North Central London Primary Care Joint Committee Minutes (Part 1)

Date: Tuesday 19 January 2016

Time: 15.00 – 16.30

Venue: St Pancras Hospital – Conference Suite, 4 St Pancras Way, London, NW1 0PE

Voting Members	
Lay Member Representatives	
Ms Cathy Herman **(Chair)**	Haringey CCG
Ms Sorrel Brookes **(Vice Chair)**	Islington CCG
Ms Bernadette Conroy	Barnet CCG
Ms Kathy Elliott	Camden CCG
Ms Karen Trew	Enfield CCG
GP Representatives	
Dr Michelle Newman	Governing Body GP Member, Barnet CCG
Dr Neel Gupta	Governing Body GP Member, Camden CCG
Dr Jahan Mahmoodi	Governing Body GP Member, Enfield CCG
Dr Dina Dhorajiwala	Governing Body GP Member, Haringey CCG
Dr Katie Coleman	Governing Body GP Member, Islington CCG
Officer Representatives	
Mr William Redlin	Interim Director of Operations, Barnet CCG
Ms Susan Achmatowicz **(Apologies)**	Director of Primary Care, Camden CCG
Ms Deborah McBeal	Interim Deputy Chief Officer, Enfield CCG
Ms Jennie Williams	Executive Nurse & Director of Quality, Haringey CCG
Ms Alison Blair	Chief Officer, Islington CCG
Practice Nurse Representative	
Ms Katherine Gerrans	Lead Nurse & Quality Workforce Manager, Haringey CCG
NHS England	
Ms Liz Wise **(Apologies)**	Director of Primary Care Commissioning, London
Mr John Atherton	Director of Commissioning Operations North Central and East London
Dr Henrietta Hughes	Medical Director North and East London
Non-Voting Members	
Ms Emma Whitby	Chief Executive, Healthwatch Islington
Mr Greg Cairns	Director of Primary Care Strategy, Londonwide LMCs
Dr Manish Kumar	Chair, Enfield LMC
To be confirmed	Health and Wellbeing Board Representative
In attendance	
Ms Fiona Erne (deputising for Ms Liz Wise)	Head of Primary Care, North Central and East London, NHS England, London Region
Mr Gordon Houliston (deputising for Ms Susan Achmatowitcz	Head of Primary Care, Camden CCG
Ms Toyin Akinyemi	Head of Finance, Primary Care Commissioning, NHS England (London)
Ms Frances Hasler	Director, Camden Healthwatch
Minutes	
Ms Keziah Bowers	NEL Commissioning Support Unit

1. Welcome and Apologies

1.1 The Chair welcomed the members and attendees to the North Central London (NCL) Primary Care Joint Committee. She also welcomed the members of the public in attendance.

1.2 Apologies were received from Ms Liz Wise, Ms Susan Achmatowicz and Ms Elizabeth James.

2. Declarations of interest

2.1 The Chair noted the register of interest and asked for any additional interests. There were no other interests declared.

2.2 It was noted that a small number of outstanding declarations of interest forms / updates were being received at the meeting.

2.3 **Action 1: Register of interests to be updated.**

3. Minutes and actions from the previous meeting

3.1 The minutes and actions from the previous meeting on 5 November 2015 were reviewed and approved subject to a minor amendment.

3.2 It was requested by Greg Cairns that the reference in paragraph 6.2.8 to 'local medical committees', be amended to 'Local Medical Councils'.

3.3 The Chair confirmed in relation to action 5 that there would be a workshop in April 2016 for committee members to review the role of the Joint Committee and to consider the NCL position on moving to delegated commissioning. Alison Blair explained that if NCL were to apply for delegated commissioning, the deadline for this is expected to be in October 2016.

3.4 **Action 2: NCL position on delegated commissioning to be considered at April 2016 workshop with Joint Committee members.**

4. Questions from the public

4.1 There were no questions from the members of the public in attendance.

5. **Practice merger:** Tufnell Park Surgery and Dartmouth Park Surgery (Islington)

5.1 Fiona Erne presented a proposed merger of two GMS GP practices in Islington CCG. The practices have proposed that they merge to hold a single contract list but continue to operate from both sites. The practices would like to open 08.30 – 18.30 Monday to Friday with Thursday afternoon closure alternating at one of the practices. NHS England are willing to support the merger but would like this to be contingent upon both practices opening all day on Thursdays.

5.2 Sorrell Brookes noted that one of the practices in question shares a premises with a different practice. She queried whether a three way merger has been explored. She explained that she is familiar with the lay out of the three practices and felt that from a patient perspective it seemed surprising that the two practices in the same building together are not being merged as they already share a reception. Fiona Erne stated that it is likely that this has been considered by the practices and that the proposed merger may be the first step to a further merger.

5.3 Emma Whitby asked how patients will know which practice to go to. Fiona Erne explained that patients will likely continue visit the practice that they had previously attended but the merger would allow the opportunity for patients to be booked an appointment at either site with the consent of the patient. The practice will have to decide their own process for this but having two sites will allow them greater flexibility.

5.4 Bernadette Conroy queried whether the practices can work together and experience the benefits of a merger without going through the costs of implementing a technical merger. Fiona Erne explained that there may be a number of reasons why the practices themselves would choose to merge. Some of these may include management and financial efficiencies.

5.5 It was noted by Greg Cairns that the comments emerging from the discussion were very locally relevant. He queried what local engagement there had been prior to the paper coming to this meeting. Fiona Erne responded that the proposal had been discussed with the CCG and that the LMC were also invited to attend the meeting. Greg Cairns indicated that he had not been aware of this and would need to check with colleagues.

5.6 Dr Katie Coleman explained in response to the previous query about why a technical merger was necessary, that if there was no shared list, the practices would not be able to share full electronic records without going through complex data sharing and information governance arrangements. In fully merging they can bring together one list which makes it much easier to work together. She also noted that she was not clear as to what was included in the premises related CQC statutory compliance condition D referred to in the paper and which has not been met. Fiona Erne stated that she would need to double check what was the definition of CQC condition D. Alison Blair highlighted that any premises related issues would be linked to Islington CCGs wider estates support.

5.7 In response to a query from William Redlin, Fiona Erne felt that based on previous experience, it seemed likely that the practices would be willing to accept the proposed condition on Thursday openings. Dr Henrietta Hughes noted that the clinical sessions to be provided by a recruited salaried GP was likely to be 2.5 clinical sessions (or 25 appointments) per week rather than 25 clinical sessions per week. Karen Trew suggested that relevant commissioners may wish to discuss possible Saturday opening with the practices alongside the discussions around Thursday openings. Fiona Erne said that she could take this back as part of the discussion.

5.8 **Islington CCG approved the recommended option.**

6. Proposal to vary APMS KPIs (Camden)

6.1 Fiona Erne presented a proposed variation to an existing APMS (Alternative Provider Medical Services) contract in Camden CCG. The practice has been contracted to provide GP services to homeless patients since December 2012. A number of the key performance indicators (KPI) have now become redundant or have been incentivised through other payment schemes. The practice has agreed in principle to the proposed variation.

6.2 The Chair invited a question from Frances Hasler who was in attendance at the meeting as an observer. Frances Hasler asked for additional information around the KPI on learning disability and was particularly interested in what volume of patients within the practice have learning disabilities. Gordon Houliston confirmed that he would look into this.

6.3 **Action 3: Camden CCG to clarify how many of the patients at the APMS practice in question have learning disabilities.**

6.4 Bernadette Conroy noted that the paper appeared to suggest that the practice had been receiving double payments through an overlap of incentives included in the APMS contract and a locally commissioned scheme. Fiona Erne stated that there had been no actual double payment, but confirmed that there was an existing overlap on paper and that the proposed variation was intended to rectify this. She also explained, in response to a query from Emma Whitby, that the contract variation would not adversely affect patients accessing the service as no services were being withdrawn, but rather, the practice was being asked to deliver more services through the contract.

6.5 Dr Neel Gupta welcomed the proposed variation to the contract, but requested that local commissioners be included in any similar discussions as early as possible as he had not

been aware of the proposed amendment prior to receiving the information outlined in the paper. Fiona Erne explained that the review of this contract was part of a wider APMS contract review taking place across London. London CCGs have already been involved in discussions around re-procuring a number of APMS services. There is also work underway to re-negotiate some existing contracts, and she noted that NHS England are keen to improve how they involve local commissioners in this process and particularly in ensuring that these re-negotiations are aligned with locally commissioned schemes.

6.6 Deborah McBeal asked whether the approach taken in this contract aligned with the pan-London work being carried out by the Healthy London Partnership around homelessness. Fiona Erne confirmed that this was the case.

6.7 **Camden CCG approved the recommended option.**

7. Practice Closure: Dr Ansari (Haringey)

7.1 Fiona Erne presented the findings of an options appraisal for the provision of primary medical services for Green Lanes Practice in Haringey. This contract is currently held by Dr Ansari, a single handed practitioner who is due to retire on 31 March 2016. NHS England have carried out engagement with the registered patients and relevant stakeholders to determine the future provision of primary care services. The options outlined in the paper consider the demographics and health needs of the local population as well as identifying alternative provision with the geographical area. Based on the findings from the options appraisal, it is proposed that the existing contract be terminated on 31 March 2016 and the patient list be dispersed.

7.2 Fiona Erne informed the Committee there has been a wider piece of strategic work underway in Haringey which has been considering the needs of the local area and potential succession planning. NHS England and the CCG had already been aware that Dr Ansari was likely to be retiring and the options appraisal therefore considered the longer term strategy for primary care medical service provision in the Green Lanes area. She noted that the existing premises has only two clinical rooms and could not be considered as a good investment for development. Had Dr Ansari remained there, NHS England would have recommended that she look for a new premises. It was also unlikely that there would be a successful procurement for the existing practice based on the small list size and the small size of the premises which would prohibit any future growth of the practice.

7.3 Emma Whitby reflected that during the engagement process, the patients had been asked their views on re-procurement although this was never really a viable option due to the aforementioned issues. Fiona Erne acknowledged that this was something that would need to be considered when planning future patient engagement

7.4 The content of the paper and the wider strategic planning work underway was commended by Karen Trew. She asked whether the retirement of Dr Ansari and a subsequent list dispersal would impact the choice of patients who wished to see a female doctor. Also, whether there was a chance that if patients joined a different practice that practice would also close? Fiona Erne confirmed that there is another female GP locally and that Dr Ansari's practice was the main practice which it had been anticipated would close.

7.5 Deborah McBeal queried whether there had been any discussion about staffing and whether TUPE (Transfer of Undertakings (Protection of Employment) Regulations) could apply under a list dispersal option. Fiona Erne agreed that this is a conversation which will need to be had as part of the process. She would need to verify whether there is any possibility for TUPE under a list dispersal.

7.6 Greg Cairns felt that it was not helpful to include specific patient feedback out of context i.e. paragraph 5.1.3 refers to the practice having been rated by patients on NHS Choices as 'one of the worst'. Cathy Herman registered concern that the two practices closest to this one also have small list sizes. However she commended NHS England and Healthwatch in having come together to discuss the future of the practice.

7.7 Dr Katie Coleman commented that Islington CCG has had recent experience of list dispersal and closures. She highlighted the huge amount of work required for practices who are taking on new patients from the dispersed list, especially patients with long term conditions. She asked whether any support would be put in place to support the neighbouring practices. Fiona Erne confirmed that there would be support available for practices who take on more than a certain percentage of patients from the closing practices i.e. a small payment to support the transfer. There may also be other ways of managing the dispersal that need to be considered in order to smooth the transition for recipient practices. Commissioners may need to be more innovative in these situations to ensure that patients continue to get the care they need during the transfer process. Jennie Williams felt that under the procurement options in section 4.4 of the paper, it would be reasonable to also note that the quality of care being provided for patients could be impacted by the length of the transition process.

7.8 **Haringey CCG approved the recommended option.**

8. NCL CCGs Commissioning Intentions

8.1 Alison Blair presented an update on NCL CCG commissioning intentions relating to the London PMS (personalised medical services) contract review. She noted that this is part of a national review but it also needs local consideration. The paper was largely for information but she informed the committee that she would be happy to take any comments from members as she appreciated that this is an issue of interest and concern. The London offer which has been discussed with NHS England, London CCGs and the Londonwide LMC is close to being finalised and will be incorporated in CCG commissioning intentions. The London offer is particularly looking at supporting proactive, accessible and coordinated care. She also explained that there is expected to be a 2 year transition period but is aware that there is some discussion locally about this.

8.2 Fiona Erne noted that the term 'transition funding' is being used currently but this might be slightly misleading. This is likely to be an interim payment whilst there is a realignment to a new contract. It is not inevitable that there will be a removal of funding for each practice. Dr Neel Gupta highlighted that Camden CCG has applied for an extension on the 2 year transition phase as they did not go through a 2012 PMS review. He asked whether a borough could be exempt from the expected 2 year limit on the transition phase. Fiona Erne stated that any exemption would need to be agreed on a case by case at a practice level. In response to a query from Neel Gupta that this approach may risk propagating the variation which Camden CCG is trying to eliminate, she felt that the existing variation is the very reason why any exemptions need to be agreed on a case by case basis as some practices will be heavily affected whilst others will not. Neel Gupta noted that it would be helpful to know as early as possible which practices NHS England are anticipating would be eligible for an exception to the 2 year limit.

8.3 Gordon Houliston felt that if criteria similar to that used for the phasing out of MPIG (minimum practice income guarantee) are being developed, then it would be helpful to have this information as early as possible. Deborah McBeal agreed that it would be good to have clear principles around the case by case discussions. It was important that no practices were advantaged simply because they were better negotiators than other practices. Fiona Erne confirmed that it will be helpful to have principles in place.

8.4 Karen Trew reflected on the importance of sharing learning from the PMS Review process e.g. in terms of the different approaches for making decisions on this and how well this has aligned with the London Strategic Commissioning Framework for primary care. Fiona Erne observed that the NCL CCGs are in different places with Islington having only 2 PMS

practices; Barnet, Enfield and Haringey are still on track for equalisation following a 2012 PMS review, and Camden being in a position of having never had a PMS review. NHS England's primary care commissioners have certainly been trying to working towards creating a commonality around these key principles.

8.5 Dr Katie Coleman agreed that the PMS review process is not having such a big impact in Islington. However she felt it is key to consider what impact this process might have on patients and the expectations that patients have around care. She asked what work is underway to involve patient groups such as Healthwach to engage them in how this is impacting practices. Fiona Erne responded that the transition period will allow some of that engagement to happen. The transition payments are intended to manage the impact on practices. Katherine Gerrans queried whether these impacts on payment would affect practice staff and in particular nursing staff. Fiona Erne stated that it is hoped that practices will not feel that they need to change staffing arrangements.

8.6 Following a question from William Redlin, it was clarified by Fiona Erne and Greg Cairns that the detail of the London offer was to be finalised at a meeting with the Londonwide LMC on 20 January and would be disseminated to CCGs on 22 January. Alison Blair noted that CCGs have already been circulated the draft London offer.

9. Quality & Performance Report

Fiona Erne presented the NCL Quality and Performance report. She explained that NHS England are looking to build on work undertaken in NCL last year around develop a quality scorecard and using this to manage quality improvement. This work will be led with NCL CCGs and NCL CSU. The quality reporting will also need to incorporate CQC ratings. She

9.1 noted that there is also a vulnerable practices fund to help practices meeting certain criteria to improve. Although practices will also need to match this funding. Where practices don't meet this criteria, commissioners will be looking at how they can provide training for practices to enable them to carry out their own improvements and quality assessments.

The Chair welcomed this work and looked forward to future updates. Bernadette Conroy enquired about the blue colour rating on the report for the patient satisfaction as it does not appear to show which practices are performing very well – only those that are not performing well. Fiona Erne agreed that she would be happy to take this feedback away. Bernadette Conroy further observed that the patient survey is a very static moment in time and asked

9.2 how we can ensure that we are getting other data on a regular basis. Fiona Erne confirmed that NHS England has discussions with CCGs to review which practices are of concern. There is sometimes additional 'soft' information which provides further insights into why a practice might be performing poorly e.g. a change in practice manager or as the result of a list dispersal. She also indicated that she would like to have these discussions with CCGs formalised so that this is a more systematic process.

9.3 It was observed by Katherine Gerrans that the report indicates that there are poor ratings for patient experience of nursing care. She suggested that consideration needs to be given as to how this can be improved. She indicated that it would be helpful to hear from the Committee's lay members on this. Fiona Erne highlighted that there have been discussions with patient representatives on this subject. It is not always clear whether patient scoring is a reflection of how they are feeling about process problems and access to staff rather than about the quality of individual staff. Dr Henrietta Hughes reflected that practices with well trained staff appear to do very well in CQC inspections compared to areas that don't have that. It is important to think about the impact of practice nurse education and job satisfaction. Dr Manish Kumar felt that it is helpful to also look at this data over a number of years to identify trends and is possible compare it against population growth to consider whether practices are actually doing very well under heavy workloads. Fiona Erne explained that this is a new reporting system and further work will be required to bring that helpful wider context.

9.4 Karen Trew asked whether there were any trends that could be identified through the findings of CQC inspections given that not all practices have yet been inspected. Dr Henrietta Hughes

responded that it might be useful to have a CQC representative at the April workshop as it would be good for Committee members to hear the feedback from the CQC. Generally CQC feedback following an inspection can vary from small specific learning which can be quickly amended to bigger more significant issues. Having a high number of CQC recommendations does not always mean that the practice is poorly performing. In response to another query from Karen Trew regarding whether it was possible to receive data on how long it has taken to close CQC cases, Dr Henrietta Hughes noted that some CQC cases can take time to close due to external delays from regulators.

9.5 In response to a question from Dr Neel Gupta Neel as to why useful GPOS data has been removed from the report, Fiona Erne explained that the previously mentioned work-stream looking into quality improvement will be considering GPOS data and how this can be used most effectively. It has been taken out of report in the interim as not all of this data is in the public domain and it is better to bring it back into the report once it has been agreed how the data can best be used.

9.6 Gordon Houliston observed that local Health and Scrutiny Committees have been asking about workforce planning and succession. He noted that it would be helpful to share the approach that has been taken in Haringey which was mentioned during item 7 on the agenda. Jennie Williams also asked how what could be done to help practices prepare for CQC given that secondary care Trusts regularly carry out work to prepare for inspection. Fiona Erne stated that this is being considered. Barnet CCG are already looking at establishing a process for practices who have passed a CQC inspection to share learning with other practices. Kathy Elliott enquired about the contractual data at the end of the report regarding which GP practitioners have retired etc. and whether this information is available looking forward? Fiona Erne responded that this is something that CCGs will need to be looking at as part of workforce planning. This can be very hard to predict although CCGs do hold information on which practices are single handed and where the GP practitioner is over 50.

9.7 **Action 4: Consider how the Committee can share learning and be strategic about how they can add value in their approach.**

10. Finance Report

10.1 Toyin Akinyemi presented the NCL financial position for primary care medical services. She noted that there is currently a £357k overspend against issued budgets for the year to 8 months ending on 30 November 2015. This overspend is largely due to the underachievement of planned QIPP **(**Quality, Innovation, Productivity and Prevention) savings. She also explained that she is awaiting the publication of population growth figures to see how this aligns with the expected growth figures and the budget that was allocated for it.

10.2 Karen Trew observed that there is a 'zero' against QIPP delivery. She asked whether the findings of the external QIPP review which has recently been underway can be shared and what the outcome of this was. How can NCL avoid being in this situation again? Toyin Akinyemi responded that there have been some savings from certain QIPP activities such as list cleansing, but it is unlikely that we will get any more savings from the big QIPP areas. Karen Trew agreed with this but said that the bigger question is around what can be done if we are not building up savings in this financial year. Fiona Erne stated that due to the way in which financials are recorded at a London level it is difficult to pull out where local QIPP savings have been made. Most of the savings have been from transactional approaches and it is unlikely that much will be saved from this anymore. There are ongoing discussions with CCGs about how we can make savings in the future. There are also discussions around delegated CCG budgets. NHS England have been looking at this nationally but there are further local levers which may be able to be used.

10.3 Bernadette Conroy noted that it would be helpful to consider how we can test and monitor future QIPP plans throughout the year so that we are not in this position again next year. Sorrell Brookes asked that the Committee refer to QIPP as 'savings' as this term is difficult for

lay people to understand. William Redlin requested that if this is an agenda item on the next meeting, information be provided on the expected QIPP starting figure for 2016. He suggested that real benefits for savings are investment in primary care. Toyin Akinyemi added that financial allocations for the coming financial year have been released and are more generous than previous years. These are currently being modelled.

10.4 **Action 5: Include QIPP on the next Committee agenda as an item for discussion.**

11. Local Service Specification (Enfield)

11.1 The Committee noted this information

12. Award of caretaking contract: Somers Town Medical Centre (Camden)

12.1 The Committee noted this information.

13. Practice Relocation: Four Trees Surgery (Camden)

13.1 The Committee noted this information.

14. Any other business

14.1 There was no other business.

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

9.1 The Committee resolved to move to Part 2 of the agenda.

NCL Primary Care Joint Committee

Action Log – Part 1

Meeting Date	Action No.	Action	Action lead	Deadline	Status update	Date closed
5/11/15	1	All Committee members to complete a declaration of interest form.	Board Secretary	31/01/16	Closed. Additional forms have been received. One form is outstanding. This action log item has been replaced by action no.1 from the meeting held on 19/1/16.	26/01/16
5/11/15	5	The Committee to review in early 2016, the NCL position on moving to delegated commissioning**.**	Chair	31/03/16	Closed. Agreed at January 2016 Committee meeting that this item would be discussed at the April 2016 workshop. This action log item has been replaced by action no. 2 from the meeting held on 19/1/16.	26/01/16
19/1/16	1	Register of interests to be updated.	Board Secretary	Ongoing	The register of interests has been updated. One form is outstanding. The Chair is aware of this.	
19/1/16	2	NCL position on delegated commissioning to be considered at April 2016 workshop with Joint Committee members.	Chair	30/04/16	Item will be discussed at the April 2016 workshop.	
19/1/16	3	Camden CCG to clarify how many of the patients at the APMS practice in question have learning disabilities.	Camden CCG representatives	31/03/16	This information has been requested from Camden CCG.	
19/1/16	4	Consider how the Committee can share learning and be strategic about how they can add value in their approach.	Chair	30/04/16	Item will be discussed at the April 2016 workshop.	
19/1/16	5	Include QIPP on the next Committee agenda as an item for discussion.	Chair	30/04/16	Agreed with the Chair that this item will be discussed at the April 2016 workshop as part of the discussion around the NCL Sustainability and Transformation Plan STP).	