rd April 2020. A revised version was subsequently approved at the Governing Body meeting on 18th June 2020.				
Next Steps	None.				
Appendices	None.				

NHS North Central London Clinical Commissioning Group
Primary Care Commissioning Committee
Terms of Reference

1. Introduction

1.1 The Primary Care Commissioning Committee ('Committee') is established in accordance with the Constitution of NHS North Central London Clinical Commissioning Group ('CCG'). It is a committee of the Governing Body to exercise Primary Care commissioning functions, as delegated to the CCG by NHS England under 13Z of the National Health Service Act 2006 (as amended) ('NHS Act 2006').

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Statutory Framework

2.1 In accordance with its statutory powers under section 13Z of the NHS Act 2006 NHS England has delegated the exercise of the functions specified in section 3 below to the CCG for its geographical area.

2.2 Arrangements made under section 13Z of the NHS Act 2006 may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

2.3 Arrangements made under section 13Z of the NHS Act 2006 do not affect the liability of NHS England for the exercise of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it) it must comply with the statutory duties set out in Chapter A2 of the NHS Act 2006 including:

No.	Statutory Duty	Section of NHS Act 2006
1.	Management of Conflicts of Interest	14O
2.	Duty to promote the NHS Constitution	14P
3.	Duty to exercise its functions effectively, efficiently and economically	14Q
4.	Duty as to improvement in quality of services	14R
5.	Duty in relation to quality of primary medical services	14S
6.	Duties as to reducing inequalities	14T
7.	Duty to promote the involvement of each patients	14U
8.	Duty as to patient choice	14V
9.	Duty as to promoting integration	14Z1
10.	Public involvement and consultation	14Z2

2.4 In respect of the delegated functions from NHS England, the CCG will need to exercise those functions in accordance with the relevant provisions of section 13 of the NHS Act 2006 including:

No.	Statutory Duty	Section of NHS Act 2006
1.	Duty to have regard to impact on services in certain areas	13O
2.	Duty as respects variation in provision of health services	13P

2.5 The Committee is established by the Governing Body in accordance with Schedule 1A of the NHS Act 2006.

2.6 The Committee members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3. Role of the Committee

3.1 The role of the Committee is to carry out the function relating to the commissioning of primary medical services under section 83 of the NHS Act 2006. The Committee will make decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

- Decisions in relation to Enhanced Services;
- Decisions in relation to Local Incentive Schemes (including the design of such schemes)
- Decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;
- Decisions about 'discretionary' payments;
- Decisions about commissioning urgent care (including home visits as required) for out of area registered patients;
- The approval of practice mergers;
- Planning primary medical care services in the area, including carrying out needs assessments;
- Undertaking reviews of primary medical care services;
- Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);
- Management of delegated funds;
- Premises costs directions functions;
- Co-ordinating a common approach to the commissioning of primary care services with commissioners across the CCG where appropriate; and
- Such other ancillary activities that are necessary in order to exercise the Delegated Functions.

3.2 In performing its role the Committee will exercise its management of the functions in accordance with the Delegation and the Delegation Agreement that the CCG has entered into with NHS England. The Delegation and the Delegation Agreement sit alongside these Terms of Reference.

3.3 The Committee will have due regard to any relevant Quality and Safety issues which may arise as agreed by Committee members.

3.4 In performing its role the Committee will act within the powers delegated to it by NHS England.

3.5 Decisions made by the Committee will be binding on NHS England as long as decisions are made within the scope of the powers delegated to it.

3.6 In performing its role Committee members will act in good faith towards each other, work collaboratively, review evidence, share information, provide objective expert input and endeavour to reach a consensus and collective view.

4. Membership

4.1 The Committee shall have a lay and executive majority.

4.2 The Committee shall comprise of the following voting members:

- 4.2.1 A Governing Body clinician;
- 4.2.2 The Governing Body Registered Nurse;
- 4.2.3 An independent GP;
- 4.2.4 The Governing Body Lay Member with responsibility for patient and public involvement;
- 4.2.5 The Governing Body Lay Member with General Portfolio;
- 4.2.6 Executive Director of Performance and Assurance;
- 4.2.7 Executive Director of Clinical Quality;
- 4.2.8 A director of finance.

4.3 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of these Terms of Reference and may be amended or updated without the need to formally amend the Terms of Reference.

4.5 Committee members may nominate deputies to represent them in their absence and make decisions on their behalf.

5. Attendance

5.1 The following people shall be invited to attend Committee meetings as standing attendees:

- 5.1.1 A patient representative;
- 5.1.2 Primary Care Contracting and Commissioning Team representative(s);
- 5.1.3 A Public Health representative from a Health and Wellbeing Board;
- 5.1.4 Healthwatch Representative(s);
- 5.1.5 LMC Representative(s);
- 5.1.6 CCG Borough Directorate representatives.

5.2 Attendees at Committee meetings are non-voting.

5.3 The list of standing attendees is set out in Schedule 1. Schedule 1 does not form part of these Terms of Reference and may be amended or updated without the need to formally amend the Terms of Reference.

5.4 The roles referred to in the list of standing attendees above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

5.5 Attendees may nominate deputies to represent them in their absence

5.6 The Committee may invite or allow additional people to attend meetings as attendees. Attendees may present at Committee meetings and contribute to the relevant Committee discussions but are not allowed to participate in any formal vote.

5.7 The Committee may invite or allow people to attend meetings as observers. Observers may not present at Committee meetings, contribute to any Committee discussion or participate in any formal vote.

5.7 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair and Vice Chair of the Committee

6.1 The Committee Chair shall be a Governing Body Lay Member. The Committee Chair shall not be the Chair of the Audit Committee nor the Conflicts of Interest Guardian.

6.2 The Vice-Chair of the Committee shall be a Lay Member. The Committee Vice-Chair shall not be the Chair of the Audit Committee nor the Conflicts of Interest Guardian.

7. Quoracy

7.1 The Committee will be considered quorate when there is a lay and executive majority and when at least the following voting members are present:

- One Lay Member;
- One officer member;
- One clinician.

7.2 If the clinician referred to in clause 7.1 above is conflicted on a particular item of business they will not count towards the quorum for that item of business and a non-conflicted clinician will be appointed or co-opted in their place.

7.3 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted to satisfy the quorum requirements.

7.4 In some very rare circumstances all clinicians may be conflicted and therefore it may not be possible to co-opt or appoint a non-conflicted clinician to satisfy the quorum requirements. In this case the Committee Chair may dis-apply the requirement to have a clinician present in clause 7.1 above and deem the meeting quorate upon the agreement of all of the Lay Members on the Committee.

8. Voting

8.1 Each voting member of the Committee shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Committee Chair shall have the casting vote.

9. Decisions

9.1 The Committee will make decisions within the bounds of its remit.

9.2 Decisions of the Committee will be binding on NHS England as long as decisions are made within the scope of the powers delegated.

9.3 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

9.4 In addition to the general authority set out in clause 9.3 above due to the nature of primary care commissioning the Committee recognises that some urgent and

immediate decisions may need to be made outside of Committee meetings and that the use of the protocol for virtual decision making is not appropriate. The Committee may therefore delegate urgent and immediate decisions that need to be made outside of Committee timescales in accordance with clauses 9.5 – 9.6 and 9.9 below.

9.5 Urgent decisions requiring a response within 24 hours will be made collectively by the following people or their nominated deputies:
9.5.1 The Committee Chair;
9.5.2 A non-conflicted clinician;
9.5.3 The Executive Director of Performance and Assurance.

9.6 Immediate decisions requiring a response within 2 weeks will be made at a Committee meeting where practicable or by the protocol for virtual decision making. Where this is not practicable the following people or their nominated deputies will collectively make the decision:
9.6.1 The Committee Chair;
9.6.2 A non-conflicted clinician;
9.6.3 The Executive Director of Performance and Assurance.

9.7 Due to the nature of primary care commissioning the Committee recognises that the following non-contentious, low risk, decisions may be made outside of Committee meetings by those listed in clause 9.8 below:

- Requests to add or remove a partner;
- Retirement of a partner and adding of a new partner;
- Partnership changes- 24 hour retirement;
- Opening of a patient list;
- Increases in practice boundaries.

9.8 The following people or their nominated deputies may collectively make the non-contentious, low risk decisions set out in clause 9.7 above:
9.8.1 The Committee Chair;
9.8.2 A non-conflicted clinician;
9.8.3 The Executive Director of Performance and Assurance.

9.9 Decisions made outside of Committee meetings will be reported to the Committee at the next Committee meeting. This may be in a public or private part of the meeting depending on the nature of the business and the decision(s) made.

10. Secretariat

10.1 The Secretariat to the Committee shall be provided by the Corporate Services Directorate.

11. Frequency of Meetings

11.1 The Committee will meet bi-monthly or as otherwise agreed by the Committee.

12. Notice of Meetings

12.1 Notice of a Committee meeting shall be sent to all Committee members no less than 7 days in advance of the meeting.

12.2 The meeting notice shall contain the date, time and location of the meeting.

12.3 Where Committee meetings are to be held in public the date, times and location of the meetings will be published on the CCG's website.

13. Agendas and Circulation of Papers

13.1 Before each Committee meeting an agenda setting out the business of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

13.2 Before each Committee meeting the papers of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

13.3 If a Committee member wishes to include an item on the agenda they must notify the Committee Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Committee Chair.

14. Minutes and Reporting

14.1 The minutes of the proceedings of a meeting shall be prepared by the Secretariat and submitted for agreement at the following Committee meeting.

14.2 The approved minutes will be presented to the NHS England area team. They will also be presented to the Governing Body.

15. Meetings Held in Public

15.1 Meetings of the Committee shall be held in public unless the Committee resolves to exclude the public from a meeting. In which case the meeting, in whole or in part, may be held in private. The Committee may also exclude non-voting attendees and observers. Meetings or parts of meetings held in public will be referred to as 'Meeting Part 1'. Meetings or parts of meetings held in private will be referred to as 'Meeting Part 2.'

15.2 Attendees, observers and the public may be excluded from all or part of a meeting at the Committee's absolute discretion whenever publicity would be prejudicial to the public interest by reason of:

15.2.1 The confidential nature of the business to be transacted; or
15.2.2 The matter is commercially sensitive or confidential; or
15.2.3 The matter being discussed is part of an on-going investigation; or
15.2.4 The matter to be discussed contains information about individual patients or other individuals which includes sensitive personal data; or
15.2.5 Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings is to be discussed;
15.2.6 Other special reason stated in the resolution and arising from the nature of that business or of the proceedings; or
15.2.7 Any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time; or
15.2.8 To allow the meeting to proceed without interruption, disruption and/or general disturbance.

16. Questions from the Public and Deputations

16.1 The Committee may receive questions from the public at its absolute discretion in line with the CCG's protocol for public questions which is available on the CCG's website.

16.2 The Committee may receive, at its absolute discretion, Deputations from members of the public or interested parties to make the Committee aware of a particular concern or concerns they have.

16.3 Any Deputations should be sent to the Committee secretariat who will pass it to the Chair for consideration.

16.4 Any Deputations must be received by the Committee secretariat at least three working days before a Committee meeting is due to take place to be eligible to be heard at that Committee meeting. However, where it is not possible to comply with this deadline due to the papers of the meeting being published later or due to a public holiday the Deputations must be submitted within a reasonable time.

16.5 Any Deputations not received within this time will not be eligible to be heard at that Committee meeting. However, on a strictly case by case basis there may be times where it would be highly beneficial to the Committee's business to waive this requirement due to the relevance or content of the Deputations. In these circumstances the Chair may do so on a case by case basis and without setting any precedents of future or further waivers.

16.6 Any Deputations must take the form of a written request together with a statement setting out what the Deputation is about. If any Deputation fails to set out this information it will be rejected.

16.7 Any Deputations which are not relevant to the Committee's business will be rejected

16.8 The Chair may accept or reject any relevant and properly completed Deputations on a strictly case by case basis at his/her absolute discretion and without setting any precedents for future or further decisions.

16.9 If a request is agreed the interested party and/or parties will be invited to a Committee meeting where the Committee will consider the Deputation.

16.10 The Chair may decide how much time to allocate to any Deputations at his/her absolute discretion on a case by case basis and without setting any precedents for future or further decisions on time allocated for Deputations.

16.11 Nothing in this section 16 shall limit, prohibit or otherwise restrict the Committee's powers contained in section 4, 15 or 17 of these Terms of Reference.

17. Confidentiality

17.1 Members of the Committee shall respect the confidentiality requirements set out in these Terms of Reference unless separate confidentiality requirements are set out for the Committee in which event these shall be observed.

17.2 Committee meetings may in whole or in part be held in private as per section 15 above. Any papers relating to these agenda items will be excluded from the public domain. For any meeting or any part of a meeting held in private all members and/or attendees must treat the contents of the meeting and any relevant papers as strictly private and confidential.

17.3 Decisions of the Committee will be published by Committee members except where matters under consideration or when decisions have been made in private and so excluded from the public domain in accordance with section 15 above.

18. Sub-Committees

18.1 The Committee may not delegate any of its powers or decision making to a sub-committee but it may appoint sub-committees and/or working groups to advise it and assist in carrying out its functions.

18.2 Any sub-committees or working groups must abide by the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19. Conflicts of Interest

19.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19.2 The Committee shall have a Declarations of Interest Register that will be presented as a standing item on the Committee's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Committee's agenda

19.3 The CCG shall ensure appropriate safeguards are in place to maintain the integrity of the role of Conflicts of Interest Guardian.

20. Gifts and Hospitality

20.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

20.2 The Committee shall have a Gifts and Hospitality Register and Committee members will have an opportunity to declare any new or relevant declarations of gifts and hospitality as a standing item on the Committee's agenda

21. Standards of Business Conduct

21.1 Committee members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:

21.1.1 The law of England and Wales;
21.1.2 The NHS Constitution;
21.1.3 The Nolan Principles;
21.1.4 The standards of behaviour set out in the CCG's Constitution;
21.1.5 The Standards of Business Conduct Policy;
21.1.6 The Conflicts of Interest Policy
21.1.7 The Counter Fraud, Bribery and Corruption Policy,
21.1.8 Any additional regulations or codes of practice relevant to the Committee.

21.2 The Committee will have access to sufficient resources to carry out its duties and Committee members will be provided with appropriate and timely training and information to allow them to exercise their responsibilities effectively.

22. Review of Terms of Reference

22.1 These Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions and the wider experience of the CCG in primary care commissioning.

22.2 These Terms of Reference will be formally reviewed annually in April. These Terms of Reference may be approved, varied or amended by the Governing Body.

Date approved by Governing Body: 23rd April 2020.
Date of next review: 22nd April 2021.

Schedule 1
List of Members and Standing Attendees

This schedule sets out the membership, attendees, Chair of the Committee.

Committee:
The voting members of the Committee are as follows:

Position	Name	Title
Governing Body clinician		
Governing Body Registered Nurse		
Independent GP		
The Governing Body Lay Member with responsibility for patient and public involvement		
The Governing Body Lay Member with General Portfolio;		
Executive Director of Performance and Assurance		
Executive Director of Clinical Quality		
A director of finance		

Chair and Vice Chair:

Position	Name
Chair	
Vice Chair	

Standing attendees
The following are standing attendees at Committee meetings:

Position	Name	Title
A Patient Representative		
A Public Health representative from a Health and Wellbeing Board		
Healthwatch representative(s)		
LMC Representative		

Primary Care Contracting and Commissioning Team Representative(s)		
CCG Borough Directorate Representatives		

North Central London CCG
Primary Care Commissioning Committee Meeting
23 July 2020

Report Title	Primary Care Commissioning Committee Risk Register	**Date of report**	10 July 2020	**Agenda Item**	5.2
Lead Director / Manager	Paul Sinden, Executive Director of Performance & Assurance	**Email / Tel**		p.sinden@nhs.net	
GB Member Sponsor	*Not Applicable*				
Report Author	Chris Hanson Governance and Risk Lead	**Email / Tel**		christopher.hanson1@nhs.net	
Name of Authorising Finance Lead	*Not Applicable*	**Summary of Financial Implications** This report assists the CCG in managing its most significant financial risks.			

Report Summary

This report is the first Risk Register for the Primary Care Commissioning Committee ('Committee') of North Central London CCG. The risk register includes the key risks within the remit of the Committee.

There are 4 risks that reach the threshold of 12 or higher for inclusion on the Primary Care Commissioning Committee Risk Register.

Key Highlights:

PERF4: *Opportunities to support struggling practices are sometimes delayed by the absence of a systematic early warning system (Threat)*: This risk is a response to regulatory action that has been taken with a series of practices recently following "inadequate" or "requires improvement" ratings following Care Quality Commission (CQC) inspections. Action in some cases has included having to put in place caretaking arrangements at practices at very short notice.

The aim of the risk is to promote earlier recognition of struggling practices, and ensure that support is provided before regulatory action is required.

Additional support has been provided to practices during the Covid period including a financial resilience support package (in advance of any national policy), and a service model establishing a central hot site and home visiting service for Covid positive patients in each Borough.

The workforce and resilience workstream for primary care recovery (from first wave of the pandemic) has a focus on supporting and early identification of struggling practices.

	At the height of the pandemic the CQC paused regulatory action with the exception of cases with a risk to patient safety. This risk is rated 12. **PERF9:** *Inadequate support from Primary Care Support England (Capita contract) for general practices (Threat))*: List cleaning activities were suspended at the request of NHS England in March 2020 due to Covid and are yet to recommence. Current reporting does not enable us to report at CCG level but this will be developed once NHS England have written to GPs informing them of the recommencement of the activity. Prior to covid, in October 2019, Capita commenced a list cleansing programme for 6 population cohorts: 1. Patients registered as living at a demolished address 2. Children Under 16 and registered as the sole occupant at an address 3. Patients aged Over 100 4. Transient patients who have been registered with a GP for 12 months 5. Patients who live in a house of multiple occupancy (10 or more residents) 6. Students who have been registered for four or more years Patients whose registration was not confirmed by either the GP practice or the patient themselves between October 2019 and March 2020 were placed on an FP69 (as a 6-month deduction notice). Due to the process timescales for response FP69s were not added to patient records until Feb 2020 and will run for 6 months until August when the first patients will begin to be removed. The three-year list reconciliation project began in January 2019 was also interrupted by covid. The original preliminary dates for when Primary Care Support England (PCSE) would undertake Borough-based audits are set out below, and the Committee will be advised of the new dates once received: • Barnet - 15/06/2020 • Camden - 26/07/2021 • Enfield - 14/06/2021 • Haringey - 07/09/2020 • Islington - 03/08/2020 This risk is rated 16. **PERF15:** *Failure to address variation in Primary Care Quality and Performance across NCL (Threat)*: Mitigations in place to help reduce unwarranted variation in quality and performance across general practices include: • Primary Care Networks (PCNs) have been established successfully across North Central London including the appointment of Clinical Directors for each PCN, in line with the new national GP contract; • PCNs have received funding for their development including support for Clinical Directors; • Use of GP Forward View monies from NHS England to support the development of primary care networks and GP Federations, and develop a resilience programme for general practice; • The new GP contract also introduces a greater quality improvement focus in the Quality Outcomes Framework; and, • Models for mutual aid across practices established during Covid including hot site and home visiting service, and training for practices in managing Covid patients This risk is rated 12.

	PERF18: *Primary care workforce development (Threat)*: The updated GP contract was published on 6/2/2020. It places additional emphasis on the importance of funding, and includes additional funding for and flexibility within the PCN workforce Scheme. PCNs are encouraged by NHSE/I to focus on recruitment. Recruitment plans will have been impacted by Covid. This risk is rated 12. <u>Legacy Risks</u> Further to a risk review as part of the merger of the 5 North Central London CCGs a number of risks reported on the February 2020 North Central London Primary Care Committee in Common Risk Register have been either closed, reduced below the Committee threshold, or merged with other risks as follows: **PCCC12:** *Failure to address variation in Primary Care Quality and Performance across NCL (Threat):* Risk renamed PERF15 and is reported above. **PCCC13:** *Failure to develop primary care workforce in line with requirements for developing primary care services in the STP (Threat):* Risk merged with others to form PERF18, reported above. **PCCC18:** *Inadequate support from Primary Care Support England (Capita contract) for general practices (Threat):* Risk renamed PERF9 and is reported above. **PCCC22:** Opportunities to support struggling practices are sometimes delayed by the absence of a systematic early warning system (Threat): Risk renamed PERF4 and is reported above. **PCCC23:** *Resources available for primary care commissioning are insufficient to carry out delegated functions taken on by CCGs in April 2017 from NHS England (Threat)*: Risk renamed PERF12. Risk rated 9 and falls below Committee reporting threshold. **PCCC24:** *The establishment of Primary Care Networks, as set out in the new national GP contract, needs to align with local primary care strategies and primary care provision including GP Federations, and avoid potential conflicts of interest (Threat):* Risk renamed PERF10. Risk rated 9 and falls below Committee reporting threshold. **PCCC25:** *Failure to align development of Primary Care Networks (PCNs) with the development of Integrated Care Partnerships under the NHS Long Term Plan (LTP) (Threat):* Risk renamed PERF14. Risk rated 9 and falls below Committee reporting threshold. **PCCC26:** *Failure to manage increased costs due to the introduction of the GP at Hand. (Threat):* Scrutiny of risk transferred to Finance Committee. Risk renamed FIN4.
Recommendation	The Committee is asked to **NOTE** the report and the risk register, provide feedback on the risks included, and, identify if there are any new or additional strategic risks.
Identified Risks and Risk Management Actions	The risk register will be a standing item for each meeting of the Committee.

Conflicts of Interest	Conflicts of interest are managed robustly and in accordance with the CCG's conflict of interest policy.
Resource Implications	This report supports the CCG in making effective and efficient use of its resources.
Engagement	This report is presented to each Committee meeting. The Committee includes clinicians and lay members.
Equality Impact Analysis	This report was written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	The Primary Care Commissioning Committee Risk Register is presented at each Committee meeting.
Next Steps	To continue to manage risk in a robust way.
Appendices	Appendices are: 1. Primary Care Commissioning Committee Risk Register; 2. The Committee Risk Tracker; and, 3. Risk scoring key.

North Central London CCG PCCC Risks - Highlight Report				2020/21				Movement From Last Report	Target Risk Score
Risk ID	**Risk Title**	**Risk Owner**	**Key Updates**	**JULY**					
PERF4	Opportunities to support struggling practices are sometimes delayed by the absence of a systematic early warning system (Threat)	Paul Sinden, Executive Director of Performance & Assurance	This risk is a response to regulatory action that has been taken with a series of practices recently following "inadequate" or "requires improvement" ratings following Care Quality Commission (CQC) inspections. Action in some cases has included having to put in place caretaking arrangements at practices at very short notice. The aim of the risk is to promote earlier recognition of struggling practices, and ensure that support is provided before regulatory action is required. Additional support has been provided to practices during the coved period including a financial resilience support package (in advance of any national policy), and a service model establishing a central hot site and home visiting service for coved positive patients in each Borough. The workforce and resilience workstream for primary care recovery (from first wave of the pandemic) has a focus on supporting and early identification of struggling practices. At the height of the pandemic the CQC paused regulatory action with the exception of cases with a risk to patient safety.	12				→	6
PERF9	Inadequate support from Primary Care Support England (Capita contract) for general practices (Threat)	Paul Sinden, Executive Director of Performance & Assurance	List cleansing activities were suspended at the request of NHS England in March 2020 due to Covid and are yet to recommence. Current reporting does not enable us to report at CCG level but this will be developed once NHS England have written to GPs informing them of the recommencement of the activity. Prior to covid, in October 2019, Capita commenced a list cleansing programme for 6 population cohorts: 1. Patients registered as living at a demolished address 2. Children Under 16 and registered as the sole occupant at an address 3. Patients aged Over 100 4. Transient patients who have been registered with a GP for 12 months 5. Patients who live in a house of multiple occupancy (10 or more residents) 6. Students who have been registered for four or more years Patients whose registration was not confirmed by either the GP practice or the patient themselves between October 2019 and March 2020 were placed on an FP69 (as a 6-month deduction notice). Due to the process timescales for response FP69s were not added to patient records until Feb 2020 and will run for 6 months until August when the first patients will begin to be removed. The three-year list reconciliation project began in January 2019 was also interrupted by covid. The original preliminary dates for when Primary Care Support England (PCSE) would undertake Borough-based audits are set out below, and the Committee will be advised of the new dates once received: • Barnet - 15/06/2020 • Camden - 26/07/2021 • Enfield - 14/06/2021 • Haringey - 07/09/2020 • Islington - 03/08/2020	16				→	6

PERF15	Failure to address variation in Primary Care Quality and Performance across NCL (Threat)	Paul Sinden, Executive Director of Performance & Assurance	Mitigations in place to help reduce unwarranted variation in quality and performance across general practices include: • Primary Care Networks (PCNs) have been established successfully across North Central London including the appointment of Clinical Directors for each PCN, in line with the new national GP contract; • PCNs have received funding for their development including support for Clinical Directors; • Use of GP Forward View monies from NHS England to support the development of primary care networks and GP Federations, and develop a resilience programme for general practice; • The new GP contract also introduces a greater quality improvement focus in the Quality Outcomes Framework; • Models for mutual aid across practices established during Covid including hot site and home visiting service, and training for practices in managing Covid patients	12					➔	6
PERF 18	Primary care workforce development (Threat):	Paul Sinden, Executive Director of Performance & Assurance	The updated GP contract was published on 6/2/2020. It places additional emphasis on the importance of funding, and includes additional funding for and flexibility within the PCN workforce Scheme. PCNs are encouraged by NHSE/I to focus on recruitment.	12					➔	9

Risk Key

Risk Improving

Risk Worsening

Risk neither improving nor worsening but working towards target ➔

Primary Care Commissioning Committee Risk Register - July 2020

ID	Risk Owner	Risk Manager	Objective	Risk	Consequence (Initial)	Likelihood (Initial)	Rating (Initial)	Controls in place	Evidence of Controls	Overall Strength of Controls in place	Consequence (Current)	Likelihood (Current)	Rating (Current)	Controls Needed	Actions	Action Deadline	Update on Actions	Consequence (Target)	Likelihood (Target)	Rating (Target)	Committee	Strategic Update for Committee	Date of Last Update	Status
PERF 4	Paul Sinden - Executive Director of Performance & Assurance			**Opportunities to support struggling practices are sometimes delayed by the absence of a systematic early warning system (Threat)** **CAUSE:** If there are delays in identifying struggling practices **EFFECT:** There is a risk that greater number of practices will go through regulatory processes and receive poor Care Quality Commission ratings **IMPACT:** This may result in more practices receiving formal contract remedies for completion, more caretaking arrangements being in place, more list dispersals / procurements being undertake, and practices not being aligned with primary care networks	5	4	20	C1. Committee performance and quality report C2. Established NCL early Warning System working group C3. Resilience programme and supporting funding C4. Primary care at scale developed through GP Federations C5. Establishing Primary Care Networks C6. Development of Quality Improvement Support Teams (QISTs) through health and care closer to home STP workstream C7. Primary Care Covid recovery workstream for workforce and resilience established C8. Practice finance resilience support package established to project practice oncome and support additional costs incurred due to coved	C1. Committee reports C2. Meeting notes C3. Meeting notes and practice correspondence C4. CCG Committee papers C5. Committee in Common papers C6. Meeting notes and practice correspondence C7. Meeting notes and recovery plan C8. Meeting notes and support package	Average	3	4	12	CN1. Development of NCL framework for early warning system CN2. Further development of performance and quality report to provide triangulated view of practice performance CN3. Development of practice resilience programme through the primary care recovery programme CN4. Determination of financial support package for coved for the rest of 2020/21	A1. Development of framework through the workforce and resilience workstream in primary care recovery programme A2. Update the quality and performance report in line with July 2020 committee requests and stocktake of Borough reports A3. Finalise action plan from workforce and resilience workstream A4. Agree CCG support programme for practices for 2020/21, including any ongoing coved support	A1. 31.08.2020 A2. 31.08.2020 A3. 31.07.2020 A4. 30.09.2020	A1. Workforce and resilience task and finish group meetings completed, with recommendations for next steps and action plan. A2. Report updated for July 2020 Committee A3. Action plan from workforce and resilience workstream in development A4. Support package in place for Q1 and Q2 2020/21	2	3	6	Primary Care Commissioning Committee	This risk is a response to regulatory action that has been taken with a series of practices recently following "inadequate" or "requires improvement" ratings following Care Quality Commission (CQC) inspections. Action in some cases has included having to put in place caretaking arrangements at practices at very short notice. The aim of the risk is to promote earlier recognition of struggling practices, and ensure that support is provided before regulatory action is required. Additional support has been provided to practices during the coved period including a financial resilience support package (in advance of any national policy), and a service model establishing a central hot site and home visiting service for coved positive patients in each Borough. The workforce and resilience workstream for primary care recovery (from first wave of the pandemic) has a focus on supporting and early identification of struggling practices. At the height of the pandemic the CQC paused regulatory action with the exception of cases with a risk to patient safety.	10/07/2020	Open
PERF 9	Paul Sinden - Executive Director of Performance & Assurance	Vanessa Piper -		**Inadequate support from Primary Care Support England (Capita contract) for general practices (Threat)** **CAUSE:** If the primary care support services provided by Capita do not operate effectively and in line with the contract held by NHS England **EFFECT:** There is a risk that support to general practices falls below the standard required to support effective service delivery **IMPACT:** This may result in risks to business continuity of GP services, reduce the quality of service to primary care users, and result in cost pressures to budgets delegated to CCGs	4	4	16	C1. Monthly report from Local Medical Committee to NHS England (London) primary care team on practice issues accruing from the contract C2. Contract management by NHS England C3. National Audit Office (NAO) report on Capita Contract C4. Inclusion of independent contractors on operational review group for London C5. Capita schedule for restarting practice list cleansing process	C1. Meeting notes C2. Contract meeting notes C3. Audit report C4. Meeting notes C5. Committee papers	Weak	4	4	16	CN1. Assurance on process and timeline for practice list cleansing CN2. Details of provider response to NAO findings and contract management meetings	A1. Obtain Capita schedule for list cleansing A2. Update on Capita Contract management through London Primary Care Management Board	A1. 20.06.2019 A2. 30.09.2020	A1. High-level timeline provided to Committee in June 2019. **Completed** A2. NHS England Primary Care Management Board meetings discontinued during the Covid pandemic.	2	3	6	Primary Care Commissioning Committee	List cleaning activities were suspended at the request of NHS England in March 2020 due to Covid and are yet to recommence. Current reporting does not enable us to report at CCG level but this will be developed once NHS England have written to GPs informing them of the recommencement of the activity. Prior to covid, in October 2019, Capita commenced a list cleansing programme for 6 population cohorts: 1. Patients registered as living at a demolished address 2. Children Under 16 and registered as the sole occupant at an address 3. Patients aged Over 100 4. Transient patients who have been registered with a GP for 12 months 5. Patients who live in a house of multiple occupancy (10 or more residents) 6. Students who have been registered for four or more years Patients whose registration was not confirmed by either the GP practice or the patient themselves between October 2019 and March 2020 were placed on an FP69 (as a 6-month deduction notice). Due to the process timescales for response FP69s were not added to patient records until Feb 2020 and will run for 6 months until August when the first patients will begin to be removed. The three-year list reconciliation project began in January 2019 was also interrupted by covid. The original preliminary dates for when Primary Care Support England (PCSE) would undertake Borough-based audits are set out below, and the Committee will be advised of the new dates once received: • Barnet - 15/06/2020 • Camden - 26/07/2021 • Enfield - 14/06/2021 • Haringey - 07/09/2020 • Islington - 03/08/2020	13/07/2020	Open
PERF15	Paul Sinden - Executive Director of Performance & Assurance			**Failure to address variation in Primary Care Quality and Performance across NCL (Threat)** **CAUSE:** If NCL CCG fails to identify and address variations in Performance and Quality **EFFECT:** There is a risk that practices across NCL will offer differential access and services for NCL residents **IMPACT:** This may result in plans to reduce health inequalities and move more care closer to home to be less effective than planned risking inferior patient experience and poor cost effectiveness	4	4	16	C1. Primary Care Committee supported by Practice and PCN based Quality and Performance Report C2. Establishment of Primary Care Networks C3. CCG work on resilience, sustainability and delivering primary care at-scale through GP Forward View C4. NCL CCG Strategy for General Practice in place with a focus on at-scale provision and support C5. Establishment of CCG Quality Improvement Support Teams (QISTs) in each Borough C6. Primary Care Recovery plan has a workstream focusing on workforce and resilience	C1. Report C2. Committee papers C3. CCG papers C4. CCG Strategy C5. CCG papers and STP workstream papers C6. Primary Care coved papers and minutes	Average	3	4	12	CN1. Development of early warning system through primary care coved workforce and resilience workstream CN2. Implement Directed Enhanced Service (DES) for PCNs CN3. Further development of performance and quality report CN4. Reflect national guidance on phase two of managing coved in primary care in NCL plans	A1. Develop action plan for workforce and resilience workstream A2. PCNs enacting DES as they can through coved A3. Revised report for Primary Care Committee and stocktake of Borough reports underway A4. Respond to requirements from national guidance	A1. 31.08.2020 A2. 31.07.2020 A3. 23.07.2020 A4. 31.08.2020	A1. Primary Care Recovery meeting held on 8 July 2020 signed off task and finish group priorities, to be converted into action plan. A2. Network DES included in practice financial resilience support package A3. Quality and Performance report on Committee agenda for 23 July 2020 A4. National guidance on primary care coved group agenda on 14 July 2020	3	2	6	Primary Care Commissioning Committee	Mitigations in place to help reduce unwarranted variation in quality and performance across general practices include: • Primary Care Networks (PCNs) have been established successfully across North Central London including the appointment of Clinical Directors for each PCN, in line with the new national GP contract; • PCNs have received funding for their development including support for Clinical Directors; • Use of GP Forward View monies from NHS England to support the development of primary care networks and GP Federations, and develop a resilience programme for general practice; • The new GP contract also introduces a greater quality improvement focus in the Quality Outcomes Framework; • Models for mutual aid across practices established during coved including hot site and home visiting service, and training for practices in managing coved patients	12/02/2020	Open

PERF18	Paul Sinden - Executive Director of Performance & Assurance	Katherine Gerrans Workforce Programme Lead	Delivery of high quality, efficient services within available resources	**Primary care workforce development (Threat):** **CAUSE:** If the CCG is ineffective in developing the primary care workforce, **EFFECT:** there is a risk that it will not deliver the primary care strategy **IMPACT:** This could mean that, for example, patients with long term conditions are not fully supported in primary care and require more frequent hospital care.	4	3	12	C1. Establishment of primary care networks These will attract further investment in staffing. C2. The education programme for GPs, practice nurses and practice staff is in place. C3. Development funding in primary care strategy for practice managers, practice nurse and practice-based pharmacists is in place. C4. Blended roles for urgent care have been developed through Community Education Provider Network (CEPN) C5. Primary Care funds have been used to establish practice based pharmacists. C6. Workforce development team in place in the CCG C7. New GP contract (February 2020) allows use of core funding across a broader skill mix and in some cases full reimbursement to practices C8. The Workforce Action Plan is in draft and will be shared with stakeholders for comment imminently.	C1. Committee papers C2. Programme papers C3. CCG papers and GPFV funding C4. CEPN papers and workforce summaries C5. PCN DES guidance; CCG papers C6. Strategy Directorate structures include workforce development C7. GP contract C8. Plan	Strong	4	3	12	CN1. PCN recruitment in line with DES requirements CN2. Supporting the development of the PCNs so they are able to develop new roles, e.g. Clinical Directors, social prescribers, building on the baseline of current workforce.	A1. PCN recruitment supported by CCG A2. Ongoing work to ensure that proposals for supporting primary care workforce are developed and approved.	A1. 31/03/2021 A2. 31/03/2021	A1. Recruitment for social prescribers will soon commence plus that of additional pharmacy roles. A2. Work ongoing	3	3	9	Primary care Commissioning Committee	The updated GP contract was published on 6/2/2020. It places additional emphasis on the importance of funding, and includes additional funding for and flexibility within the PCN workforce Scheme. PCNs are encouraged by NHSE/I to focus on recruitment. Recruitment plans will have been impacted by Covid.	10/07/2020	Open

Risk Scoring Key

This document sets out the key scoring methodology for risks and risk management.

1. Overall Strength of Controls in Place

There are four levels of effectiveness:

Level	Criteria
Zero	The controls have no effect on controlling the risk.
Weak	The controls have a 1- 60% chance of successfully controlling the risk.
Average	The controls have a 61 – 79% chance of successfully controlling the risk
Strong	The controls have a 80%+ chance or higher of successfully controlling the risk

2. Risk Scoring

This is separated into Consequence and Likelihood.

Consequence Scale:

Level of Impact on the Objective	Descriptor of Level of Impact on the Objective	Consequence for the Objective	Consequence Score
0 - 5%	Very low impact	Very Low	1
6 - 25%	Low impact	Low	2
26-50%	Moderate impact	Medium	3
51 – 75%	High impact	High	4
76%+	Very high impact	Very High	5

Likelihood Scale:

Level of Likelihood the Risk will Occur	Descriptor of Level of Likelihood the Risk will Occur	Likelihood the Risk will Occur	Likelihood Score
0 - 5%	Highly unlikely to occur	Very Low	1
6 - 25%	Unlikely to occur	Low	2
26-50%	Fairly likely to occur	Medium	3
51 – 75%	More likely to occur than not	High	4
76%+	Almost certainly will occur	Very High	5

3. Level of Risk and Priority Chart

This chart shows the level of risk a risk represents and sets out the priority which should be given to each risk:

LIKELIHOOD	**CONSEQUENCE**				
	Very Low (1)	Low (2)	Medium (3)	High (4)	Very High (5)
Very Low (1)	**1**	**2**	**3**	**4**	**5**
Low (2)	**2**	**4**	**6**	**8**	**10**
Medium (3)	**3**	**6**	**9**	**12**	**15**
High (4)	**4**	**8**	**12**	**16**	**20**
Very High (5)	**5**	**10**	**15**	**20**	**25**

1-3 **Low Priority**	**4-6** **Moderate Priority**	**8-12** **High Priority**	**15-25** **Very High Priority**

NCL PRIMARY CARE COMMISSIONING COMMITTEE

FORWARD PLANNER 2020 / 21

Area	23 July 2020	20 Aug 2020	22 Oct 2020	17 Dec 2020	18 Feb 2021			
Governance								
Review of Risk Register	X	X	X	X	X			
Review of Terms of Reference (TOR)	X				X			
Review of Committee Effectiveness					X			
Contracting								
Decisions relating to GMS, PMS and APMS contracts eg: practice mergers	X	X	X	X	X			
Local Commissioned Services	As required							
Procurements	As required							
Quality & Performance								
Quality and Performance Report	X	X	X	X	X			
Finance Report								
Finance Report	X	X	X	X	X			

Strategy								
NHS Long Term Plan and Operating Plan				X	X			
Other papers								
Developing Primary Care workforce			X					
GP Patient Survey learning			X					
New GP Contract Update		X						
PCN Development		X			X			
Covid report	X	X						