NHS
North Central London
Clinical Commissioning Group

NHS North Central London CCG
Primary Care Commissioning Committee
Thursday 21 April 2022
2:30pm to 4pm
Online Meeting via MS Team Live

Item	Title	Lead	Action	Page	Time
Pre-meet to be held for committee members between 2pm & 2:25pm					
	AGENDA **Part 1**				
1.0	**INTRODUCTION**				
1.1	Welcome and Apologies	Ian Bretman	Note	Oral	2:30pm to 2:40pm
1.2	Declarations of Interest Register	Ian Bretman	Note	4	
1.3	Declarations of Interest relating to the items on the Agenda	All	Note	Oral	
1.4	Declarations of Gifts and Hospitality	Ian Bretman	Note	Oral	
1.5	Draft Minutes of the NCL Primary Care Commissioning Committee Meeting on 17 February 2022	Ian Bretman	Approve	10	
1.6	Action Log	Ian Bretman	Approve	21	
1.7	Matters Arising	All	Note	Oral	
1.8	**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	Primary Care Finance update	Simon Goodwin / Anthony Browne	Note	Oral	2:40pm to 3:15pm
2.2	Quality & Performance Report	Paul Sinden	Note	24	
2.3	Interim Operating Plan Update	Paul Sinden	Note	40	
2.4	NCL Long Term Condition Locally Commissioned Service Update	Sarah Mcilwaine	Note	46	

3.0	ITEMS FOR DECISION				
3.1	**Contract Variations** **All Boroughs** • PMS Changes <u>Barnet</u> Ravenscroft Medical Practice – 24 hour retirement of a partner <u>Haringey</u> Cheshire Road Surgery – The Addition of a partner <u>Haringey</u> Rutland House Surgery – Removal of a partner	Vanessa Piper	Approve	71	
3.2	**Barnet** • Lichfield Grove Surgery **–** Request to revert from a PMS agreement to a GMS Contract	Vanessa Piper / Borough Rep	Approve	77	
3.3	**Enfield** • The Town Surgery – Request to Novate a PMS Agreement	Vanessa Piper / Borough Rep	Approve	84	3:15pm to 3:55pm
3.4	**Camden** • Belsize Priority Medical Practice – Request to relocate and Change in Rent	Vanessa Piper / Borough Rep	Approve	89	
3.5	**Enfield & Camden** • Direct Payments – Under the premises cost directions: ○ Chalfont Road Surgery ○ Boundary Court Surgery ○ James Wigg Practice	Vanessa Piper / Borough Rep	Approve	94	
3.6	**Haringey** • Lawrence House Practice & Spur Road Surgery Merger	Vanessa Piper / Borough Rep	Approve	98	
3.7	**Haringey** • Additional facility in Somerset Gardens health centre	Owen Sloman	Approve	103	
3.8	**Islington** • Change to Islington PCN composition	Vanessa Piper / Borough Rep	Approve	111	

3.9	**Islington** • Finsbury Leisure Centre/City Road Medical Centre - Islington Relocation Project	Rebecca Kingsnorth	Approve	114	
4.0	**ITEMS TO NOTE – URGENT DECISIONS TAKEN SINCE 17 FEBRUARY 2022**				
4.1	**Enfield** • Changes to Enfield PCN composition	Vanessa Piper / Borough Rep	Note	130	
4.2	**Camden** • Merger and consideration of co-location	Vanessa Piper / Borough Rep	Note	141	
4.3	Deploying CCG Funds in General Practice	Diane Macdonald	Note	150	
5.0	**GOVERNANCE AND COMMITTEE ADMINISTRATION**				
5.1	PCCC Risk Register	Paul Sinden	Note	154	3:55pm to 4:00pm
5.2	PCCC Forward Planner	Ian Bretman	Note	163	
6.0	**ANY OTHER BUSINESS**				**4.00pm**
6.1	Any other Business				
7.0	**DATE OF NEXT MEETING**				
	• Thursday 16 June 2022 - 2:30pm to 4pm				

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** **21 April 2022**	 North Central London Clinical Commissioning Group

Report Title	Declaration of Interests Register – Primary Care Commissioning Committee Meeting	**Agenda Item:** 1.2

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 - April 2022

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				Actions to be taken to mitigate risk (to be agreed with line a manager of a senior CCG manager)
			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 (when in session) Chair of Patient and Public Engagement Committee Chair of Primary Care Commissioning Committee Member of Audit Committee Member of Remuneration Committee Member of Quality and Safety Committee Chair of STP Engagement Advisory Board Attend other committee meetings as and when required	Biomedical Healthcare Ltd	No	No	Yes	Indirect	Son is Chief Technology Officer in a company offering an App for people to manage prescription requests and long-term medication programmes	01/04/2017	current	14/08/2019	21/07/2021	
		Timewise Foundation CIC	no	no	yes	direct	Provides occasional consultancy services for this social enterprise that helps organisations make better use of flexible working.	17/10/2018	current	14/08/2019	21/07/2021	
		Timewise Jobs Ltd	no	no	yes	direct		15/05/2019	current	01/10/2019	21/07/2021	
		Timewise Solutions Ltd	no	no	yes	direct		15/05/2019	current	01/10/2019	21/07/2021	
Simon **Goodwin**	Chief Finance Officer of NCL CCG Member of CCG Governing Body Finance Committee Procurement Committee Attendee, Audit committee Strategy and Commissioning Committee 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	19/07/2021	
Claire **Johnston**	Registered Nurse of NCL CCG Governing Body Member of Primary Care Commissioning Committee Member of Quality and Safety Committee Member of Strategy and Commissioning Committee Member of Medicines Management Committee Member of Public and Patient Engagement Committee Member of Covid Response Oversight Committee (when in session) Member of IFR Panel Attend Committee meetings as and when required	Our Time	No	Yes	No	Direct	Chair of Trustees . A charity which provides interventions and campaigns for children and young people with a mentally ill parent.			12/09/2019	19/07/2021	
		Nursing and Midwifery Council	No	Yes	No	Direct	Registrant Member			12/09/2019	19/07/2021	
		The Guardian	No	No	No	Indirect	Spouse is Public Services Editor			12/09/2019	19/07/2021	
Dr Subir **Mukherjee**	Secondary Care Clinician, NCL CCG Member of Covid Reponse Oversight Committee (when in session) Primary Care Commissioning Committee Quality and Safety Committee Individual Funding Request Appeals Panel Medicines Management Committee Strategy and Commissioning Committee Procurement Committee	Health Education England, KSS	yes	no	yes	direct	Associate post graduate Dean	2003	current	05/09/2020	13/08/2021	
		Diagnostic services procurement contract	no	no	no	direct	Clinical Lead		current	26/10/2021		
		GP Direct Access Diagnostic Service procurement	no	no	no	direct	Clinical Lead		current	24/02/2022		
		Interview Panel for Advisory Appointments Committee (AAC) for Consultant Physician (Royal College of Physicians)	no	no	yes	direct	Panel member - South East Region		current	01/10/2021		
Arnold **Palmer**	Lay Member of NCL CCG Governing Body Chair of Remuneration Committee Member of IFR Appeals Panel Strategy and Commissioning Committee Primary Care Commissioning Committee Finance Committee Audit Committee Public and Patient Engagement Committee Procurement Committee	A & C Palmer Associates	Yes	No	No	Direct	Director and Owner of private LTD company, providing training, executive coaching and consultancy services (including coaching and consultancy services to the NHS but excluding NCLCCG) Spouse is also a shareholder and company secretary.	01/01/2006	current	16/04/2020	31/07/2021	
		Mental Health & Community Service Review, led by Carnell Farrar	No	Yes	Yes	Direct	Member of the Programme Board - from May 2021 to March 2022. An acquaitance of a partner at Carnell Farrar, known of since 1995, as professional colleagues at the same NHS Trust.	05/05/2021	current	11/05/2021	31/07/2021	
Dr Dominic **Roberts**	Independent GP Clinical Lead, Primary Care Sustainability, Strategic Commissioning, NCL CCG Member of Primary Care Commissioning Committee Procurement Committee Medicines Management Committee		n	n	n	none		07/11/2018	current	02/08/2019	31/03/2022	

		Clinical Director, Islington Borough, NCL CCG	y	y	n	direct	member	07/11/2018	current	02/08/2019	31/03/2022	
		Conflict of interest issues for the Governing Body and CCG.	n	y	n	direct	Lead	07/11/2018	current	02/08/2019	31/03/2022	
		Caldicott Guardian for Islington & Haringey	n	y	n	direct	Caldicott Guardian	07/11/2018	current	02/08/2019	16/02/2021	
		Freedom to Speak up Guardian forNCL GP Practices	n	y	n	direct	Guardian	07/11/2018	current	02/08/2019	31/03/2022	
		Freedom to Speak up Guardian for Islington Federation	n	y	n	direct	Guardian	07/11/2018	current	02/08/2019	31/03/2022	
		Individual Funding Request Panel				direct	Chair	07/11/2018	current	02/08/2019	16/02/2021	
		Locally Commissioned Services Working Group				direct	Chair	07/11/2018	current	02/08/2019	31/03/2022	
		Member of NCL Primary Care Commissioning Committee				direct	Clinical representative	07/11/2018	current	02/08/2019	16/02/2021	
		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	31/03/2022	
		Medicines and devices Safety Officer (MSO & MDSO)				direct	Safety Officer	07/11/2018	current	02/08/2019	31/03/2022	
		MSO/MDSO network for local CCGs and Providers				direct	Chair	07/11/2018	current	02/08/2019	31/03/2022	
		Controlled drugs safety lead and Antimicrobial stewardship lead.				direct	Lead	07/11/2018	current	02/08/2019	31/03/2022	
		Whittington Care Quality Review Group				direct	member	07/11/2018	current	02/08/2019	31/03/2022	
		Islington Transformation Group				direct	member	07/11/2018	current	02/08/2019	31/03/2022	
		QIPP Delivery Group				direct	member	10/05/2020	current	10/05/2020	31/03/2022	
		ICCG Website				direct	Provide clinical leadership	10/05/2020	current	10/05/2020	31/03/2022	
		Serious incident reviews & patient safety				direct	Provide clinical leadership	07/11/2018	current	02/08/2019	16/02/2021	
		GP Practice Quality				direct	Provide clinical leadership	07/11/2018	current	02/08/2019	31/03/2022	
		Federation Working Group				direct	Provide clinical leadership	07/11/2018	current	02/08/2019	16/02/2021	
		Federation Contracts and Quality Group				direct	Co Chair	10/05/2020	current	10/05/2020	31/03/2022	
		Care Homes Working Group				direct	Chair	10/05/2020	current	10/05/2020	31/03/2022	
		NLP IG Working Group				direct	Chair	07/11/2018	current	02/08/2019	31/03/2022	
		Locum GP	y	y	n	direct	Homerton Hospital OOH care, Paradoc emergency home visiting service , Tower Hamlets, SELDOC GP OOH services and Croydon (including Brigstock surgery, Thornton Heath (ad hoc sessions in various GP surgeries across London, excluding Islington)	07/11/2018	current	02/08/2019	31/03/2022	
		Greenland Passage residential association	n	y	y	direct	Board Director	07/11/2018	current	02/08/2019	31/03/2022	
		1-12 Royal Court Ltd	n	y	y	direct	Secretary & director	07/11/2018	current	02/08/2019	31/03/2022	
		Novo Nordisk pharmaceutical company.	n	n	n	Indirect	My Sister is a Medical Advisor	07/11/2018	current	02/08/2019	31/03/2022	
		St Helier Hospital in Sutton.	n	n	n	Indirect	Partner is an ITU Consultant	07/11/2018	current	02/08/2019	31/03/2022	
		BMA	y	y	n	direct	member	07/11/2018	current	02/08/2019	31/03/2022	
		City and Hackney Local Medical Committee	n	y	n	direct	member	07/11/2018	current	02/08/2019	31/03/2022	
		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	31/03/2022	
		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	31/03/2022	
		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	31/03/2022	
		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	31/03/2022	
		I am a GP Appraiser for the London area.	y	y	n	direct	GP Appraiser	07/11/2018	current	02/08/2019	31/03/2022	
		I am a mentor for GPs under GMC sanctions.	y	y	n	direct	GP Mentor	07/11/2018	current	02/08/2019	31/03/2022	
		Lantum GP locum agency	y	y	n	direct	Registered with the agency		current	11/03/2022	31/03/2022	
		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	31/03/2022	
Paul **Sinden**	Chief Operating Officer (and to be Managing Director of NCL GP Provider Alliance (GPPA) from April 2022) Attend Governing Body Primary Care Commissioning Committee exec lead Member of NCL CCG Executive Management Team Attend Quality and Safety Committee Attend Medicines Management Committee (exec lead) Attend other committee meetings as required	none	N/A	N/A	N/A	N/A	nil return			20/08/2019	01/09/2021	
Karen **Trew**	Deputy Lay Chair of Governing Body Member of Covid Response Oversight Committee (when in session) Finance Committee Primary Care Commissioning Committee Remuneration Committee IFR Appeals Panel Strategy and Commissioning Committee Chair of Audit Committee Chair of Procurement Committee Member of Fertility Policy Group	Broxbourne School Hertfordshire	No	No	Yes	direct	Chair of the Governing Body (previously Governing Body members since Nov. 2004)	01/07/2015	current	15/07/2015	01/09/2021	
		Wormley C of E Primary School, Hertfordshire	No	No	Yes	direct	Chair of the Governing Body	28/06/2005	current	15/07/2015	01/09/2021	
Attendees												
Vivienne **Ahmad**	Board Secretary	No interests declared	No	No	No	No	Nil Return	25/10/2018	current	16/10/2019	23/07/2021	

NCL CCG Primary Care Committee Declaration of Interest Register - April 2022

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	No	No	No	Direct	Salaried GP	15/03/2018	current	07/11/2018	19/07/2021	
		Muswell Hill Practice is a member of Federation4Health, the pan- Haringey Federation of GP Practices	No	No	No	Direct	Salaried GP `	15/03/2018	current	07/11/2018	19/07/2021	
		Muswell Hill Practice provides anitcoagulant care to Haringey residents under a contract with the CCG	No	No	No	Direct	Salaried GP	15/03/2018	current	07/11/2018	19/07/2021	
		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	19/07/2021	
		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	19/07/2021	
		The Lost Chord Charity - organises interactive musical sessions for people with dementia in residential homes.	No	No	No	Indirect (Wife)	Patron	15/03/2018	current	07/11/2018	19/07/2021	
		North West Primary Care Nework	No	No	No	Direct	Practice is a member	01/07/2019	current	04/09/2019	19/07/2021	
		Haringey Health Connected, the federation of West Haringey GP Practices.	No	No	Yes	Indirect	. Pactice Manager is Finance Manager	15/03/2018	current	07/11/2018	19/07/2021	
Dr Louise **Jones**	Healthwatch Representative	Camden Healthwatch	No	Yes	No	Direct	Chair	01/11/2020	current	04/11/2020		
		St George's School, Weybridge, Surrey	No	Yes	No	Direct	Governor		current	04/11/2020		
		Marie Curie Palliative Care Research Department, Division of Psychiatry, UCL	No	Yes	No	Direct	Honorary Clinical Senior Lecturer		current	04/11/2020		
		Covid Evidence Service, Nuffield Department of Primary Care, Oxford and Hospice UK	No	Yes	No	Direct	Member of Palliative Care interest group under umbrella		current	04/11/2020		
Dr Will **Maimaris**	Director of Public Health, Haringey Council	attend Governing Body Member of NCL CCG LTC LCS review group	n/a	n/a	n/a	n/a	n/a	30/08/2018	current	09/08/2019	20/12/2021	
Rev Kostakis **Christodoulou**	Community Member, Primary Care Commissioning Committee	Church of England	Yes	Yes	Yes	Direct	Priest, accountable to Robert Wickham, Bishop of Edmonton, responsible for four north London Boroughs of Barnet, Camden, Enfield and Haringey. Medical ethics, health and social care		current	16/10/2020	14/10/2021	
Mark **Agathangelou**	Community Member	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	13/10/2020	16/10/2021	
Anthony **Marks**	Assistant Head of Primary Care	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30.10.2018	13/08/2021	
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**	Assistant Director of Primary Care, North Central London Primary Care Commissioning & Contracting Team	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	13/08/2020	23/08/2021	
Sarah **McDonnell-Davies**	Executive Managing Borough Partnerships Attend Governing Body Member of NCL EMT Attend NCL Committee Meetings as required e.g. Strategic Commissioning Committee, Borough Commissioning Committee Attend other committee meetings as required	None	no	no	no	Direct	n/a			20/06/2018	09/09/2021	
Sarah **McIlwaine**	Director of Transformation (Primary Care)	None	N/A	N/A	N/A	N/A	none			09/10/2018	21/07/2021	
Deborah **McBeal**	Director of Integration, Enfield Borough Attend Borough meetings, Primary Care Commissioning Committee and Strategy and Commissioning Committee	We are Pareto	no	no	no	N/A	director of company, dormant, non-trading	2013	current	28.03.2018	21/07/2021	
Tracey **Lewis**	Head of Finance – Primary Care Attend Primary Care Commissioning Committee	N/A	N/A	N/A	N/A	N/A	N/A			29/07/2020	10/09/2021	
Owen **Sloman**	Assistant Director of Primary Care, Haringey Borough attend Primary Care Commissioning Committee (Boro rep)	St Ann's church, South Tottenham.	N/A	N/A	X	direct	Churchwarden	01/04/2020	31/03/2020	03/10/2019	22/07/2021	
		Fowler Newsam Hall in South Tottenham and the Emily Mary Robbins Trust.	N/A	N/A	X	direct	Trustee	01/04/2020	31/03/2020	26/07/2020	22/07/2021	
		Arsenal Football Club	N/A	N/A	X	indirect	Brother is Operations Director at Arsenal Football Club which supports Islington primary care on a pro-bono basis	01/04/2020		22/07/2021		
Rebecca **Kingsnorth**	Assistant Director of Primary Care, Islington Borough attend Primary Care Commissioning Committee (Boro rep)	Yes	No	No	Yes	Indirect	My sister-in-law is a salaried GP in City Road Medical Centre. Part of my role is the support of the CCG's delegated responsibility for commissioning core primary care services and the commissioning of Locally Commissioned Services, which can result in changes to funding to Islington practices including City Road.	Dec-17	current	18/10/2018	11/08/2021	I will declare this in any meetings where decisions are being taken about either services commissioned from or performance of City Road. This might include decisions taken about LCSs. I would be able to participate in any decision that relates to Islington-wide commissioning of which City Road may be one of many beneficiaries, but not decisions that relate singly to City Road.
Dr Cathy **Winfield**	Local Medical Committee, London Member of Primary Care Commissioning Committee Attend other committee meetings as and when required	Fresh Solutions for Health	yes	yes	yes	direct	Director	01/06/2019	current	14/09/2021		No work undertaken London wide
		Education for Health	no	no	yes	direct	Trustee	May 2021	current	14/09/2021		
		Local Government Association	no	no	yes	direct	Associate Member	July 2021	current	14/09/2021		
		Southdown Housing Association	yes	Yes	yes	direct	Non executive director	July 2021	current	14/09/2021		
		Novartis	yse	yes	yse	direct	Expert Advisory Panel member	Sept 2021	current	14/09/2021		

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Dr Sue **Dickie**	LMC Haringey Borough Representative	Highgate Group Practice Have done 3 triage sessions for LCW ooh over the Christmas period in the pandemic Haringey Federation Haringey North West PCN	yes yes no No	yes yes yes yes	yes yes yes yes	direct direct direct direct	GP Partner Practice is a member Practice is a member	 2016 2019	current current current	08/03/2021 08/03/2021 08/03/2021		
Daniel **Glasgow**	Deputy Director of Primary Care Transformation, Barnet Borough	None	no	no	no	N/A	N/A	N/A	N/A	15/12/2017	11/08/2021	
Colette **Wood**	Director of Integration (Barnet) attend Primary Care Commissioning Committee (Boro rep)	None	no	no	no	N/A	N/A	N/A	N/A	27/10/2017	11/08/2021	
Simon **Wheatley**	Director of Integration (Camden borough directorate) Attendee of NCL CCG PCCC	None	no	no	no	N/A	N/A	N/A	N/A	28/05/2019	11/08/2021	
Riyad **Karim**	Assistant Director of Primary Care, Enfield Directorate, NHS North Central London CCG Commissioner who attends NCL CCG Primary Care Commissioning Committee in the absence of the Director of Integration. Non voting member.	The Lordship Lane surgery, East Dulwich	no	yes	no	direct	unpaid practice management advisor at surgery.	2015	current	13/07/2019	22/09/2021	No actions required. Discussed and agreed with line manager
		The Lordship Lane Surgery, East Dulwich (out of area) which is part of South Southwark GP Federation (Improving Health Limited)	no	yes	no	direct	Unpaid practice management advisor	2015	current	22/09/2021		No actions required. Discussed and agreed with line manager
		London Care Rochester (City and County Healthcare Group)	no	no	no	Indirect	Spouse is a Care Worker	2013	current	22/09/2021		No actions required. Discussed and agreed with line manager
Cllr Patricia **Callaghan**	Deputy Leader and Cabinet Member for a Healthy and Caring Camden	Attendee NCL CCG • Governing Body • Primary Care Commissioning Committee	no	yes	no	N/A	N/A	N/A	N/A	29/06/2021		
Cllr Caroline **Stock**	Totteridge Ward, Barnet Councillor Member serving on: • Health & Wellbeing Board (Chairman) London Borough of Barnet • Local Strategic Partnership (Barnet Partnership Board) London Borough of Barnet • Policy and Resources Committee • Chipping Barnet Area Committee (Substitute)	Attendee NCL CCG • Governing Body • Primary Care Commissioning Committee	no	YES	no	direct	N/A	N/A	current	03/07/2021		
		Middlesex University					Pro-Chancellor	01/07/2020	current	03/07/2021		
		Camden and Islington NHS Trust					Daughter is employed as a doctor					
Cllr Alev **Cazimoglu**	Jubilee Ward Councillor Enfield Attendee NCL CCG • Governing Body • Primary Care Commissioning Committee	Health & Social Care Joint Health Overview Scrutiny Committee for North Central London Sector North Middlesex Hospital	yes	yes	yes	direct direct direct	Cabinet member member bank staff - no paid work received to date		current	11/08/2021		
Cllr Nurullah **Turan**	St Mary's Ward Councillor	Attendee NCL CCG • Governing Body • Primary Care Commissioning Committee	no	YES	no	direct	N/A	N/A	n/A	29/06/2021		
	Executive Member for Health and Social Care	Islington Council	no	YES	yes	direct				29/06/2021		
		Derman for the well being being of the Kurdish and Turkish Communities	yes	YES	yes	direct	Director	2014	current	29/06/2021		
		East London NHS Mental Health Trust	yes	YES	yes	direct	Approved Mental Health Professional			29/06/2021		
Cllr Lucia **Das eves**	Woodside Ward, Haringey Councillor Cabinet Member for Health, Social Care and Well-Being	Attendee NCL CCG • Governing Body • Primary Care Commissioning Committee	no		yes	direct						
		The Selby Trust	no		yes	direct	Trustee	08/06/2021	current	31/08/2021		
		Bridge Renewal Trust	no		yes	direct	Trustee	01/07/2021	current	31/08/2021		
Olivia **Clymer**	CEO Healthwatch –Central West London provider for Healthwatch Enfield Committee member on NCL CCG Quality and Safety Committee and Primary Care Commissioning Committee	CEO Healthwatch –Central West London, provider for Healthwatch Enfield	yes	yes	yes	direct	Secretary	26/03/2018	current	28/10/2021		
		United World Colleges, Great Britain	yes	yes	yes	direct	Director	01/05/2020	current	28/10/2021		
		Healthwatch Central West London are commissioned from time to time to support engagement for NHS organisations.	yes	yes	no	direct			current	28/10/2021	Should this arise a declaration of interest will be made.	
		Healthwatch Central West London receive core funding from the National Institute of Health Research – North West London region	yes	yes	no	direct			current	28/10/2021		
		Vale of Aylesbury Housing	yes	yes	yes	direct	Non executive director	23/06/2017	current	28/10/2021		

NHS
North Central London
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

Draft Minutes of Meeting held on Thursday 17 February 2022 between 2:30pm and 4pm

Online Meeting via MS Teams Live

Voting Members Present:	
Mr Ian Bretman ***(Chair)***	Governing Body Lay Member, Patient and Public Engagement, and Committee Chair
Dr Dominic Roberts	Independent GP *(covering for Dr Subir Mukherjee)*
Ms Claire Johnston	Governing Body Member Registered Nurse
Ms Deirdre Malone	Assistant Director, Quality *(representing Kay Matthews, Executive Director of Quality)*
Mr Paul Sinden	Chief Operating Officer *(covering for Finance & Barnet Borough)*
Ms Karen Trew	Governing Body Member, Lay Member for Audit & Governance
In Attendance	
Dr Peter Christian	Governing Body Member, Clinical Representative (non-voting)
Ms Vanessa Piper	Assistant Director, Primary Care Contracts and Commissioning
Mr Anthony Marks	Assistant Head of Primary Care
Ms Su Nayee	Assistant Head of Primary Care, Primary Care Contracting and Commissioning
Ms Rebecca Kingsnorth	Assistant Director of Primary Care, Islington Directorate
Mr Owen Sloman	Assistant Director of Primary Care, Haringey Directorate
Ms Deborah McBeal	Director of Integration, Enfield Directorate
Mr Mark Agathangelou	Community Representative
Rev Kostakis Christodoulou	Community Representative
Cllr Patricia Callaghan	London Borough of Camden
Cllr Caroline Stock	London Borough of Barnet
Dr Cathy Winfield	Director of Primary Care, Londonwide LMCs
Dr Sue Dickie	Chair of Haringey LMC, London Wide LMCs
Ms Sharon Seber	Advanced Nurse Practitioner, Clinical Lead for Adults, LTC / Prevention, Haringey Borough (item 2.4)
Dr Karl Roberts	GP, Clinical Lead for Adults, LTC / Prevention, Islington Borough (item 2.4)
Ms Katherine Gerrans	Director of Primary Care Nursing, NCL (item 2.5)
Ms Tessa Newton	Programme Manager, Primary Care, NCL (item 2.5)
Ms Diane MacDonald	Interim Strategic Estates, Finance Lead, NLP (items 2.6 & 3.8)
Ms Anna Walsh	Projects Lead, Healthwatch Camden (item 2.7)
Mr Stephen Heard	Director of Healthwatch Camden
Ms Nicola Theron	Director of Estates, NCL (item 3.8)
Ms Priyal Shah	Programme Manager, NCL (*covering for Ruth Donaldson*)(item 3.9)
Ms Sarah Rothenberg	POD Director of Finance, NCL CSU (item 3.9)
Ms Usha Banga	Commissioning Manager, NCL
Mr Kamran Bhatti	Assistant Director for Primary Care, Camden Directorate *(covering for Simon Wheatley)*
Ms Caroline Rowe	Head of Communications and Engagement
Ms Vivienne Ahmad ***(Minutes)***	Board Secretary

Apologies:	
Mr Simon Goodwin	Chief Finance Officer
Dr Subir Mukherjee	Governing Body Member, Secondary Care Clinician
Mr Arnold Palmer	Governing Body Member, Lay Member, General Portfolio
Mr Anthony Browne	Director of Finance Strategic Commissioning
Ms Tracey Lewis	Head of Finance, STP Primary Care
Ms Sarah Mcilwaine	Director of Primary Care
Ms Sarah McDonnell-Davies	Executive Director of Borough Partnerships
Mr Simon Wheatley	Director of Integration, Camden Directorate
Ms Colette Wood	Director of Primary Care Transformation, Barnet Directorate
Ms Ruth Donaldson	Director of Communities, NCL
Mr Will Maimaris	Director of Public Health, Haringey Council *(representing all five Boroughs across NCL)*
Cllr Nurullah Turan	Executive member for Health and Social Care, London Borough of Islington
Cllr Alev Cazimoglu	London Borough of Enfield
Cllr Lucia das Neves	Cabinet Member for Health, Social Care and Well-Being, London Borough of Haringey
Ms Olivia Clymer	CEO of Healthwatch Central West London
Dr Louise Jones	Healthwatch Representative, Camden

1.0	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	The Chair welcomed everyone to the meeting. Apologies were recorded as above.
1.2	**Declarations of Interests Register**
1.2.1	The Declarations of Interest Register was noted by the Committee.
	The Committee NOTED the Register
1.3	**Declarations of Interest Relating to Items on the Agenda**
1.3.1	The Chair invited members of the Committee to declare any interests in respect to the items on the agenda. There were no declarations declared.
1.4	**Declarations of Gifts and Hospitality**
1.4.1	There were no declarations declared.
1.5	**Minutes of the NCL Primary Care Commissioning Committee Meeting on 16 December 2021**
1.5.1	The minutes of the NCL Primary Care Commissioning Committee on 16 December 2021 were considered and agreed as a true record of the meeting.
	The Committee APPROVED the minutes of the meeting dated 16 December 2021.
1.6	**Action Log**
1.6.1	The Action Log was reviewed and updated.

	The Committee NOTED the updates to the action log.
1.7	**Matters Arising**
1.7.1	There were no matters arising.
1.8	**Questions from the public relating to items on the agenda received prior to the meeting**
1.8.1	No questions from the public had been received in advance of the meeting and no questions were asked by those attending via the MS Teams public link.
2.0	**BUSINESS**
2.1	**Primary Care Finance Update** **(M9 NCL Primary Care Delegated Commissioning Finance Report)**
2.1.1	The Committee request that the finance report includes prior year expenditure to allow year-on-year comparisons and greater granularity on Barnet's 'other committed funds' and 'other medical services' for all boroughs was provided subsequent to distribution of the papers and would be included in the report to the Committee in April 2022.
2.1.2	In considering the report, the following comments and observations were made: • A reconciliation to be provided for the April 2022 meeting between page 24 - the annual budget for primary care medical services £252m versus page 28 - the allocation transfer to boroughs £248m; • An inflationary uplift would be included in plans and allocations to practices in 2022/23 in line with planning guidance. There was a risk that the planning assumption for inflation would be less than actual inflationary pressures; • The reported 2021 forecast £14.7m overspend would be offset, back to a breakeven position, by further allocations for the Winter Access Fund and Additional Roles Reimbursement Scheme. The exit strategy from Winter Access Fund schemes would create capacity risks.

2.1.3	**Previous Action of 16 December 2021 – item 2.1.1:**
	• **The next Financial Report to include:**
	  ○ **Prior year position to help compare current and previous years' costs;**
	  ○ **Clarify the deficit position in Barnet against 'other committed funds' and provide information of what constituted 'other medical services' for all boroughs**
	  ○ **To clarify the difference in financial figures of the annual budget and the allocation transfer to boroughs.** ***(Tracey Lewis and Anthony Browne)***

	The Committee NOTED the report.
2.2	**Quality & Performance Report**
2.2.1	The Committee considered the report and the following comments and observations were made: • The variable uptake of online booking and online repeat prescriptions within and across practices would be addressed through the operating plan response for 2022/23 alongside work on the local priorities for access identified by Healthwatch to help ensure an equitable offer for access; • To help address violence and intimidation to practice staff, and many patients refusing to wear a mask in practices, it was requested that the practice SITREPs report go to integrated borough partnerships for discussion and to utilise community engagement mechanisms in boroughs to reach a wider audience; • An on-going voluntary process continued for vaccine uptake by unvaccinated staff;

	• The CCG was awaiting guidance on the shape of the covid vaccination programme for 2022/23 including follow-up boosters.
2.2.2	**Action:** • **To add the practice SITREPs report to the Integrated Borough agendas and highlight the issue of violence and intimation in practices. (Paul Sinden)**
	The Committee NOTED the report.
2.3	**Operating Plan Update**
2.3.1	An overview of the national priorities for primary care in 2022/23 was provided with a focus on access and integration at a local level. It was also noted that plans for 2022/23 would incorporate local work that Healthwatch and others had undertaken on access. The report included a digest of Healthwatch reports alongside the national guidance.
2.3.2	In considering the report, the following comments and observations were made: • Support for the joint work with Healthwatch on access, and the transparency of the report in setting out the challenges to access identified in the Healthwatch reports; • The first draft of the Operating Plan would be prepared by the end of February and would be shared for comment. The first submission to NHS England would be mid-March with the final submission by the end of April. It was noted the Interim Operating Plan would be brought to the next meeting in April.
2.3.3	**Action:** • **To bring the interim Operating Plan to the next Committee meeting on 21 April 2022. *(Sarah McIlwaine)***
	The Committee NOTED the report.
2.4	**NCL Long Term Condition Locally Commissioned Service (LTC LCS) Update**
2.4.1	The Committee was updated on further work on the NCL LTC LCS harmonising the service offer across the five boroughs. The following points were highlighted: • The model of care had been agreed for the metabolic cluster of long-term conditions, with the year-of-care approach adopted to allow a person-centred approach and co-production with patients; • Childhood Asthma Model was not yet complete but would focus on reducing prescribing of rescue medication and increasing preventative treatment; • The service model had been developed with clinical input from the five boroughs and had four stages, was consistent with the Quality Outcomes Framework, and included outcomes for prevention, detection, personalisation, and disease specific metrics; • The contract would cover three to five years, compared to the current annual contract, to support practice planning, investment, and financial stability. The longer-term contract would allow practices to adapt to the new service model with a more personalised approach, providing more time with patients to agree their priorities for care and associated care plan; • The service model placed an emphasis on addressing inequalities and ensuring that funding matched the differential work to support patients in different risk categories; • To introduce the service model 2022/23 would be a transition year on a block contract, with outcomes (with an element of payment for delivery) introduced on a phased basis from 2023/24; • As a transition year 2022/23 would be used for training practices in delivery of the new model and establishing the supporting infrastructure including EMIS templates; • The preparatory year would also be used to establish baselines and thresholds for outcome delivery. This was in recognition that supported by existing LCS good

	outcomes were already being delivered for people with long-term conditions and that historic supporting investment was differential across the five boroughs; • Risk stratification, supported by UCL Partners' tools, would recognise the differential needs of people with long-term conditions. Patients would have up to four clinical reviews per year supported by a multi-disciplinary team to ensure needs were addressed. This would ideally link in with secondary, community care and voluntary sectors services.
2.4.2	In considering the report, the following comments and observations were made: • The cost of delivering the service should be covered by the financial envelope for the LCS, with achievement of the outcomes as an additional incentive payment. This was supported by the proposed cap and collar payment mechanism that would be used for the service; • As the service model was introduced delivery models at both a practice and PCN level could evolve, as already used in Camden. Areas of innovation and collaboration should be shared to support delivery of the full service across NCL; • Delivery of the service model was predicated on equal access to diagnostics (including phlebotomy and respiratory testing) across NCL.
	The Committee NOTED the report
2.5	**General Practice Nursing in NCL**
2.5.1	The report responded to a Committee request in December 2021 to receive further information on work to increase general practice nursing capacity and leadership. The report highlighted that: • In NCL general practice workforce had grown with the exception of nurse numbers, and NCL had the lowest general practice nurses to patient ratio in England; • Nursing numbers were up in Haringey and Enfield but had reduced in the other three boroughs, and 44% of the workforce were over 55; • Limited models for career progression and pre-reg employment impacted on recruitment; • The NCL Training Hub had developed a Nursing Strategy to address these challenges, and increase the nursing workforce, including opportunities to create primary care nursing leadership roles and wellbeing support through the CARE programme; • The strategy set out the value general practice nursing brought to population health management, patient satisfaction and freeing up GP capacity.
2.5.2	In considering the report, the following comments and observations were made: • Work was underway with UCLP to develop portfolio careers following on from the successful work in Enfield with UCLP to increase GP numbers. This would be supported by NCL work on passporting for cross-organisation working; • The potential for future recruitment through new vocational qualifications in health and social care aligned to CCG discussions on becoming an anchor partner providing 16 to 19 year olds with nine weeks of work experience; • The need to build nurse leadership roles in PCNs, perhaps supported by nurse recruitment through the Additional Roles Reimbursement Scheme (ARRS); • To support recruitment an audit of utilisation would be undertaken, and a review of terms and conditions for nurses working in general practice was recommended; • Northern Ireland has introduced a full career structure for general practice nurses, and this was something to be considered as part of the migration into an Integrated Care System.
	The Committee NOTED the report.

2.6	**NCL Submission of GP Expression of Interest for 2022/23 London Improvement Grants**
2.6.1	The Committee was asked to note the 2022/23 GP Expressions of Interest submissions to the London Improvement Grant programme.
2.6.2	In considering the report, the following comments and observations were made: • The process to identify priorities for NCL was in line with the process agreed by the Committee in April 2021, with practice proposals reviewed by NCL Estates and Primary Care Borough teams for compliance with Premises Costs Directions and strategic and operational fit (premises part of longer-term plans for primary care provision and fit for purpose); • It was noted that Camden schemes to go to London Region for approval were to be confirmed due to not having all the details at the time of the report; • Schemes supported by London Region for improvement grants in 2022/23 would come back to the Committee for approval; • For approved schemes the improvement grant would cover 66% of costs with practices picking up the balance (34%). Fees were 100% funded.
	The Committee NOTED the report
2.7	**Surviving Domestic Abuse – Camden Healthwatch Report**
2.7.1	The Committee received the report undertaken by Camden Healthwatch in response to the increase in domestic abuse during the lockdown. Domestic abuse was a major public health issue with many societal costs, and could take the form of coercive control, psychological and physical abuse, financial abuse, harassment, stalking and online abuse. The interviews for this report were held with nine Camden survivors during the summer of 2021. There was an online survey that people could also participate in. Focussing on health impacts specific to primary care, the findings were as follows: • Most people who participated in this research stressed the severe impact of emotional abuse as well as physical abuse, with the former much more difficult to prove; • 80% of victims would speak to a healthcare professional at some point about their abuse, with this often being the victim's first and only point of contact. According to World Health Organisation (WHO) and NICE, health professionals could help victims of domestic abuse by providing a safe space and support. • From this the report provided a series of recommendations for primary care, noting that some work had already been done since the report was written in October 2021: o The CCG should work with primary care networks (PCNs) to fund the signposting of services for victims within GP settings. There had been some success with the Identification and Referral to Improve Society (IRIS) project in NCL; o Patients should be able to have in person appointments with their practice if there were concerns of privacy at home. Perhaps there could be a system in place to check that when they are booking an appointment. o GPs should consider risk of domestic abuse as part of the holistic approach to patient care; o If there were concerns about domestic abuse and a patient is accompanied by a family member for interpretation purposes, attempts should be made to offer an independent interpreter.
2.7.2	In considering the report, the following comments and observations were made: • Reiterated that Domestic Violence should be treated as a Public Health issue; • The stigma associated with Domestic Violence should be offset by a publicity campaign to encourage people to report occurrences and concerns; • The report had previously been supported by the Camden Safeguarding Board.

	The Committee endorsed the recommendations in the report and CCGs would work with PCNs on the signposting of services for victims within GP settings including IRIS.
2.7.3	**Action:** • **For the CCG to work with PCNs on the signposting of services for victims within GP settings including IRIS. (Simon Wheatley)**
	The Committee NOTED the report.
3.0	**ITEMS FOR DECISION**
	Contract Variations
3.1	**Contract Variations PMS / APMS / GMS Changes** **PMS Agreement Changes**
3.1.1	The Committee was requested to consider a series of contract variations, with the Committee decision cognisant of practice access levels against benchmarks.
3.1.2	**Barnet – Wentworth Medical Practice – Addition of a GP Partner**
3.1.3	The practice requested approval of an additional GP partner to the PMS agreement with effect from 1 January 2022, increasing the total partners on the agreement to four.
	The Committee NOTED and APPROVED the contract variation
3.1.4	**Barnet – Speedwell Practice - Removal of GP Partner**
3.1.5	The practice requested the removal of a GP partner from the PMS Agreement with effect from 31 December 2021, leaving four partners to the contract. The practice was currently providing the recommended amount of GP and nursing appointments.
	The Committee NOTED and APPROVED the contract variation
3.1.6	**Camden – Brondesbury Medical Centre – 24 hour retirement of a GP Partner**
3.1.7	The practice requested for a 24-hour retirement of a GP Partner leaving three partners on the agreement during the 24-hour retirement. There was a shortfall in both GP and nursing provision for which the practice was recruiting. The practice was a training practice.
	The Committee NOTED and APPROVED the contract variation
3.2	**Barnet – Temple Fortune Medical Group – Request for additional clinical space**
3.2.1	The Committee was asked to approve the request for two additional clinical rooms and associated increase in annual rent (£8,469) on the basis that: • The request for the additional space kept the practice within recommended space allocation from the DH HBN space estimation; • The practice list had grown by 18.5% over the past five years, with further increases expected from residential developments in the area over the next five to ten years; • The practice did not require any capital funding for conversion of the space; • Any approval given was on the condition that the practice increased the number of nurse appointments offered.
	The Committee APPROVED the recommendation.
3.3	**Request to revert from Personal Medical Services (PMS) to General Medical services (GMS) Contracts:** • **Haringey – Alexander Surgery**

	• **Barnet – Woodlands Medical Practice**
3.3.1	The contract holders for both practices were requesting to revert their current PMS contracts to GMS contracts, with this permitted under the PMS National Regulations subject to giving three months' notice for reversion to the GMS contract. Both practices wanted the GMS contract to commence from 1 April 2022. The Committee was therefore asked to note and approve the following: • The CCG was required to carry out due diligence checks to make sure the contract holders were eligible to hold the GMS contract and to assess any risks under that contract change. It was noted the two practices had no current performance or contractual concerns and therefore were eligible to hold the GMS Contracts; • Subject to approval the PMS agreements would be terminated on 1 April 2022 and the new GMS contracts would be issued; • There were no financial implications from the contract change as the PMS transition process was complete in Barnet and Haringey from April 2022.
	• **The Committee APPROVED the recommendation.**
3.4	**NCL Special Allocation Scheme (SAS) Service – request for additional space**
3.4.1	The NCL Special Allocation Scheme (SAS) Provider, Medicus Health Select Care were requesting two additional rooms, in Freezywater Health Centre (Enfield) to provide the following; (a) a digital consulting room, (b) an administration hub to house paper records and (c) a reception to facilitate the booking of appointments and (d) team meetings. The Committee was therefore asked to approve the practice using two additional rooms at a cost of £6,440 per annum. Approval would be subject to the District Valuer valuation and evidence that a signed lease was in place.
3.4.2	In considering the report, the following comments and observations were made: • The Special Allocation Scheme (SAS) Service operated from a single site in NCL (Bingfield Health Centre in Islington) to carry out face-to-face appointments as sites at St Ann's and Margarete Centre (Camden) had been lost. There was therefore no dedicated site for an administration base for the staff (clinical and non-clinical); • The SAS service was rated Good overall in four domains and outstanding in the Well Led domain by the Care Quality Commission; • Freezywater Practice is currently operating from the site and the the additional rooms requested for the SAS services were not within the current practice space at Freezywater; • The boroughs with the highest referrals for the service were Enfield and Camden; • A comprehensive provision of the service was required for all the five boroughs, not necessarily one in each borough but does need to be accessible to all.
	The Committee APPROVED the recommendation.
3.5	**Haringey – Hornsey Wood Green Practice – Relocation**
3.5.1	The Committee was asked to approve the relocation of Hornsey Park and Wood Green practice into the integrated health and wellbeing hub in Wood Green Shopping City subject to: • The rent being capped at £100k per annum; • Receipt of the final Healthwatch patient survey report and outcome from the public and patient engagement on the service changes; and • Receipt of the funding for the fit out of the health centre (£1.2m for the practice element) Further points to note were:

	• Whittington Health was leading on the proposal to develop an integrated health and wellbeing hub in Wood Green Shopping City. The landlords, Capital-Regional, had identified potential space for the hub but were considering other options too; • The Hub would consolidate Whittington Health's central Haringey community health services, alongside the GP practice, other Whittington, North Middlesex, BEH services, and potentially Council and voluntary services. Also the Whittington Health Community Diagnostics Centre in the Shopping City would open in Spring 2023; • The CCG ran an open expression of interest exercise for nearby practices to apply to move into the hub, Hornsey and Wood Green surgery were the only practice to apply; • The space for the practice was consistent with the current list size and projected growth, and was within 0.5 miles of the current practice site. The practice Patient Participation Group were in favour of the relocation and Healthwatch were carrying out a broader patient survey; • The Scheme was in early stages of development and financial negotiations were complex, and it was noted that Whittington Health would need to secure additional funding from the Integrated Care System to pay for the fit-out of the health centre.
	The Committee APPROVED the recommendation.
3.6	**Haringey – Welbourne Health Centre Update**
3.6.1	The Committee was asked to approve the following: • The signing of the legal documents confirming the Welbourne transaction in time to purchase the 125 year lease from Haringey Council in this financial year; • Fund £352k revenue expenses from the delegated budget for the transaction (stamp duty / professional fees) in 2021/22; • To make a decision on use of the space identified for a community pharmacy at a later date, holding the space in the interim as void subject to the final decision about use. The CCG would, by exception, underwrite service charge and rates costs until the decision was made. Lease negotiations were expected to be concluded in February 2022, so that a £3.6m payment to support the development could be transferred to Haringey Council and the 125 year lease on the property secured. The annual rent for the practice would be £225k reducing by £60k if a community pharmacy moved in. The developers Healthlink would hold the lease on that property for the NHS and then manage the fit-out. The Committee was asked for more time to make a final decision.
	The Committee APPROVED the recommendations in the paper.
3.7	**Haringey – Changes to Haringey Primary Care Network (PCN) composition**
3.7.1	The Committee was asked to approve the new PCN structure in Haringey which would take effect from April 2022, reducing the number of PCNs from eight to seven. The new composition met the PCN criteria for geographic coherence and population size. The Local Medical Committee (LMC) had supported the allocation of the remaining practices in West Central PCN to other PCNs in Haringey, as the PCN was no longer viable after Vale Practice left to join North Central PCN. The LMC would also help practices allocate the West Central additional roles staff between the recipient PCNs.
	The Committee APPROVED the recommendation.
3.8	**PCCC Assurance Paper – Premises Capital and Revenue Financial Implication – Progress Report**
3.8.1	The Committee was asked to approve the following five principles to underpin investment in primary care estates:

	1. All void reductions savings in the primary budget, generated from elimination of voids, are retained within the primary care budget. 2. Void savings in the corporate budget are retained in the primary care budget for reinvesting in new schemes. 3. The GP rationalisation savings in the primary care budget are retained the primary care budget. 4. Where there is surplus budget, this would only be utilised by the recipient borough where the void reductions have been reached. This would be a prerequisite for funding. It is an incentive to get the voids eliminated. 5. Surplus revenue in one budget may be deployed elsewhere, where need and a deliverable project exists. Further context was given as follows: • The principles would be used to support investment in prioritised estates developments in each borough and act as context for investment decisions being brought to the Committee; • The principles supported services strategies (national and local) to accelerate the delivery of more care in local settings, and would augment limited funds for primary care estates developments; • £5.9m investment would be need to deliver the 30 prioritised schemes across NCL over the next five years, but this would be reduced to a net £1.7m from the offset of void costs. Void costs in NCL amounted to £3.8m in 2021/22 of which £3.2m were avoidable; • There was a differential net investment position across the five boroughs with the principles designed to maximise investment across NCL on the basis that boroughs requiring net investment removed avoidable void costs to receive funding; • A more detailed paper would come to the April 2022 Committee to approve detailed plans at a System and Borough Level.
3.8.2	In considering the report, the following comments and observations were made: • It was noted that plans for better use of void spaces being considered focused on incentives for tenants including time limited subsidies until tenants build up the revenue to pay for the space, using booking systems so that space could be booked for the time required rather than taking up a whole lease, and utilisation where tenants held the lease but were not utilising space fully; • The need to tackle inequalities across populations and across boroughs through developments linked to regeneration schemes, equality impact assessments in business cases developed for approval, and the work being undertaken with PCNs to develop clinical estates strategies that would come back to the Committee in April; • The Committee approved the principles, but recommended that work should be done consensually and that it is based on need and part of tackling inequalities.
3.8.3	**Action:** • **To bring back a further assurance paper to the April meeting to approve detailed implications at a System and Borough Level.** ***(Nicola Theron)***
	The Committee APPROVED the recommendation.
3.9	**Revised Locally Commissioned Service (LCS) for asylum seekers**
3.9.1	The Committee was asked to approve the revised draft of the LCS that was funded by NHS England. The LCS contained an update on healthcare assessments carried out for asylum seekers, with the update reflecting their complex needs and based on significant engagement with clinical leads and the Local Medical Committee (LMC). The overall cost of the revised LCS is was within the funding envelope and activity additional to the core contract.

3.9.2	In considering the report, the following comments and observations were made: • Variable access to interpretation services was still challenging and variable and was under review, as was the complexities for registration through PCSE • The LCS would be a cost pressure if NCHS England funding was withdrawn; • The need to meet the on-going needs of asylum seekers who were now settled and therefore not classed as asylum seekers was being considered; • The complex needs of asylum seekers would need to be met through a multidisciplinary team approach following health assessment carried out by the GP.
	The Committee APPROVED the recommendation.
4.0	**ITEMS TO NOTE – URGENT DECISIONS TAKEN SINCE 16 DECEMBER 2021**
4.1	None.
5.0	**GOVERNANCE AND COMMITTEE ADMINISTRATION**
5.1	**PCCC Risk Register**
	The Committee NOTED the risk register.
5.2	**PCCC Forward Planner**
	The Committee NOTED the forward planner.
6.0	**ANY OTHER BUSINESS**
6.1	No further business was discussed.
7.0	**DATES OF NEXT MEETINGS**
7.1	• 21 April 2022 • 16 June 2022

NHS
North Central London
Clinical Commissioning Group

NCL CCG Primary Care Commissioning Committee - Action Log - March 2022 ITEM 1.6

Meeting Date	Action No.	Minutes Ref	Action	Action lead	Deadline	Status update	Date closed
17.02.22	1	2.2.2	**Quality & Performance Report** – To add the practice SITREPs report to the Integrated Borough agendas and highlight the issue of violence and intimidation in practices.	Paul Sinden	**April 2022**	**8.04.22** - Borough Directors of Integration to include SITREPs on Borough Partnership agendas. **Recommend to close the action.**	
17.02.22	2	2.3.3	**Operating Plan Update** – To bring the Interim Operating Plan to the next Committee meeting on 21 April 2022.	Sarah McIlwaine	**April 2022**	**8.04.22** - Interim Plan on Agenda for the April 2022 Committee. **Recommend to close the action.**	
17.02.22	3	2.7.3	**Surviving Domestic Abuse – Camden Healthwatch Report –** For the CCG to work with PCNs on the signposting of services for victims within GP settings including IRIS.	Simon Wheatley	**April 2022**	**8.04.22** - Baseline of support services underway.	
17.02.22	4	3.8.3	**PCCC Assurance Paper – Premises Capital and Revenue Financial Implication – Progress Report –** To bring back a further assurance paper to the April meeting to approve detailed implications at a System and Borough Level.	Nicola Theron	**June 2022**	**8.04.22** - A report will be come to Part I of the Committee in June 2022.	
16.12.21	2	2.1.1	**Finance Report** – for the next report to include: • Prior year position to help compare current and previous years' costs. • Clarify the deficit position in Barnet against 'other committed funds' and provide information of what	Tracey Lewis / Anthony Browne	**April 2022**	**17.02.22 – The Committee agreed to keep this action open.** 31.01.22 – This is included in the finance report Recommend to close the action	

			constituted 'other medical services' for all boroughs. • To clarify the difference in financial figures of the annual budget and the allocation transfer to boroughs.				
21.10.21	3	3.9.2	**London Operating Model 2021/22 for the Collaborative Commissioning of Primary Care Services (General Practice)** proposed changes, effective from 1st April 2021, would need further review with ICS being established.	Vanessa Piper	**April 2022**	**17.02.22 - The Committee agreed to keep the action open.** **8.02.22** – Required to wait for NHSEI guidance on whether there will be further changes to the document with the ICS's being established. Recommend to close the action.	

CLOSED ITEMS

16.12.21	**1**	**1.7.1**	**Long Term Conditions (LTC) Development (para 2.4.1 of the October minutes), -** to provide a progress report at the February 2022 meeting.	Sarah Mcilwaine	**Feb 2022**	**17.02.22 - The Committee agreed to close the action.** 31.01.22 – An update has been provided in the Planning paper for 2022/23 Recommend to close the action	**17.02.22**
16.12.21	3	2.2.6	**Quality & Performance Report** To provide a progress on workforce (which would include nursing capacity) to the next meeting.	Tessa Newton	**Feb 2022**	**17.02.22 - The Committee agreed to close the action.** 31.01.22 – The report on workforce is on the agenda Recommend to close the action	**17.02.22**
16.12.21	4	3.3	**PCCC Assurance paper – Premises Capital and Revenue Financial implication -** Provide a progress report	Nicola Theron	**Feb 2022**	**17.02.22 - The Committee agreed to close the action.** 31.01.22 – The report is on the agenda Recommend to close the action	**17.02.22**

16.12.21	5	6.2	**AOB -** A paper by Health watch Camden on 'Surviving Domestic Abuse' to come to the February 2022 meeting.	Simon Wheatley & Anna Walsh of Healthwatch Camden	**Feb 2022**	**17.02.22 - The Committee agreed to close the action.** 31.01.22 – The report is on the agenda Recommend to close the action	**17.02.22**
21.10.21	1	2.2.4	**Quality & Performance Report** To carry out a borough analysis of nursing capacity across NCL	Sarah McIlwaine / Ali Malik / Jenny Goodridge	**Feb 2022**	**17.02.22 - The Committee agreed to close the action.** **15.11.21** – This is on the agenda for February 2022. Recommend to close the action.	**17.02.22**
19.8.21	3	2.2.3	**Quality & Performance Report –** To bring the dashboard on primary care and the primary care programme to a future Committee meeting.	Sarah Mcilwaine	**Feb 2022**	**17.02.22 - The Committee agreed to close the action.** **16.12.21 –** A draft of the dashboard went to CCG EMT on 7.12.21 and will come to the Committee in February 2022. Recommend to close the action.	**17.02.22**

North Central London
Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee Meeting
21 April 2022

<table>
<tr><td>Report Title</td><td>Primary Care Quality and Performance Report</td><td>Date of report</td><td>12 April 2022</td><td>Agenda Item</td><td>2.2</td></tr>
<tr><td>Lead Director / Manager</td><td>Paul Sinden,
Chief Operating Officer</td><td>Email / Tel</td><td colspan="3">p.sinden@nhs.net</td></tr>
<tr><td>GB Member Sponsor</td><td colspan="5"></td></tr>
<tr><td>Report Author</td><td>Paul Sinden,
Chief Operating Officer

Sarah Mcilwaine,
Director of Primary Care</td><td>Email / Tel</td><td colspan="3">p.sinden@nhs.net

sarah.mcilwaine@nhs.net</td></tr>
<tr><td>Name of Authorising Finance Lead</td><td>Not Applicable</td><td colspan="4">Summary of Financial Implications

Not Applicable</td></tr>
<tr><td>Report Summary</td><td colspan="5">Introduction

This report sets out:
• The latest Quality and Performance Report for comment;
• A summary of actions accruing from the quality report;
• An update on the Winter Access Fund.</td></tr>
<tr><td>Recommendation</td><td colspan="5">The Committee is asked to:

• COMMENT ON future development of the quality and performance report to support onward quality and performance improvement.</td></tr>
<tr><td>Identified Risks and Risk Management Actions</td><td colspan="5">The report outlines areas where support to practices is required, and where formal action requiring remedial actions plans are required.</td></tr>
<tr><td>Conflicts of Interest</td><td colspan="5">Conflicts of interest are managed robustly and in accordance with the CCG’s conflict of interest policy.</td></tr>
<tr><td>Resource Implications</td><td colspan="5">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.</td></tr>
<tr><td>Engagement</td><td colspan="5">The report includes patient experience measures from the Friends and Family Test and GP Patient Survey carried out by Ipsos MORI.</td></tr>
</table>

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 Commissioning Committee 2. Quality dashboard for each Borough

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 update on the Winter Access Fund

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.

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;	1. GP Hubs 2. DES sign up 3. National access programme

	Direct Enhanced Service (DES) sign up	
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 for practices across each Borough including an overview of practice outliers in performance compared to Borough 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 black and ethnic minorities;
- Average list size per practice and list size change over the 12 months to November 2021.

	Barnet	Camden	Enfield	Haringey	Islington
Contract type	GMS 28/51 PMS 22/51 APMS 1/51	GMS 14/33 PMS 14/33 APMS 5/33	GMS 9/31 PMS 19/31 APMS 3/31	GMS 14/35 PMS 19/35 APMS 2/35	GMS 28/32 PMS 2/32 APMS 2/32
Deprivation:					
1 = most deprived	0	0	17	10	1
2	3	10	8	16	26
3	11	12	10	5	5
4	27	6	7	3	0
5 = least deprived	10	4	3	1	0
Null	0	1	0	0	0
Patients aged > 75 on list	7%	4%	6%	4%	4%
% list black & ethnic minority	37%	35%	41%	43%	33%
Average list size	8,619	10,655	11,499	9,524	9,254
Annual list size change	+1%	+10%	+4%	+4%	+9%

To note:

- The relatively high rates of deprivation in Enfield, Haringey and Islington;
- The higher proportion of people aged over 75 on practice lists in Barnet and Enfield;
- The April 2021 report reported the number of practices in Enfield reducing from 47 to 33 following the merger of 15 practices to create Medicus Health Partnership which was approved by the Committee in December 2020. Forest Road Group Practice is the host for the partnership with a list size of circa 90,000 for the merged practice. The number of practices has now reduced to 31 with the merger of Park Lodge Medical Centre and Winchmore Hill Practice from 1st May 2021. Average list size in Enfield has therefore increased from 7,445 to 11,499 per practice;
- Following the creation of Medicus Health Partnership for Enfield some indicators are still reported on the previous practice baseline. This includes deprivation indices, patient feedback and Quality Outcomes Framework delivery;
- List sizes, and annual changes, are based on the movement from March 2021 to March 2022, with an overall list increase of 3.4% year-on-year. List size growth recorded across the five Boroughs compared to the last report (based on January 2022 lists) is 0.3%.

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 Borough as at March 2020:

CQC ratings	Barnet	Camden	Enfield	Haringey	Islington
Overall rating:					
Outstanding	0	0	0	1	0
Good	49	31	44	29	30
Requires Improvement	2	2	2	2	2
Inadequate	0	0	0	3	0
Yet to be rated	0	0	0	0	0
Total	51	33	46	35	32

To note from the above:

- The majority of practices assessed to date have received a good rating. 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;
- Three practices in NCL now have an inadequate rating from the CQC as per the last report. All three practices are in Haringey. Staunton Group Practice remains on an inadequate rating, with the rating relating to the previous partnership and not the current caretaking arrangements. Charlton House Surgery and Grover Road Surgery have moved to an inadequate rating following inspections in August 2021 and September 2021 respectively;
- The number of practices with a requires improvement (RI) rating (ten) shows no change from the February 2022 report to the Committee;

- Practices with an inadequate or requires improvement rating 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.

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 practices in each Borough and now includes published data for 2020/21. The table shows performance in 2020/21 and 2019/20 compared to the range for previous years:

Quality Outcomes Framework	Barnet	Camden	Enfield	Haringey	Islington
% achievement in 2020/21	95.0%	94.2%	94.8%	94.5%	96.2%
% achievement in 2019/20	94.5%	94.4%	95.8%	95.8%	96.1%
% achievement in prior years	95.8%-96.8%	96.3%	95.2%-95.3%	95.8%-96.1%	96.4%
Practices with less than 70%	0	1	0	1	0
Practices with less than 80%	0	0	0	0	0
Practices with 80% to 90%	5	1	2	2	1

The table reports by exception the number of practices in each Borough 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, all the 13 practices across the five Boroughs achieving less than 90% QOF scores in 2020/21 currently have a Good rating from the Care Quality Commission, with the exception of Charlton House Medical Centre in Haringey (score 89.4%) and CQC inadequate rating and Bingfield practice in Islington (score 89.3%) and CQC requires improvement rating, with the CQC rating for Bingfield practice relating to the previous contract holder.

Care Quality Commission (CQC) ratings provided an overall assessment of practice performance and service quality with the overall rating determined by assessment against the following domains for quality of care – effective, caring, responsive, safe and well-led. The Quality Outcomes Framework (QOF) targets performance in specific areas in particular to support planned care and chronic disease management, and practices receive an incentive payment for delivery of the QOF metrics. It was therefore possible for practices to deliver strong performance against the targeted QOF metrics whilst struggling to get a good rating from the broader CQC assessment.

At the end of 2019/20 and in 2020/21 practice delivery against QOF indicators has been materially reduced by the covid pandemic. The financial resilience support package for practices therefore includes payment protection for practices based on prior year performance.

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.

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 July 2021 and cover the period from January to March 2021.

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 February 2021.

Patient Experience	Barnet	Camden	Enfield	Haringey	Islington
GP patient survey – good overall experience of the practice	79%	85%	76%	80%	84%
GP patient survey – easy getting through by phone	64%	81%	62%	71%	79%

GP patient survey – satisfied with type of appointment offered	77%	84%	76%	78%	81%
Friends and family test: Average recommendation % Practices with results Range of recommendation %	 85% 19/51 69% - 100%	 89% 12/33 76% - 100%	 86% 25/45 50% - 100%	 87% 21/35 54% - 100%	 90% 15/32 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.

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 has been updated to show the number of written complaints made by patients and/or their carers during 2020/21 on receipt of the information from NHS England. 2018/19, 2017/18 and 2016/17 in total, and then per practice and per 1,000 people on practice lists.

Written complaints received	Barnet	Camden	Enfield	Haringey	Islington
Number of complaints received in 2020/21	485	292	362	371	281
Complaints escalated to NHSE in 2020/21	23/485	22/292	22/362	28/371	16/281
Average received per practice in 2020/21	10	9	8	11	9
Average per 1000 people on list in 2020/21	1.1	0.9	1.0	1.1	1.0
Number of complaints received in prior years	568-610	406-430	483-530	389-411	208-377
Average received per practice prior years	11	12	11	11	9
Average per 1000 people on list in prior years	1.3	1.3	1.4	1.2	1.0

In 2020/21 the number of complaints received by per head of population, and by practice, is broadly consistent across practices in the five Boroughs. The number and rate of complaints shows a marked reduction for Enfield in 2020/21 compared to prior years, with reductions also seen in Barnet and Camden. The impact of the pandemic on complaints will be investigated.

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

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 as at January 2022 (in black) compared to the previous report (in red) using November 2021 data.

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	42% 40%	43% 39%	33% 30%	36% 35%	37% 34%
% of population with on-line ordering of repeat prescriptions enabled	49% 46%	46% 44%	35% 32%	43% 41%	43% 40%

Population coverage for booking appointments on-line and ordering repeat prescriptions on-line is increasing gradually with an increase across all five Boroughs for the proportion if people with on-line access enabled from November 2021 to January 2022.

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 for Quarter One 2020/21 (April to June 2020).

Workforce	Barnet	Camden	Enfield	Haringey	Islington
% of GPs aged over 55	30%	15%	32%	37%	28%
% locum GPs	2%	4%	8%	7%	4%
% of nurses aged 55 and over	47%	21%	55%	53%	50%
Number of patients per full-time GP	2.281	1,865	2,818	2,757	2,342
Number of patients per full-time nurse	10,251	12,130	9,802	11,268	9,155

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 accruing from the Primary Care Network Additional Roles Reimbursement Scheme. Additional roles now funded include pharmacists, physicians, physiotherapists, social prescribers and mental health professionals.

Development of the NCL Primary Care Dashboard will incorporate available workforce data to provide an overview at practice and PCN levels.

Additional Roles Reimbursement Scheme (ARRS) staff working in Primary Care Networks (PCN) already make up more than 20% of our clinical or direct patient care in NCL.

The August 2021 return for PCNs showed that NCL PCNs:

- Had recruited 327 FTE staff up to March 2021 under the Additional Roles Reimbursement Scheme (ARRS);
- Intending to recruit a further 114 FTE ARRS staff in 2021/22;
- Have the highest funding draw down in London, and are 30% higher than national average. PCNs have a maximum weighted allocation against which they can draw down. Forty-five percent of the funding is retained centrally, and is only able to be drawn down on evidence of recruitment.

There are data quality issues with recording for some PCN roles, who work across more than one practice. PCNs are required to report their intention to recruit and roles recruited to; there is risk of duplication for roles working at a practice and PCN level, if not recorded correctly. In September 2021 (latest available return) 11 out of 32 PCNs submitted a zero return.

Schemes to support recruitment in NCL include supporting PCNs to aid recruitment to ARRS; promotion and expansion of clinical placements; GP and GP Nursing fellowship and mentoring scheme; expansion and promotion of apprenticeship roles

Schemes to support staff retention and development include the development of a primary care flexible staffing pool, local GP retention schemes, delivery of GPN initiatives and a wellbeing pilot.

5. Primary Care Access and Demand

Primary care continues to operate a hybrid model for access, utilising remote access where appropriate. A face-to-face appointment is offered to patients where clinically necessary, and patients can also be signposted to other services where appropriate. Extended access hubs continue to offer appointments over evenings and weekends, with temporary additional capacity from 111 and extended access services.

Primary care has seen an increase in demand with appointments in January 2022 being 10.5% above pre-Covid-19 activity from January 2020. Demand also increased 3.5% between December 2021 and January 2022, with over half of appointments now being delivered face-to-face (53%) compared to (80%) before the pandemic. Attendance rates improved slightly from 90% to 91%.

Work undertaken to prepare to meet the national requirement for all health staff to be fully vaccinated by April 2022 has now been stood down, although work and conversations continue to support all staff to be vaccinated.

Several key actions are underway to support primary care with the current winter and Covid-19 pressures:

NCL Winter Resilience Communications Campaign - this is supporting key primary care messages to patients and the public in general. This includes supporting people to access the right care and help when needed, gathering insight to help people better understand any specific barriers to accessing services, building confidence in the NHS and also helping people to understand the importance of immunisation.

Delivery of Winter Access Funding – NCL received £6.89 million in national funding to support primary care to improve access to primary care. NCL CCG has worked with practices and other primary care stakeholders to develop and deliver: targeted support to NCL's most deprived areas; a universal offer to support all practices with access; CCG-led programmes to support primary care access in the wider system.

Targeted support: NCL identified around 20% of NCL practices that would most benefit from enhanced funding and support, using a deprivation-based approach. Around £1.4 million of WAF funding was directed to the seven most deprived PCN footprints in NCL to improve access to general practice. This has been spent on a range of projects to increase resilience in these practices, including new paediatric models in Haringey and Enfield to reduce demand at the North Middlesex Emergency Department (ED).

Universal offer: this has included workforce development and capacity boosting schemes for healthcare assistants and administrators, funding to bring in additional locums to create appointments and support to mobilise and make best use of the Community Pharmacy Consultation Scheme (CPCS) to allow community pharmacies to see more patients with low acuity needs. All Primary Care Networks (PCNs) received access innovation funding for self-directed access improvement work which has included investment in digital enablers and testing new models of access, from which we expect valuable learning for NCL.

Wider system: NCL CCG invested in boosting capacity in extended access services, increased primary care presence in Emergency Departments (EDs), and in community pharmacy to support access to primary care in the wider health and care system.

A full evaluation of the Winter Access Fund programme is underway, but as of 14/03/22 we estimate that NCL has added ~75,000 primary care appointments to the system using this funding. Learning from the programme, particularly the PCN-led innovation schemes, will be used to shape NCL's ongoing approach to improving primary care access.

There continues to be a weekly NCL all GP practice-webinar, hosted by the NCL CCG chair with clinical and officer guest speakers. This provides an opportunity for practices to receive relevant updates and to raise questions. A range of local forums are also in place to support practices with any borough specific questions.

Healthwatch Insight

During 2021/22 Healthwatch has continued to carry out extensive research and engagement with local communities on a broad range of issues, including access to primary care services, and the impact of the pandemic on the way services are received and delivered. Some of the reports received from Healthwatch colleagues are listed below:

- Life in Lockdown (Healthwatch Camden, October 2020);
- From Digital Exclusion to Inclusion (Healthwatch Islington, May 2021);
- Deaf people's GP challenges (Healthwatch Barnet, May 2021);
- Locked out: digitally excluded people's experiences of remote GP appointments (Healthwatch England, supported by Healthwatch Haringey, June 2021);
- Accessing GP services (Healthwatch Haringey, June 2021);
- Accessing your GP remotely (Healthwatch Barnet, August 2021);
- Accessing GP services (Healthwatch Enfield, Sept 2021);
- Surviving Domestic Abuse: Improving systems that support victims (Healthwatch Camden, Oct 2021)

Through the Winter Access Fund, NCL has identified a scheme which allows the development of interventions to improve access to general practice, based on insight from local communities. This insight has come from the community outreach work commissioned in boroughs to support the delivery of the NCL winter resilience campaign, as well as from existing insight in the reports listed above.
The starting point has been to summarise the key insight and recommendations from these Healthwatch reports to try and help the areas where actions are already in place and assess further actions to be carried out, all using the Winter Access Fund where necessary.

NCL colleagues met with Healthwatch in January 2022 to hear more verbal feedback from residents and have asked for their input to help NCL prioritise the areas of focus with suggestions of solutions that should be considered. This insight will inform both the current work under this scheme, and also NCL CCG's wider operating plan priorities around primary care. Further meetings are planned with Healthwatch in March 2022.

Work continues with NCL boroughs and other areas to understand where some of this insight is already being addressed e.g., digital inclusion. The aim is to develop an action plan setting out the areas of focus, and the steps required for achievement, all for approval by the Winter Access Fund Board.

Barnet Directorate APRIL 2022			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 - Safe	CQC - Effective	CQC - Caring	CQC - Responsive	CQC - Well led	Written complaints (Total) 2020/21	Written complaints (via NHSE) 2020/21	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 20/21	QOF Personalised Care Adjustment Rate 20/21	List size - March 22	Annual List Size Change March 21 - March 22	FFT: % likely to recommend GP service to friends & family (Feb 2020) (* = nos <6; 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 20/21	Online Appointments Enabled	% Of Reg Pop with online appointment enabled	Total no. pt transactions using online appointments service (Jan 22)	Order Repeat Prescriptions Online Enabled	% Of Reg Pop with order repeat prescriptions online enabled	Total no. prescriptions ordered via online pt transaction service (Jan 22)	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%	Green	Green	Green	Green	Green	Green	25	2	Large	20%	0%	100%	1,502	12,793	94.8%	4.2%	9193	0.5%	93%	82%	85%	75%	£159	✓	50%	0	✓	50%	585	FULL	7	✓
2	E83005	Lichfield Grove Surgery	Del	PMS	✗	5 - Least Deprived	4.8%	64%	Green	Green	Green	Green	Green	Green	1	0	Small-medium	15%	0%	100%	2,458	20,281	97.8%	5.0%	6497	3.3%	no data	93%	72%	90%	£131	✓	69%	148	✓	68%	295	FULL	7	✓
3	E83006	Greenfield Medical Centre	Del	PMS	✗	3	5.6%	58%	Green	Green	Green	Green	Green	Green	4	0	Medium-large	17%	0%	58%	1,675	7,243	95.9%	4.4%	7137	2.3%	no data	85%	78%	81%	£172	✓	49%	12	✓	49%	315	FULL	7	✓
4	E83007	Squires Lane Medical Practice	Del	GMS	✗	3	6.6%	59%	Green	Green	Green	Green	Green	Green	7	1	Single-handed	0%	0%		2,132	26,245	98.7%	6.6%	5593	-2.5%	71%	66%	37%	65%	£126	✓	46%	0	✓	46%	53	FULL	7	✓
5	E83008	Heathfielde Medical Centre	Del	PMS	✗	5 - Least Deprived	7.6%	78%	Green	Green	Green	Green	Green	Green	12	0	Medium-large	50%	0%	15%	3,821	5,449	97.3%	3.6%	8854	0.2%	no data	82%	79%	75%	£136	✓	65%	36	✓	64%	511	FULL	7	✓
6	E83009	PHGH Doctors	Del	PMS	✗	5 - Least Deprived	8.4%	75%	Green	Green	Green	Green	Green	Green	4	0	Medium-large	25%	4%	100%	3,375	11,808	94.3%	5.2%	11882	4.7%	87%	85%	71%	81%	£146	✓	56%	0	✓	56%	1070	FULL	7	✓
7	E83010	The Speedwell Practice	Del	PMS	✗	4	6.7%	63%	Green	Green	Green	Green	Green	Green	23	0	Medium-large	13%	0%	36%	2,389	4,646	97.5%	6.3%	11228	2.6%	77%	66%	47%	68%	£150	✓	0%	0	✓	50%	594	FULL	7	
8	E83011	The Everglade Medical Practice	Del	GMS	✗	2	2.9%	42%	Green	Green	Green	Green	Green	Green	12	1	Medium-large	21%	0%	0%	1,621	9,087	95.3%	8.6%	10378	15.9%	74%	74%	54%	64%	£149	✓	0%	0	✓	32%	316	FULL	7	✓
9	E83012	The Old Courthouse Surgery	Del	GMS	✗	4	8.7%	77%	Green	Green	Green	Green	Green	Green	12	1	Medium-large	0%	0%	0%	1,775	8,804	99.6%	8.7%	8603	2.1%	85%	83%	78%	83%	£138	✓	0%	0	✓	50%	248	PARTIAL	6	✓
10	E83013	Cornwall House Surgery	Del	GMS	✗	5 - Least Deprived	8.2%	63%	Green	Green	Green	Green	Green	Green	5	0	Medium-large	33%	0%	0%	1,202	19,674	95.8%	6.1%	5767	-1.4%	86%	69%	46%	69%	£140	✓	47%	0	✓	46%	250	FULL	7	✓
11	E83016	Millway Medical Practice	Del	PMS	✗	4	7.3%	65%	Green	Green	Green	Green	Green	Flag	83	0	Large	2%	0%	12%	1,682	22,729	99.8%	7.8%	19613	5.6%	no data	81%	44%	84%	£178	✓	96%	54	✓	96%	1307	FULL	7	✓
12	E83017	Longrove Surgery	Del	PMS	✗	4	8.6%	79%	Green	Green	Green	Green	Green	Green	3	3	Large	29%	0%	53%	1,718	8,315	97.9%	5.5%	17364	-0.3%	no data	78%	63%	74%	£128	✓	50%	0	✓	50%	1354	FULL	7	✓
13	E83018	Watling Medical Centre	Del	GMS	✗	3	6.1%	51%	Green	Green	Green	Green	Green	Green	13	0	Large	7%	0%	0%	1,314	7,778	96.5%	7.4%	17175	3.7%	85%	85%	62%	78%	£133	✓	46%	319	✓	45%	1061	FULL	7	✓
14	E83020	St George’s Medical Centre	Del	PMS	✗	4	5.9%	60%	Green	Green	Green	Green	Green	Green	29	2	Medium-large	0%	0%	0%	1,911	11,619	96.9%	4.5%	11531	-2.4%	no data	83%	46%	73%	£147	✓	31%	8	✓	58%	867	FULL	7	✓
15	E83021	Torrington Park Group Practice	Del	PMS	✗	4	9.1%	63%	Green	Green	Green	Green	Green	Green	1	1	Medium-large	27%	0%	55%	1,722	6,294	94.9%	9.2%	12402	0.5%	100%	85%	56%	81%	£134	✓	0%	0	✓	55%	664	FULL	7	✓
16	E83024	St Andrews Medical Practice	Del	PMS	✗	5 - Least Deprived	9.4%	72%	Green	Green	Green	Green	Green	Flag	14	2	Large	15%	0%	48%	1,354	4,301	97.2%	4.4%	11375	1.6%	no data	79%	56%	79%	£159	✓	69%	36	✓	69%	875	FULL	7	✓
17	E83025	Pennine Drive Practice	Del	GMS	✗	3	5.8%	55%	Green	Green	Green	Green	Green	Green	0	0	Small-medium	24%	0%	0%	2,231	7,564	95.0%	6.7%	8567	-2.2%	no data	68%	56%	68%	£129	✓	28%	0	✓	29%	251	FULL	7	✓
18	E83026	Supreme Medical Centre	Del	GMS	✗	5 - Least Deprived	8.3%	65%	Green	Green	Green	Green	Green	Green	2	0	Small-medium	76%	0%	0%	2,488	5,558	94.5%	8.6%	4468	0.9%	no data	83%	67%	77%	£143	✓	50%	0	✓	50%	232	FULL	7	✓
19	E83027	The Practice @ 188	Del	PMS	✗	4	8.9%	69%	Green	Green	Green	Green	Green	Green	7	0	Small-medium	7%	52%	0%	4,373	ND	96.8%	9.2%	9010	4.4%	no data	59%	57%	59%	£157	✓	37%	0	✓	37%	255	FULL	7	✓
20	E83028	Parkview Surgery	Del	PMS	✗	2	3.1%	47%	Green	Green	Green	Green	Green	Green	8	0	Small-medium	40%	0%	100%	3,289	10,962	93.6%	6.5%	6574	-0.7%	no data	85%	83%	79%	£130	✓	32%	3	✓	32%	211	FULL	7	✓
21	E83030	Penshurst Gardens Surgery	Del	GMS	✗	4	9.9%	61%	Green	Green	Green	Green	Amber	Green	1	1	Medium-large	0%	0%	0%	1,568	6,940	92.1%	2.9%	6263	-7.3%	no data	66%	23%	64%	£143	✓	71%	35	✓	71%	481	no data	-	✓
22	E83031	The Village Surgery	Del	PMS	✗	4	8.9%	76%	Green	Green	Green	Green	Green	Green	4	0	Small-medium	42%	0%	100%	1,882	7,638	95.1%	4.2%	5206	-1.0%	no data	85%	81%	78%	£137	✓	0%	0	✓	39%	327	FULL	7	
23	E83032	Oak Lodge Medical Centre	Del	GMS	✗	3	4.1%	43%	Green	Green	Green	Green	Green	Green	13	1	Large	0%	0%	11%	1,490	5,821	98.1%	9.1%	17899	-0.2%	no data	88%	44%	76%	£148	✓	57%	0	✓	57%	174	FULL	7	✓
24	E83034	Mulkis Hb-The Surgery	Del	GMS	✗	3	6.5%	69%	Green	Green	Green	Green	Green	Green	5	0	Single-handed	100%	0%	100%	2,469	7,407	95.0%	5.3%	5346	1.1%	no data	88%	78%	78%	£128	✓	49%	54	✓	49%	274	FULL	7	✓
25	E83035	Wentworth Medical Practice	Del	PMS	✗	4	6.8%	59%	Green	Green	Green	Green	Green	Green	12	1	Medium-large		0%	0%	1,836	5,346	92.9%	3.2%	12963	4.3%	86%	71%	44%	81%	£151	✓	47%	0	✓	47%	528	FULL	7	✓
26	E83037	Derwent Crescent Medical Centre	Del	PMS	✗	5 - Least Deprived	8.6%	68%	Green	Green	Green	Green	Green	Green	10	0	Small-medium	41%	0%	52%	1,625	10,461	99.3%	7.7%	5587	0.6%	no data	88%	83%	82%	£157	✓	91%	0	✓	93%	492	FULL	7	✓
27	E83038	Jai Medical Centre	Del	GMS	✗	3	8.1%	50%	Green	Green	Green	Green	Green	Green	9	0	Small-medium	31%	0%	76%	5,045	3,179	95.2%	7.0%	8928	4.3%	no data	80%	72%	82%	£144	✓	32%	0	✓	32%	220	FULL	7	✓
28	E83039	Ravenscroft Medical Centre	Del	PMS	✗	4	4.4%	62%	Green	Green	Green	Green	Green	Green	2	0	Small-medium		0%	100%	2,380	14,120	92.5%	5.2%	5639	1.6%	no data	82%	81%	75%	£169	✓	0%	0	✓	40%	108	FULL	7	✓
29	E83041	Wakeman’s Hill Surgery	Del	GMS	✗	3	5.3%	40%	Green	Green	Green	Green	Green	Green	2	0	Small-medium	0%	35%	0%	3,582	ND	95.1%	7.7%	4304	0.2%	no data	80%	69%	82%	£140	✓	27%	24	✓	26%	58	FULL	7	✓
30	E83044	Addington Medical Centre	Del	GMS	✗	4	8.2%	76%	Green	Green	Green	Green	Green	Green	23	0	Medium-large	50%	0%	76%	2,669	ND	93.3%	3.1%	9348	-1.0%	90%	88%	74%	77%	£129	✓	47%	172	✓	47%	97	FULL	7	✓
31	E83045	Friern Barnet Medical Centre	Del	GMS	✗	4	6.0%	63%	Green	Green	Green	Green	Green	Green	0	0	Medium-large	42%	0%	100%	1,662	9,748	98.8%	8.8%	9745	1.9%	no data	78%	59%	72%	£126	✓	41%	0	✓	41%	437	PARTIAL	5	✓
32	E83046	Mulberry Medical Practice	Del	GMS	✗	3	5.2%	53%	Green	Green	Green	Green	Green	Green	15	0	Medium-large	23%	0%	26%	2,141	6,010	93.6%	8.7%	9115	-3.9%	no data	54%	37%	56%	£138	✓	36%	0	✓	36%	343	no data	-	✓
33	E83049	Langstone Way Surgery	Del	PMS	✗	4	5.4%	59%	Amber	Amber	Amber	Green	Amber	Red	26	2	Medium-large	30%	0%	34%	2,186	2,313	96.1%	11.7%	9036	5.8%	no data	64%	39%	73%	£163	✓	0%	0	✓	42%	449	FULL	7	✓
34	E83050	East Finchley Medical Centre	Del	GMS	✗	5 - Least Deprived	6.4%	77%	Green	Green	Green	Green	Green	Green	4	0	Medium-large	0%	0%	0%	3,054	9,067	86.4%	7.2%	7754	-2.9%	no data	74%	60%	85%	£131	✓	45%	0	✓	47%	403	no data	-	✓
35	E83053	Lane End Medical Group	Del	GMS	✗	4	7.7%	60%	Green	Green	Green	Green	Green	Green	10	1	Large	18%	0%		1,255	14,153	97.1%	9.8%	14212	6.3%	93%	80%	65%	83%	£153	✓	61%	41	✓	55%	971	FULL	7	✓
36	E83600	Adler Js-The Surgery	Del	GMS	✗	4	4.4%	73%	Green	Green	Green	Green	Green	Green	2	0	Small-medium	50%	0%	0%	2,257	12,300	91.6%	3.6%	6569	2.8%	100%	97%	95%	90%	£136	✓	0%	0	✓	38%	253	FULL	7	✓
37	E83613	East Barnet Health Centre	Del	PMS	✗	4	7.5%	76%	Green	Green	Green	Green	Green	Green	4	0	Large		0%	40%	1,482	8,891	96.0%	2.9%	11384	-0.3%	no data	81%	59%	74%	£146	✓	41%	158	✓	41%	504	FULL	7	✓
38	E83621	Brunswick Park Medical Centre	Del	GMS	✗	4	8.9%	68%	Green	Green	Green	Green	Green	Green	19	0	Large		0%	100%	1,176	4,274	98.5%	3.5%	8443	-1.0%	75%	63%	61%	60%	£150	✓	52%	1	✓	51%	577	FULL	7	✓
39	E83622	Temple Fortune Medical Group	Del	GMS	✗	5 - Least Deprived	7.6%	74%	Green	Green	Green	Green	Green	Green	8	0	Medium-large	51%	0%	55%	2,245	11,951	98.9%	9.4%	8308	5.9%	no data	87%	75%	88%	£131	✓	50%	150	✓	49%	396	no data	-	✓
40	E83637	Colindale Practice (Dr Lamba)	Del	PMS	✗	3	2.9%	41%	Green	Green	Green	Green	Green	Green	2	0	Medium-large	47%	0%	65%	3,388	19,648	97.1%	6.3%	10477	4.7%	80%	81%	61%	83%	£129	✓	39%	0	✓	38%	366	FULL	7	✓
41	E83638	The Mountfield Surgery	Del	PMS	✗	5 - Least Deprived	7.8%	66%	Green	Green	Green	Green	Green	Green	2	0	Small-medium	93%	0%	100%	4,390	4,098	95.8%	3.5%	4906	-1.7%	80%	87%	85%	83%	£148	✓	43%	0	✓	43%	202	FULL	7	✓
42	E83639	Rosemary Surgery	Del	GMS	✗	4	3.5%	62%	Green	Green	Green	Green	Green	Green	2	0	Medium-large	15%	0%		1,488	ND	96.0%	4.0%	6174	0.3%	99%	86%	84%	82%	£139	✓	54%	169	✓	54%	323	FULL	7	✓
43	E83649	The Hodford Road Surgery	Del	PMS	✗	4	5.4%	67%	Amber	Red	Amber	Green	Green	Amber	16	1	Small-medium	100%	0%	0%	2,137	10,258	94.0%	4.4%	4120	2.3%	no data	81%	79%	82%	£142	✓	92%	8	✓	92%	203	FULL	7	✓
44	E83650	Gloucester Road Surgery	Del	GMS	✗	4	12.2%	75%	Green	Green	Green	Green	Green	Green	1	0	Single-handed	100%	0%	100%	1,628	4,490	86.3%	2.4%	1784	-4.4%	no data	85%	85%	88%	£128	✓	42%	0	✓	42%	61	FULL	7	
45	E83653	The Phoenix Practice	Del	GMS	✗	4	6.1%	61%	Green	Green	Green	Green	Green	Green	6	1	Medium-large	13%	0%	42%	2,511	8,523	90.5%	4.1%	10323	0.0%	no data	91%	74%	82%	£137	✓	53%	227	✓	52%	430	FULL	7	✓
46	E83657	The Hillview Surgery	Del	GMS	✗	4	6.7%	62%	Green	Green	Green	Green	Green	Green	1	0	Small-medium	100%	0%	100%	1,974	8,333	87.6%	8.0%	2,009	5.6%	no data	79%	89%	81%	£159	✓	29%	0	✓	29%	30	NO	0	✓
47	E83668	Medical Centre (Deans Lane)	Del	GMS	✗	4	3.5%	52%	Green	Green	Green	Green	Green	Green	3	1	Single-handed	0%	0%	100%	4,538	7,941	98.8%	5.5%	4,230	-1.6%	no data	80%	78%	81%	£112	✓	32%	0	✓	32%	75	FULL	7	✓
48	Y00316	Woodlands Medical Practice	Del	PMS	✗	4	6.1%	68%	Green	Green	Green	Green	Green	Green	2	0	Medium-large	0%	0%	0%	1,187	11,635	98.3%	5.3%	4,661	5.3%	69%	70%	52%	75%	£139	✓	60%	0	✓	60%	263	FULL	7	✓
49	Y02986	Cricklewood Health Centre	Del	APMS	✗	2	0.5%	54%	Green	Green	Green	Green	Green	Green	0	0	Small-medium	0%	0%	100%	1,914	4,121	81.6%	6.5%	3,964	-18.0%	no data	78%	64%	77%	£146	✓	37%	0	✓	37%	114	no data	-	
50	Y03663	Hendon Way Surgery	Del	GMS	✗	3	3.3%	53%	Green	Green	Green	Green	Green	Green	15	0	Medium-large		10%		2,675	41,133	94.7%	5.5%	8,800	0.7%	92%	71%	57%	76%	£130	✓	40%	0	✓	40%	192	no data	-	✓
51	Y03664	Dr Azim & Partners	Del	GMS	✗	4	3.7%	55%	Green	Green	Green	Green	Green	Green	1	1	Medium-large		0%		2,464	10,868	88.1%	6.6%	8,847	0.7%	no data	56%	36%	66%	£147	✓	70%	0	✓	72%	229	FULL	7	✓

Comments:

No. 37 - 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)

01.01.21 - E83036 Vale Drive Medical Practice merged with E83017 Longrove Surgery

Camden Directorate
APRIL 2022

#	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 - Safe	CQC - Effective	CQC - Caring	CQC - Responsive	CQC - Well led	Written complaints (Total) 2020/21	Written complaints (via NHSE) 2020/21	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
			Practice			Practice Demographics			Quality								Workforce					
1	F83003	Park End Surgery	Del	PMS	✗	5 - Least Deprived	9.3%	79%	●	●	●	●	●	●	9	1	Large	14%	0%	0%	1,029	15,233
2	F83005	Gower Street Practice	Del	GMS	✗	3	1.3%	61%	●	●	●	●	●	●	6	0	Medium-large	55%	0%	0%	3,134	ND
3	F83006	Ampthill Practice	Del	GMS	✗	2	4.5%	55%	●	●	●	●	●	●	8	0	Medium-large	25%	0%	0%	1,330	7,518
4	F83011	Primrose Hill Surgery	Del	GMS	✗	4	6.6%	79%	●	●	●	●	●	●	5	1	Medium-large	0%	0%		1,633	ND
5	F83017	Hampstead Group Practice	Del	PMS	✗	4	5.3%	73%	●	●	●	●	●	●	10	0	Large	7%	0%	0%	1,064	7,270
6	F83018	Prince Of Wales Group Surgery	Del	PMS	✗	2	5.0%	63%	●	●	●	●	●	●	18	0	Large	22%	3%	55%	961	26,496
7	F83019	Abbey Medical Centre	Del	GMS	✗	3	5.2%	62%	●	●	⚑	●	●	●	17	1	Large	11%	0%	0%	1,491	ND
8	F83020	Adelaide Medical Centre	Del	GMS	✗	4	6.8%	71%	●	●	●	●	●	●	20	0	Large	12%	0%	60%	1,542	6,874
9	F83022	Caversham Group Practice	Del	GMS	✗	3	4.8%	70%	●	●	●	●	●	●	0	0	Large	46%	0%	0%	1,217	7,001
10	F83023	James Wigg Practice	Del	PMS	✗	2	4.0%	67%	●	●	●	●	●	●	38	0	Large	13%	0%	17%	1,095	6,696
11	F83025	The Regents Park Practice	Del	PMS	✗	2	4.9%	52%	●	●	●	●	●	●	5	0	Medium-large	0%	0%	35%	872	6,199
12	F83042	Grays Inn Road Medical Centre	Del	PMS	✗	3	2.1%	58%	●	●	●	●	●	●	18	2	Medium-large	30%	0%	100%	1,961	11,664
13	F83043	Ridgmount Practice	Del	GMS	✗	3	0.4%	59%	●	●	●	●	●	●	2	0	Large	29%	0%		2,401	6,673
14	F83044	The Bloomsbury Surgery	Del	GMS	✗	2	3.8%	52%	●	●	●	●	●	●	0	0	Medium-large	0%	0%	0%	1,885	ND
15	F83048	Brunswick Medical Centre Uhpc	Del	APMS	✗	3	2.9%	56%	●	●	●	●	●	●	2	2	Medium-large	0%	43%	0%	5,396	ND
16	F83050	Fortune Green Road Surgery	Del	GMS	✗	4	6.1%	69%	●	●	●	●	●	●	7	0	Small-medium	0%	13%	0%	1,542	5,871
17	F83052	Brookfield Park Surgery	Del	GMS	✗	3	5.8%	77%	●	●	●	●	●	●	4	0	Small-medium	35%	0%	0%	1,317	ND
18	F83055	West Hampstead Medical Centre	Del	PMS	✗	4	2.9%	72%	●	●	●	●	●	●	10	0	Large	13%	0%	53%	2,003	14,831
19	F83057	Parliament Hill Surgery	Del	PMS	✗	3	4.3%	78%	●	●	●	●	●	●	11	1	Large	3%	0%	100%	1,121	18,701
20	F83058	Holborn Medical Centre	Del	PMS	✗	3	2.1%	57%	●	●	●	●	●	●	7	0	Large	24%	0%	0%	1,359	12,030
21	F83059	Brondesbury Medical Centre	Del	PMS	✗	2	3.0%	63%	●	●	●	●	●	●	38	0	Large	10%	0%	31%	1,750	ND
22	F83061	Museum Practice	Del	PMS	✗	3	4.2%	63%	●	●	●	●	●	●	3	0	Medium-large	0%	10%		988	13,173
23	F83615	Cholmley Gardens Surgery	Del	PMS	✗	5 - Least Deprived	4.5%	73%	○	○	●	●	●	○	3	1	Medium-large	40%	0%	0%	1,743	18,722
24	F83623	Keats Group Practice	Del	PMS	✗	5 - Least Deprived	5.9%	79%	●	●	●	●	●	●	10	0	Large	12%	0%	0%	1,451	10,953
25	F83632	Queens Crescent Practice	Del	GMS	✗	2	4.1%	61%	●	●	●	●	●	●	12	0	Medium-large	5%	0%	0%	1,261	7,743
26	F83633	Daleham Gardens Health Centre	Del	PMS	✗	5 - Least Deprived	4.8%	73%	●	●	●	●	●	●	9	0	Small-medium	0%	0%	0%	2,436	11,379
27	F83635	Kings Cross Surgery	Del	APMS	✗	2	1.2%	51%	●	●	●	●	●	●	5	5	Small-medium	6%	15%	0%	4,003	ND
28	F83658	Belsize Priory Medical Practice (Group)	Del	GMS	✗	3	4.6%	62%	○	○	○	●	●	○	3	0	Small-medium	76%	22%		2,016	16,861
29	F83665	Swiss Cottage Surgery	Del	GMS	✗	4	2.7%	66%	●	●	●	●	●	●	5	5	Large	0%	0%	40%	1,743	5,177
30	F83672	St Philips Medical Centre	Del	GMS	✗	3	0.4%	63%	●	●	●	●	●	●	3	0	Large	0%	0%		1,860	44,281
31	F83683	Somers Town Medical Centre	Del	APMS	✗	2	2.4%	48%	●	●	●	●	●	●	1	1	Single-handed	0%	33%		5,685	9,324
32	Y02674	Camden Health Improvement Practice	Del	APMS	✗	2	0.7%		●	●	●	●	●	●	1	0	Small-medium	0%	0%	50%	397	461
33	Y03103	Medicus Select Care (SAS)		APMS	✗		0.0%		●	●	●	●	●	⚑	2	2						

#	Practice Code	QOF Achievement 20/21	QOF Personalised Care Adjustment Rate 20/21	List size - March 22	Annual List Size Change March 21 - March 22	FFT: % likely to recommend GP service to friends & family (Feb 2020) (* = nos <6; 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 20/21	Online Appointments Enabled	% Of Reg Pop with online appointment enabled	Total no. pt transactions using online appointments service (Jan 22)	Order Repeat Prescriptions Online Enabled	% Of Reg Pop with order repeat prescriptions online enabled	Total no. prescriptions ordered via online pt transaction service (Jan 22)	Category Full / Partial / No	No. of extended access days	Directed Enhanced Services (Extended Access payment)
		Efficiency				Patient Experience				Finance	Patients Online						Extended Access		
1	F83003	96.9%	4.8%	7,537	5.5%	no data	94%	93%	91%	£163	✓	79%	0	✓	79%	440	FULL	7	✓
2	F83005	95.6%	6.8%	9,826	29.5%	*	87%	98%	79%	£142	✓	36%	170	✓	36%	164	FULL	7	
3	F83006	92.7%	4.1%	7,518	-0.8%	no data	81%	75%	90%	£149	✓	35%	88	✓	32%	444	FULL	7	✓
4	F83011	94.4%	4.7%	7,100	5.3%	NA	84%	70%	84%	£152	✓	52%	0	✓	52%	365	FULL	7	✓
5	F83017	96.6%	4.9%	17,928	1.6%	96%	89%	90%	86%	£166	✓	51%	45	✓	51%	645	FULL	7	✓
6	F83018	95.1%	6.6%	8,815	-2.0%	no data	77%	62%	68%	£182	✓	45%	0	✓	45%	232	FULL	7	✓
7	F83019	97.6%	4.7%	12,659	5.5%	88%	82%	60%	77%	£165	✓	51%	0	✓	51%	398	PARTIAL	1	✓
8	F83020	99.6%	11.7%	11,982	1.1%	*	94%	91%	92%	£149	✓	65%	42	✓	65%	376	FULL	7	✓
9	F83022	95.1%	5.3%	16,877	5.5%	no data	90%	81%	82%	£147	✓	43%	121	✓	43%	747	PARTIAL	2	✓
10	F83023	94.9%	5.7%	22,062	0.7%	100%	90%	70%	95%	£184	✓	0%	0	✓	41%	858	FULL	7	✓
11	F83025	90.5%	3.5%	6,220	3.0%	no data	84%	83%	74%	£165	✓	33%	71	✓	32%	328	FULL	7	
12	F83042	98.2%	14.0%	7,451	5.4%	86%	92%	83%	91%	£150	✓	40%	120	✓	40%	90	FULL	7	✓
13	F83043	99.5%	13.4%	20,574	16.2%	76%	81%	100%	100%	£158	✓	62%	75	✓	62%	75	FULL	7	
14	F83044	94.0%	5.8%	5,756	36.1%	100%	86%	90%	89%	£217	✓	0%	0	✓	59%	117	PARTIAL	6	✓
15	F83048	98.9%	8.9%	8,303	18.4%	87%	77%	73%	72%	£178	✓	49%	0	✓	49%	145	FULL	7	
16	F83050	96.9%	14.6%	3,070	4.9%	*	84%	85%	80%	£146	✓	39%	9	✓	39%	85	FULL	7	
17	F83052	98.6%	6.6%	3,655	1.4%	no data	83%	84%	79%	£152	✓	45%	31	✓	45%	123	FULL	7	✓
18	F83055	98.2%	6.9%	20,685	12.8%	100%	86%	68%	80%	£146	✓	91%	115	✓	88%	659	FULL	7	✓
19	F83057	96.7%	4.0%	7,973	5.4%	no data	92%	78%	83%	£160	✓	63%	0	✓	63%	301	FULL	7	✓
20	F83058	95.9%	4.1%	12,359	3.8%	89%	77%	87%	72%	£163	✓	33%	154	✓	33%	197	FULL	7	✓
21	F83059	96.3%	10.2%	20,993	7.1%	no data	84%	79%	84%	£165	✓	51%	0	✓	49%	568	FULL	7	✓
22	F83061	97.8%	4.8%	5,262	2.4%	*	98%	99%	98%	£157	✓	50%	177	✓	50%	95	FULL	7	✓
23	F83615	91.7%	4.3%	7,953	0.7%	*	88%	79%	72%	£138	✓	45%	0	✓	45%	250	FULL	7	✓
24	F83623	96.6%	4.7%	13,457	2.6%	no data	89%	73%	89%	£173	✓	59%	39	✓	59%	640	FULL	7	✓
25	F83632	94.9%	7.1%	6,587	-3.7%	83%	78%	59%	86%	£142	✓	0%	0	✓	26%	218	FULL	7	✓
26	F83633	96.3%	11.5%	4,876	21.3%	*	86%	91%	89%	£196	✓	53%	102	✓	53%	120	FULL	7	
27	F83635	100.0%	16.4%	9,936	34.7%	78%	69%	74%	67%	£152	✓	47%	23	✓	47%	196	FULL	7	
28	F83658	96.4%	4.8%	4,965	12.0%	no data	85%	88%	81%	£144	✓	43%	70	✓	43%	108	FULL	7	✓
29	F83665	97.1%	4.5%	16,043	7.9%	*	93%	91%	90%	£160	✓	62%	0	✓	62%	299	FULL	7	✓
30	F83672	96.7%	5.5%	14,408	15.9%	no data	71%	96%	96%	£134	✓	54%	0	✓	54%	254	PARTIAL	6	
31	F83683	100.0%	8.7%	7,481	40.6%	83%	79%	68%	81%	£182	✓	30%	0	✓	30%	114	FULL	7	
32	Y02674	82.1%	9.1%	600	10.1%	no data	~	~	~	£1,081	✓	5%	0	✓	5%	4	*no data*	-	
33	Y03103	34.9%	11.0%	190	15.9%	no data	~	~	~	£1,194		0%	0		0%	0	NO	0	

Comments:
F83677 The Matthewman Practice now merged with F83632 Queens Crescent Practice as of 01 May 2020.
F83682 Rosslyn Hill Surgery now merged with F83017 Hampstead Group Practice as 01 July 2020.

Enfield Directorate
APRIL 2022

#	Practice Code	Practice Name	Practice: Co-commissioning model	Practice: Contract Type	Practice: Dispensing Practice	Practice Demographics: Practice Linked IMD 2019 (National Quintiles)	Practice Demographics: % Patients Aged 75+	Practice Demographics: % Patients Non-BME	Quality: CQC Rating - Overall	Quality: CQC - Safe	Quality: CQC - Effective	Quality: CQC - Caring	Quality: CQC - Responsive	Quality: CQC - Well led	Quality: Written complaints (Total) 2020/21	Quality: Written complaints (via NHSE) 2020/21	Workforce: Practice Size (Based on FTE GPs)	Workforce: % GPs aged 55 years and over	Workforce: % Locum GPs	Workforce: % Nurses aged 55 years and over	Workforce: Number of patients per FTE GP	Workforce: Number of patients per FTE Nurse	Efficiency: QOF Achievement 20/21	Efficiency: QOF Personalised Care Adjustment Rate 20/21	Efficiency: List size - March 22	Efficiency: Annual List Size Change March 21 - March 22	Patient Experience: FFT: % likely to recommend GP service to friends & family (Feb 2020) (* = nos <6; no data = zero return)	Patient Experience: GPPS - Good overall experience of GP practice	Patient Experience: GPPS – Easy to get through by phone (~ = nos <10; * = < 0.5%)	Patient Experience: GPPS - Satisfied with the type of appointment offered (~ = nos <10; * = < 0.5%)	Finance: Average payment per weighted patient 20/21	Patients Online: Online Appointments Enabled	Patients Online: % Of Reg Pop with online appointment enabled	Patients Online: Total no. pt transactions using online appointments service (Jan 22)	Patients Online: Order Repeat Prescriptions Online Enabled	Patients Online: % Of Reg Pop with order repeat prescriptions online enabled	Patients Online: Total no. prescriptions ordered via online pt transaction service (Jan 22)	Extended Access: Category Full / Partial / No	Extended Access: No. of extended access days	Extended Access: Directed Enhanced Services (Extended Access payment)
1	F85002	Forest Rd Group Practice	Del	PMS	✗	1 - Most deprived	5.1%	44%	●	●	●	●	●	●	0	0	Large	21%	0%	23%	2,123	7,845	96.6%	5.1%	91,818	1.3%	83%	72%	55%	71%	£153	✓	28%	0	✓	28%	2004	FULL	7	✓
2	F85003	Riley House Surgery	Del	PMS	✗	1 - Most deprived	6.5%	60%	●	●	●	●	●	●	0	0	Medium-large	55%	#N/A	27%	#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	no data	73%	38%	55%	£112							PARTIAL	1	✓
3	F85004	Eagle House Surgery	Del	PMS	✗	1 - Most deprived	6.0%	53%	● (amber)	●	● (amber)	●	● (amber)	●	48	1	Medium-large	29%	0%	100%	2,201	3,611	97.9%	6.4%	13,014	-1.1%	79%	67%	33%	73%	£148	✓	36%	0	✓	36%	493	PARTIAL	4	✓
4	F85010	Keats Surgery	Del	GMS	✗	2	6.7%	52%	●	●	●	●	●	●	8	2	Small-medium	100%	0%	100%	2,584	3,863	92.1%	6.4%	5,069	-0.7%	93%	71%	74%	77%	£125	✓	30%	0	✓	30%	123	PARTIAL	6	✓
5	F85016	Cockfosters Medical Centre	Del	GMS	✗	5 - Least Deprived	10.8%	76%	●	●	●	●	●	●	10	0	Medium-large	67%	0%	100%	1,800	11,028	94.3%	2.8%	6,890	2.4%	no data	80%	70%	82%	£132	✓	38%	0	✓	38%	156	FULL	7	✓
6	F85020	The Woodberry Practice	Del	PMS	✗	4	7.7%	74%	●	●	●	●	●	●	33	1	Medium-large	3%	0%	50%	3,832	13,743	95.8%	5.7%	9,178	1.5%	no data	86%	74%	88%	£148	✓	44%	0	✓	45%	390	FULL	7	✓
7	F85023	The Ordnance Unity Centre For Health	Del	APMS	✗	1 - Most deprived	2.8%	57%	●	●	●	●	●	●	10	0	Small-medium	0%	0%	0%	2,297	8,388	97.2%	9.3%	11,810	7.8%	98%	74%	59%	63%	£160	✓	30%	303	✓	29%	255	*no data*	-	
8	F85024	Dean House Surgery	Del	PMS	✗	2	5.8%	51%	●	●	●	●	●	●	0	0	Single-handed	100%	#N/A		#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	no data	82%	84%	83%	£117							NO	0	✓
9	F85025	White Lodge Medical Practice	Del	PMS	✗	4	8.4%	78%	●	●	●	●	●	●	15	1	Large	18%	0%	13%	1,319	8,639	98.3%	4.1%	12,027	6.2%	90%	92%	76%	85%	£152	✓	51%	0	✓	50%	925	FULL	7	✓
10	F85027	Carlton House Surgery	Del	GMS	✗	3	8.5%	80%	●	●	●	●	●	●	0	0	Large	11%	#N/A	0%	#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	no data	86%	45%	75%	£107							PARTIAL	4	✓
11	F85029	Abernethy House Surgery	Del	PMS	✗	4	10.1%	79%	●	●	●	●	●	●	16	1	Large	27%	0%	51%	975	5,609	99.2%	4.3%	12,689	-2.0%	94%	91%	80%	88%	£142	✓	47%	46	✓	48%	1072	FULL	7	✓
12	F85032	Southgate Surgery	Del	PMS	✗	4	7.6%	69%	●	●	●	●	●	●	23	0	Large	44%	0%	0%	2,187	13,278	90.2%	4.0%	10,080	0.7%	87%	77%	57%	75%	£135	✓	38%	107	✓	38%	463	*no data*	-	✓
13	F85033	Winchmore Hill Practice	Del	PMS	✗	5 - Least Deprived	9.2%	76%	● (amber)	● (amber)	●	●	●	● (amber)	1	1	Large	0%	0%	58%	1,617	12,710	91.8%	0.0%	21,819	29.9%	79%	78%	62%	76%	£155	✓	55%	302	✓	54%	1219	FULL	7	✓
14	F85035	Highlands Practice	Del	GMS	✗	5 - Least Deprived	9.4%	73%	●	●	●	●	●	●	61	1	Large		0%		1,138	7,647	82.8%	3.9%	11,218	1.2%	no data	81%	46%	84%	£140	✓	33%	52	✓	33%	495	PARTIAL	5	
15	F85036	Willow House Surgery	Del	GMS	✗	3	6.0%	74%	●	●	●	●	●	●	0	0	Small-medium	38%	#N/A	0%	#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	100%	95%	94%	91%	£100							FULL	7	✓
16	F85039	Rainbow Practice	Del	PMS	✗	1 - Most deprived	4.1%	43%	●	●	●	●	●	●	1	1	Small-medium	29%	29%	0%	3,737	9,024	91.2%	7.1%	6,423	7.7%	82%	82%	64%	80%	£132	✓	30%	105	✓	30%	157	PARTIAL	6	✓
17	F85043	Boundary Court Surgery	Del	APMS	✗	1 - Most deprived	3.4%	42%	●	●	●	●	●	●	2	0	Small-medium	0%	0%	0%	2,224	7,127	94.7%	4.6%	3,684	-8.1%	no data	88%	70%	75%	£157	✓	28%	178	✓	28%	74	FULL	7	✓
18	F85044	The Bounces Road Surgery	Del	GMS	✗	1 - Most deprived	4.4%	44%	●	●	●	●	●	●	2	0	Medium-large	0%	0%	0%	1,449	5,479	95.5%	4.8%	5,981	4.4%	100%	76%	72%	80%	£142	✓	28%	2	✓	28%	78	FULL	7	✓
19	F85048	Moorfield Road Health Centre	Del	GMS	✗	1 - Most deprived	4.7%	59%	●	●	●	●	●	●	0	0	Small-medium	70%	#N/A	0%	#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	no data	79%	62%	79%	£91							PARTIAL	2	✓
20	F85055	Connaught Surgery	Del	GMS	✗	3	8.8%	63%	●	●	●	●	●	●	0	0	Small-medium	0%	#N/A	0%	#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	no data	70%	82%	83%	£98							PARTIAL	6	✓
21	F85058	Nightingale House Surgery	Del	PMS	✗	2	5.7%	49%	●	●	●	●	●	●	16	0	Small-medium	20%	0%	100%	2,656	4,434	97.8%	8.5%	6,810	1.4%	83%	86%	82%	79%	£151	✓	28%	32	✓	27%	128	PARTIAL	4	✓
22	F85072	Grovelands Medical Centre	Del	PMS	✗	3	7.3%	64%	●	●	●	●	●	●	2	0	Small-medium	40%	41%	100%	3,328	6,469	91.8%	1.0%	10,662	-0.8%	no data	74%	67%	67%	£136	✓	31%	89	✓	31%	237	FULL	7	✓
23	F85076	Freezywater Primary Care Centre	Del	PMS	✗	2	5.7%	62%	●	●	●	●	●	●	3	3	Medium-large	16%	#N/A	58%	#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	80%	41%	12%	51%	£105							PARTIAL	2	✓
24	F85625	Bincote Surgery	Del	PMS	✗	4	8.2%	77%	●	●	●	●	●	●	5	0	Medium-large	69%	11%	0%	2,048	9,532	92.0%	3.4%	6,598	1.0%	93%	88%	68%	82%	£133	✓	51%	0	✓	50%	443	PARTIAL	2	✓
25	F85634	East Enfield Practice	Del	PMS	✗	1 - Most deprived	2.3%	51%	●	●	●	●	●	●	0	0	Small-medium	0%	0%	100%	5,174	14,747	99.3%	7.3%	7,857	137.5%	no data	77%	65%	76%	£146	✓	27%	0	✓	27%	174	PARTIAL	1	✓
26	F85642	The North London Health Centre	Del	GMS	✗	4	7.0%	67%	●	●	●	●	●	●	0	0	Medium-large	0%	0%	35%	1,917	7,918	89.4%	3.1%	8,834	-0.1%	90%	77%	55%	81%	£127	✓	41%	0	✓	41%	465	*no data*	-	✓
27	F85650	Morecambe Surgery	Del	GMS	✗	2	6.3%	51%	●	●	●	●	●	●	14	2	Small-medium		0%	100%	2,722	5,940	98.6%	6.0%	5,225	1.2%	96%	67%	59%	67%	£134	✓	34%	0	✓	34%	224	FULL	7	✓
28	F85652	Southbury Surgery	Del	PMS	✗	3	5.5%	73%	●	●	●	●	●	●	0	0	Small-medium	100%	#N/A	100%	#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	no data	74%	69%	89%	£117							FULL	7	✓
29	F85656	Bush Hill Park Med Centre	Del	GMS	✗	3	6.3%	68%	●	●	●	●	●	●	0	0	Small-medium	50%	#N/A		#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	no data	78%	81%	87%	£112							FULL	7	✓
30	F85663	Latymer Road Surgery	Del	GMS	✗	2	7.3%	47%	●	●	●	●	●	●	20	0	Small-medium	34%	0%	0%	14,272	0	96.8%	6.9%	4,557	1.2%	no data	65%	56%	72%	£132	✓	31%	0	✓	31%	212	FULL	7	
31	F85666	Edmonton Medical Centre	Del	PMS	✗	1 - Most deprived	5.6%	43%	●	●	●	●	●	●	7	0	Small-medium	0%	0%	100%	1,638	5,869	92.9%	3.7%	3,789	1.7%	93%	83%	67%	79%	£147	✓	28%	11	✓	28%	65	FULL	7	
32	F85676	Boundary House Surgery	Del	PMS	✗	1 - Most deprived	4.7%	46%	●	●	●	●	●	●	4	0	Small-medium	19%	18%	100%	4,118	3,669	97.6%	6.0%	5,358	2.1%	91%	74%	62%	75%	£161	✓	29%	0	✓	29%	76	PARTIAL	2	✓
33	F85678	Town Surgery	Del	PMS	✗	3	3.1%	71%	●	●	●	●	●	●	2	0	Small-medium	31%	0%	100%	1,758	56,538	96.7%	8.4%	4,480	1.5%	no data	81%	87%	76%	£143	✓	37%	0	✓	37%	148	FULL	7	✓
34	F85681	Green Street Surgery	Del	PMS	✗	1 - Most deprived	6.1%	57%	●	●	●	●	●	●	0	0	Single-handed	100%	#N/A	100%	#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	50%	85%	57%	77%	£118							PARTIAL	1	✓
35	F85682	Chalfont Road Surgery	Del	APMS	✗	1 - Most deprived	3.6%	46%	●	●	●	●	●	●	4	0	Small-medium	0%	59%	100%	2,108	7,859	93.6%	3.6%	3,943	-10.4%	no data	76%	48%	67%	£234	✓	31%	164	✓	31%	95	FULL	7	
36	F85684	Curzon Avenue Surgery	Del	GMS	✗	1 - Most deprived	3.9%	50%	●	●	●	●	●	●	0	0	Medium-large	40%	#N/A	0%	#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	no data	85%	39%	89%	£95							PARTIAL	3	✓
37	F85686	Trinity Avenue Surgery	Del	PMS	✗	3	6.7%	66%	●	●	●	●	●	●	0	0	Small-medium	0%	#N/A		#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	71%	68%	55%	68%	£116							PARTIAL	4	✓
38	F85687	Oakwood Medical Centre	Del	PMS	✗	4	7.3%	71%	●	●	●	●	●	●	10	1	Medium-large	19%	0%	0%	1,783	8,095	97.9%	5.6%	7,922	3.7%	83%	75%	61%	66%	£148	✓	36%	0	✓	36%	279	FULL	7	✓
39	F85700	Arnos Grove Medical Centre	Del	PMS	✗	3	3.9%	61%	●	●	●	●	●	●	2	0	Small-medium	43%	62%	100%	3,290	12,712	96.1%	16.2%	7,518	10.0%	no data	58%	47%	67%	£130	✓	0%	0	✓	36%	173	FULL	7	✓
40	F85701	Gillan House Surgery	Del	GMS	✗	3	4.9%	66%	●	●	●	●	●	●	7	1	Medium-large	41%	0%	100%	2,314	12,330	96.1%	4.2%	12,214	6.4%	84%	83%	70%	82%	£137	✓	37%	0	✓	37%	390	FULL	7	✓
41	F85703	Lincoln Road Med Practice	Del	PMS	✗	2	3.2%	61%	●	●	●	●	●	●	0	0	Medium-large	23%	#N/A	100%	#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	88%	57%	41%	76%	£107							PARTIAL	2	✓
42	F85707	Enfield Island Surgery	Del	PMS	✗	2	1.7%	49%	●	●	●	●	●	●	0	0	Small-medium	50%	#N/A	100%	#N/A	#N/A	#VALUE!	#N/A	#N/A	#N/A	no data	60%	68%	71%	£113							FULL	7	✓
43	Y00057	Angel Surgery	Del	PMS	✗	1 - Most deprived	3.3%	42%	●	●	●	●	●	●	15	3	Medium-large	57%	0%	100%	3,831	4,873	95.5%	5.5%	13,451	7.9%	80%	67%	60%	69%	£125	✓	23%	14	✓	23%	134	FULL	7	✓
44	Y00612	Green Cedars Medical Centre	Del	GMS	✗	1 - Most deprived	3.3%	44%	●	●	●	●	●	●	4	0	Small-medium	16%	22%	100%	2,541	8,437	95.3%	8.4%	5,572	-8.4%	71%	76%	69%	76%	£128	✓	0%	0	✓	21%	35	FULL	7	
45	Y03402	Evergreen Primary Care Centre	Del	PMS	✗	1 - Most deprived	3.1%	42%	●	●	●	●	●	●	17	3	Large	9%	0%	58%	2,377	6,658	95.0%	6.7%	19,986	2.3%	no data	72%	46%	72%	£139	✓	45%	1247	✓	45%	457	FULL	7	✓

Comments:

No.43 - List size reflects merger with Dover House (F85015) in October 2018

Figures for 'Patient Online' section relating to MHP practices all recorded under F85002 Forest Road Group Practice.

PLEASE NOTE - As of 01.01.21, all MHP practices merged under F85002 Medicus Health Partners. As some data reflects the pre-merger structure, MHP practices will remain split on the dashboard until data is able to be presented accurately under F85002.

01.05.21 F85053 Park Lodge Medical Centre merged with F85033 Winchmore Hill Practice.

01.07.21 F85654 Brick Lane Surgery merged with F85634 East Enfield Medical Practice.

Haringey Directorate APRIL 2022

	Practice Code	Practice Name	Practice: Co-commissioning model	Practice: Contract Type	Practice: Dispensing Practice	Practice Demographics: Practice Linked IMD 2019 (National Quintiles)	Practice Demographics: % Patients Aged 75+	Practice Demographics: % Patients Non-BME	Quality: CQC Rating - Overall	Quality: CQC - Safe	Quality: CQC - Effective	Quality: CQC - Caring	Quality: CQC - Responsive	Quality: CQC - Well led	Quality: Written complaints (Total) 2020/21	Quality: Written complaints (via NHSE) 2020/21
1	F85007	Lawrence House Surgery	Del	PMS	✗	1 - Most deprived	3.4%	49%	Green	Green	Green	Green	Green	Green	11	0
2	F85008	Staunton Group Practice	Del	GMS	✗	2	4.1%	57%	Red	Red	Red	Red	Red	Red	42	1
3	F85013	Tynemouth Medical Practice	Del	PMS	✗	1 - Most deprived	3.7%	44%	Amber	Green	Green	Amber	Amber	Green	8	1
4	F85014	Highgate Group Practice	Del	PMS	✗	4	7.4%	81%	Green	Green	Green	Green	Green	Green	5	0
5	F85017	Charlton House Medical Centre	Del	GMS	✗	1 - Most deprived	4.5%	43%	Red	Red	Red	Amber	Red	Red	2	2
6	F85019	Morris House Group Practice	Del	GMS	✗	1 - Most deprived	4.1%	47%	Green	Green	Green	Green	Green	Green	30	1
7	F85028	Bruce Grove Primary Health Care Ctr	Del	GMS	✗	1 - Most deprived	4.8%		Green	Green	Green	Green	Green	Green	1	1
8	F85030	Somerset Gardens Family Health Centre	Del	PMS	✗	1 - Most deprived	5.0%	42%	Green	Green	Green	Green	Green	Green	1	1
9	F85031	Westbury Medical Centre	Del	PMS	✗	2	4.1%	54%	Green	Green	Green	Green	Green	Flag	21	5
10	F85034	Arcadian Gardens Surgery	Del	GMS	✗	2	5.2%	60%	Green	Green	Green	Green	Green	Green	6	0
11	F85046	Hornsey Park Surgery	Del	GMS	✗	2	2.9%	59%	Green	Green	Green	Green	Green	Green	1	1
12	F85052	Spur Road Surgery	Del	GMS	✗	2	6.4%	50%	Green	Green	Green	Green	Green	Green	3	3
13	F85060	Havergal Surgery	Del	PMS	✗	2	5.0%	58%	Green	Green	Green	Green	Green	Green	7	0
14	F85061	Christchurch Hall Surgery	Del	GMS	✗	3	4.6%	73%	Green	Green	Green	Green	Green	Green	2	0
15	F85063	The Muswell Hill Practice	Del	PMS	✗	5 - Least Deprived	5.5%	82%	Green	Green	Green	Green	Green	Green	13	1
16	F85064	Stuart Crescent Health Centre	Del	PMS	✗	2	5.1%	57%	Green	Green	Green	Green	Green	Green	3	1
17	F85065	Stuart Crescent Medical Practice	Del	GMS	✗	2	5.2%	56%	Amber	Green	Amber	Amber	Green	Green	5	1
18	F85066	Bounds Green Group Practice	Del	PMS	✗	3	4.4%	65%	Green	Green	Green	Green	Green	Green	41	1
19	F85067	The 157 Medical Practice	Del	PMS	✗	2	6.5%	65%	Green	Green	Green	Green	Green	Flag	4	0
20	F85069	Crouch Hall Road Surgery	Del	PMS	✗	4	4.4%	77%	Green	Green	Green	Green	Green	Green	7	0
21	F85071	Fernlea Surgery	Del	PMS	✗	2	3.0%	57%	Green	Green	Green	Green	Green	Green	38	0
22	F85615	Tottenham Health Centre	Del	PMS	✗	1 - Most deprived	3.4%	43%	Green	Green	Green	Green	Green	Green	2	0
23	F85623	Grove Road Surgery	Del	PMS	✗	1 - Most deprived	3.3%	48%	Red	Red	Amber	Green	Amber	Red	5	0
24	F85628	Dowsett Road Surgery	Del	GMS	✗	1 - Most deprived	4.3%	44%	Green	Green	Green	Green	Green	Green	5	0
25	F85640	Cheshire Road Surgery	Del	PMS	✗	2	4.4%	61%	Green	Green	Green	Green	Green	Green	0	0
26	F85669	West Green Road Surgery	Del	GMS	✗	2	1.1%	54%	Flag	Green	Green	Green	Flag	Flag	17	4
27	F85675	The Alexandra Surgery	Del	PMS	✗	3	6.8%	70%	Green	Amber	Green	Green	Green	Green	2	2
28	F85688	Rutland House Surgery	Del	PMS	✗	4	4.5%	74%	Green	Green	Green	Green	Green	Green	4	0
29	F85697	The Old Surgery	Del	GMS	✗	2	6.9%	61%	Green	Green	Green	Green	Green	Green	5	0
30	F85705	JS Medical Practice	Del	PMS	✗	1 - Most deprived	3.4%	49%	Green	Green	Green	Green	Green	Green	3	0
31	Y01655	The Vale Practice	Del	GMS	✗	3	1.6%	74%	Green	Green	Green	Green	Green	Green	4	0
32	Y02117	The Laurels Medical Practice	Del	APMS	✗	2	3.3%	50%	Green	Green	Green	Green	Green	Green	1	1
33	Y03035	Queenswood Medical Practice	Del	GMS	✗	3	4.4%	75%	Green	Green	Green	Green	Green	Green	50	1
34	Y03135	Bridge House Medical Practice	Del	PMS	✗	2	4.1%	64%	Green	Green	Green	Green	Green	Green	17	0
35	Y05330	Tottenham Hale Medical Practice	Del	APMS	✗	2	0.5%	0%	Green	Green	Green	Green	Green	Green	5	0

	Practice Code	Workforce: Practice Size (Based on FTE GPs)	Workforce: % GPs aged 55 years and over	Workforce: % Locum GPs	Workforce: % Nurses aged 55 years and over	Workforce: Number of patients per FTE GP	Workforce: Number of patients per FTE Nurse	Efficiency: QOF Achievement 20/21	Efficiency: QOF Personalised Care Adjustment Rate 20/21	Efficiency: List size - March 22	Efficiency: Annual List Size Change March 21 - March 22	Patient Experience: FFT: % likely to recommend GP service to friends & family (Feb 2020) (* = nos <6; no data = zero return)	Patient Experience: GPPS - Good overall experience of GP practice	Patient Experience: GPPS – Easy to get through by phone (~ = nos <10; * = < 0.5%)	Patient Experience: GPPS - Satisfied with the type of appointment offered (~ = nos <10; * = < 0.5%)	Finance: Average payment per weighted patient 20/21
1	F85007	Large	25%	0%	82%	1,275	5,630	97.1%	5.8%	15,475	-3.2%	82%	81%	69%	84%	£149
2	F85008	Medium-large	39%	0%	27%	20,369	8,216	92.5%	6.1%	13,031	-1.5%	70%	75%	57%	77%	*no data*
3	F85013	Medium-large	8%	0%	26%	1,373	2,647	91.8%	8.0%	9,053	-0.3%	75%	72%	45%	75%	£148
4	F85014	Large	0%	0%	0%	1,913	6,741	93.5%	5.5%	16,612	2.1%	78%	94%	77%	87%	£137
5	F85017	Small-medium	50%	0%	76%	3,831	7,785	87.6%	4.3%	6,403	-7.6%	no data	74%	57%	76%	£120
6	F85019	Large	15%	0%	0%	2,302	8,554	95.2%	5.4%	13,747	4.4%	78%	77%	41%	74%	£152
7	F85028	Small-medium	65%	0%	100%	2,626	14,179	96.2%	8.2%	7,560	-2.3%	no data	73%	71%	81%	£140
8	F85030	Medium-large		0%	42%	2,381	33,345	94.8%	9.8%	13,364	1.9%	no data	70%	40%	81%	£141
9	F85031	Small-medium	0%	0%	100%	3,637	17,711	97.6%	7.8%	10,835	-0.7%	92%	88%	76%	81%	£150
10	F85034	Small-medium	7%	0%	100%	2,961	4,019	95.9%	7.2%	6,053	15.8%	no data	79%	79%	65%	£135
11	F85046	Small-medium	100%	100%	0%	9,354	18,708	93.6%	8.8%	8,107	42.4%	no data	79%	95%	81%	£124
12	F85052	Small-medium	87%	0%	100%	1,121	13,263	99.7%	11.7%	2,129	5.6%	77%	76%	93%	79%	£140
13	F85060	Small-medium	10%	24%	90%	2,130	5,194	95.8%	7.0%	5,667	-5.6%	no data	81%	63%	72%	£146
14	F85061	Small-medium	92%	33%	0%	1,645	7,423	93.0%	5.9%	3,158	-5.6%	98%	78%	89%	75%	£132
15	F85063	Large	21%	0%	0%	1,274	6,648	87.4%	4.1%	14,623	0.5%	no data	87%	74%	85%	£136
16	F85064	Small-medium	0%	0%		1,655	7,172	97.3%	7.5%	6,914	10.6%	100%	87%	70%	85%	£131
17	F85065	Small-medium	50%	0%	0%	1,290	4,300	97.6%	9.0%	3,103	-2.0%	84%	59%	63%	68%	£135
18	F85066	Large	12%	2%	37%	1,101	49,848	95.6%	5.4%	18,565	1.3%	96%	86%	58%	87%	£136
19	F85067	Small-medium	60%	22%	100%	3,878	5,816	62.2%	11.7%	4,670	3.5%	no data	72%	65%	65%	£132
20	F85069	Medium-large	73%	0%	54%	3,168	5,645	99.6%	4.1%	8,250	-1.8%	94%	88%	90%	91%	£144
21	F85071	Medium-large	32%	0%	100%	1,583	5,836	96.2%	7.1%	11,060	4.1%	81%	80%	66%	78%	£138
22	F85615	Small-medium	98%	15%	0%	2,111	10,451	95.3%	7.7%	5,568	1.3%	no data	67%	66%	71%	£150
23	F85623	Small-medium	44%	0%	100%	1,343	21,394	96.6%	13.2%	4,552	-1.7%	100%	84%	77%	77%	£139
24	F85628	Medium-large	0%	0%	100%	2,136	4,034	98.0%	7.0%	4,863	1.2%	82%	84%	78%	81%	£133
25	F85640	Small-medium	0%	0%	0%	2,168	7,914	93.8%	5.3%	6,332	-2.6%	no data	84%	63%	65%	£139
26	F85669	Large	19%	6%	100%	2,722	0	94.2%	7.7%	19,251	6.6%	99%	83%	90%	74%	£123
27	F85675	Small-medium	58%	39%		2,162	8,578	94.1%	5.9%	5,689	2.0%	95%	78%	68%	77%	£143
28	F85688	Medium-large	24%	0%	100%	2,746	10,030	97.7%	5.0%	11,239	60.1%	no data	92%	88%	84%	£143
29	F85697	Small-medium	43%	0%	100%	1,603	9,938	94.7%	10.9%	2,107	0.3%	no data	81%	91%	87%	£127
30	F85705	Small-medium	50%	0%	40%	3,091	8,758	98.8%	12.0%	12,613	1.0%	no data	80%	68%	76%	£142
31	Y01655	Large	55%	5%	66%	2,091	11,089	95.6%	3.8%	10,604	-2.8%	100%	83%	80%	85%	£156
32	Y02117	Small-medium	19%	0%	0%	6,969	10,682	100.0%	8.9%	16,220	7.9%	96%	71%	54%	70%	£155
33	Y03035	Large	6%	0%	0%	1,496	16,914	100.0%	7.3%	22,110	-1.0%	54%	92%	73%	83%	£152
34	Y03135	Small-medium	50%	0%	0%	2,213	9,768	92.4%	4.5%	9,767	-0.2%	no data	62%	43%	58%	£148
35	Y05330	Small-medium	40%	0%	100%	3,726	14,902	96.1%	8.7%	4,057	23.4%	89%	85%	92%	88%	£221

	Practice Code	Patients Online: Online Appointments Enabled	Patients Online: % Of Reg Pop with online appointment enabled	Patients Online: Total no. pt transactions using online appointments service (Jan 22)	Patients Online: Order Repeat Prescriptions Online Enabled	Patients Online: % Of Reg Pop with order repeat prescriptions online enabled	Patients Online: Total no. prescriptions ordered via online pt transaction service (Jan 22)	Extended Access: Category Full / Partial / No	Extended Access: No. of extended access days	Extended Access: Directed Enhanced Services (Extended Access payment)
1	F85007	✓	65%	0	✓	65%	477	FULL	7	✓
2	F85008	✓	0%	0	✓	27%	428	*no data*	-	✓
3	F85013							*no data*	-	✓
4	F85014	✓	89%	99	✓	89%	1136	FULL	7	✓
5	F85017	✓	41%	0	✓	40%	203	PARTIAL	1	✓
6	F85019	✓	52%	147	✓	52%	630	FULL	7	✓
7	F85028	✓	20%	0	✓	19%	83	*no data*	-	✓
8	F85030	✓	24%	12	✓	24%	374	FULL	7	✓
9	F85031	✓	47%	0	✓	46%	308	FULL	7	✓
10	F85034	✓	40%	1	✓	40%	234	FULL	7	✓
11	F85046	✓	32%	0	✓	32%	177	FULL	7	✓
12	F85052	✓	36%	0	✓	36%	43	FULL	7	
13	F85060	✓	45%	0	✓	42%	133	FULL	7	✓
14	F85061	✓	27%	19	✓	27%	25	FULL	7	✓
15	F85063	✓	67%	525	✓	67%	839	FULL	7	✓
16	F85064	✓	45%	111	✓	45%	154	FULL	7	✓
17	F85065	✓	32%	0	✓	32%	47	FULL	7	✓
18	F85066	✓	56%	327	✓	56%	1222	PARTIAL	6	✓
19	F85067	✓	0%	0	✓	27%	115	NO	0	✓
20	F85069	✓	104%	0	✓	104%	391	FULL	7	✓
21	F85071	✓	32%	27	✓	32%	132	FULL	7	✓
22	F85615	✓	33%	0	✓	32%	97	FULL	7	✓
23	F85623	✓	0%	0	✓	25%	69	FULL	7	✓
24	F85628	✓	0%	0	✓	34%	103	FULL	7	✓
25	F85640	✓	62%	95	✓	62%	152	FULL	7	✓
26	F85669	✓	26%	0	✓	26%	162	FULL	7	✓
27	F85675	✓	54%	0	✓	54%	355	*no data*	-	✓
28	F85688	✓	46%	108	✓	45%	655	FULL	7	✓
29	F85697	✓	19%	0	✓	19%	11	FULL	7	✓
30	F85705	✓	58%	45	✓	58%	347	FULL	7	✓
31	Y01655	✓	0%	0	✓	62%	342	FULL	7	✓
32	Y02117	✓	0%	0	✓	0%	0	FULL	7	✓
33	Y03035	✓	56%	116	✓	56%	844	FULL	7	✓
34	Y03135	✓	31%	168	✓	31%	257	FULL	7	✓
35	Y05330	✓	0%	0	✓	44%	114	FULL	7	

Comments:

01/05/21 F85045 Queens Avenue Practice merged with F85688 Rutland House Surgery

Islington Directorate APRIL 2022

	Practice Code	Practice Name	Practice: Co-commissioning model	Practice: Contract Type	Practice: Dispensing Practice	Practice Demographics: Practice Linked IMD 2019 (National Quintiles)	Practice Demographics: % Patients Aged 75+	Practice Demographics: % Patients Non-BME	Quality: CQC Rating - Overall	Quality: CQC - Safe	Quality: CQC - Effective	Quality: CQC - Caring	Quality: CQC - Responsive	Quality: CQC - Well led	Quality: Written complaints (Total) 2020/21	Quality: Written complaints (via NHSE) 2020/21	Workforce: Practice Size (Based on FTE GPs)	Workforce: % GPs aged 55 years and over	Workforce: % Locum GPs	Workforce: % Nurses aged 55 years and over	Workforce: Number of patients per FTE GP	Workforce: Number of patients per FTE Nurse
1	F83002	River Place Health Centre	Del	GMS	✗	2	3.9%	72%	🟢	🟢	🟢	🟢	🟢	🟢	2	0	Large	0%	5%	83%	1,262	7,008
2	F83004	Archway Medical Centre	Del	PMS	✗	2	2.9%	66%	🟢	🟢	🟢	🟢	🟢	🟢	17	0	Small-medium	44%	0%	73%	5,324	12,973
3	F83007	Roman Way Medical Centre	Del	GMS	✗	2	6.3%	66%	🟢	🟢	🟢	🟢	🟢	🟢	3	0	Small-medium	35%	36%	0%	1,744	8,718
4	F83008	The Goodinge Group Practice	Del	GMS	✗	2	4.1%	66%	🟢	🟢	🟢	🟢	🟢	🟢	16	2	Large	21%	0%	0%	1,782	16,674
5	F83010	Islington Central Medical Centre	Del	GMS	✗	3	3.3%	73%	🟢	🟢	🟢	🟢	🟢	🟢	5	0	Large	41%	0%	100%	3,819	24,823
6	F83012	Elizabeth Avenue Group Practice	Del	GMS	✗	2	5.5%	73%	🟢	🟢	🟢	🟢	🟢	🟢	14	1	Large	0%	0%	0%	1,463	7,395
7	F83015	St Johns Way Medical Centre	Del	GMS	✗	2	4.9%	67%	🟢	🟢	🟢	🟢	🟢	🟢	16	2	Large	22%	0%	27%	1,139	7,382
8	F83021	Ritchie Street Group Practice	Del	GMS	✗	2	3.1%	73%	🟢	🟢	🟢	🟢	🟢	🟢	33	0	Large	25%	0%	31%	1,890	9,131
9	F83027	Drs Bowry & Bowry's Practice	Del	GMS	✗	2	4.9%	66%	🟢	🟢	🟢	🟢	🟢	🟢	4	0	Small-medium	47%	0%		2,195	12,803
10	F83032	St Peter's Street Medical Practice	Del	GMS	✗	2	3.2%	74%	🟢	🟢	🟢	🟢	🟢	🟢	29	0	Large	49%	0%	0%	1,273	14,107
11	F83033	Dr Haffiz	Del	GMS	✗	2	6.5%	61%	🟠	🟢	🟠	🟢	🟠	🟠	0	0	Small-medium	0%	23%	100%	2,804	5,028
12	F83034	New North Health Centre	Del	GMS	✗	2	9.1%	70%	🟢	🟢	🟢	🟢	🟢	🟢	3	0	Single-handed	100%	0%		1,624	0
13	F83039	The Rise Group Practice	Del	GMS	✗	2	5.2%	64%	🟢	🟢	🟢	🟢	🟢	🟢	2	2	Small-medium	54%	0%	100%	1,858	5,149
14	F83045	The Miller Practice	Del	GMS	✗	3	4.1%	73%	🟢	🟢	🟢	🟢	🟢	🟢	0	0	Medium-large	33%	0%	100%	998	7,826
15	F83053	Mildmay Medical Practice	Del	GMS	✗	2	3.8%	65%	🟢	🟢	🟢	🟢	🟢	🟢	16	0	Medium-large	32%	9%	100%	1,447	6,178
16	F83056	The Mitchison Road Surgery	Del	APMS	✗	2	2.5%	67%	🟢	🟢	🟢	🟢	🟢	🟢	9	0	Small-medium	44%	0%	0%	3,173	10,206
17	F83060	The Northern Medical Centre	Del	GMS	✗	2	4.1%	67%	🟢	🟢	🟢	🟢	🟢	🟢	4	1	Medium-large	17%	0%	59%	1,998	6,740
18	F83063	Killick Street Health Centre	Del	GMS	✗	2	2.8%	62%	🟢	🟢	🟢	🟢	🟢	🟢	12	0	Large	20%	0%	21%	1,501	4,746
19	F83064	City Road Medical Centre	Del	GMS	✗	2	4.1%	64%	🟢	🟢	🟢	🟢	🟢	🟢	10	1	Medium-large	0%	0%		1,295	0
20	F83624	Clerkenwell Medical Practice	Del	GMS	✗	3	1.3%	68%	🟢	🟢	🟢	🟢	🟢	🟢	18	1	Large	13%	0%	7%	2,010	4,499
21	F83652	Amwell Group Practice	Del	GMS	✗	2	2.2%	69%	🟢	🟢	🟢	🟢	🟢	🟢	1	1	Large	0%	0%	52%	1,374	11,463
22	F83660	Highbury Grange Medical Practice	Del	GMS	✗	3	3.8%	72%	🟢	🟢	🟢	🟢	🟢	🟢	15	2	Medium-large	59%	0%	0%	2,989	5,487
23	F83664	The Village Practice	Del	GMS	✗	1 - Most deprived	1.8%	57%	🟢	🟢	🟢	🟢	🟢	🟢	7	0	Medium-large	0%	0%	0%	2,237	7,318
24	F83666	Andover Medical Centre	Del	GMS	✗	2	4.9%	58%	🟢	🟢	🟢	🟢	🟢	🟢	14	1	Medium-large	0%	0%	30%	1,840	4,781
25	F83671	The Beaumont Practice	Del	GMS	✗	2	3.3%	63%	🟠	🔴	🟠	🟢	🟢	🟠	7	0	Small-medium	80%	0%	100%	1,775	20,563
26	F83673	The Medical Centre	Del	PMS	✗	2	3.2%	65%	🟢	🟢	🟢	🟢	🟢	🟢	0	0	Small-medium	100%	0%	16%	2,232	6,088
27	F83674	The Junction Medical Practice	Del	GMS	✗	3	5.0%	71%	🟢	🟢	🟢	🟢	🟢	🟢	16	0	Medium-large	0%	47%	100%	2,559	5,141
28	F83678	The Pine Street Medical Practice	Del	GMS	✗	2	6.8%	67%	🟢	🟢	🟢	🟢	🟢	🟢	0	0	Small-medium	0%	0%	0%	1,468	4,698
29	F83680	Sobell Medical Centre	Del	GMS	✗	2	3.5%	63%	🟢	🟢	🟢	🟢	🟢	🟢	1	0	Small-medium	57%	13%	100%	3,466	15,945
30	F83681	Partnership Primary Care Centre	Del	GMS	✗	2	4.4%	68%	🟢	🟢	🟢	🟢	🟢	🟢	1	0	Small-medium	10%	0%	100%	2,663	4,111
31	F83686	Stroud Green Medical Centre	Del	GMS	✗	2	2.2%	67%	🟢	🟢	🟢	🟢	🟢	🟢	4	0	Single-handed	0%	0%	100%	7,044	8,501
32	Y01066	Hanley Primary Care Centre	Del	APMS	✗	2	2.1%	61%	🟢	🟢	🟢	🟢	🟢	🟢	2	2	Small-medium	0%	0%		4,685	0

	Practice Code	Efficiency: QOF Achievement 20/21	Efficiency: QOF Personalised Care Adjustment Rate 20/21	Efficiency: List size - March 22	Efficiency: Annual List Size Change March 21 - March 22	Patient Experience: FFT: % likely to recommend GP service to friends & family (Feb 2020) (* = nos <6; no data = zero return)	Patient Experience: GPPS - Good overall experience of GP practice	Patient Experience: GPPS – Easy to get through by phone (~ = nos <10; * = < 0.5%)	Patient Experience: GPPS - Satisfied with the type of appointment offered (~ = nos <10; * = < 0.5%)	Finance: Average payment per weighted patient 20/21	Patients Online: Online Appointments Enabled	Patients Online: % Of Reg Pop with online appointment enabled	Patients Online: Total no. pt transactions using online appointments service (Jan 22)	Patients Online: Order Repeat Prescriptions Online Enabled	Patients Online: % Of Reg Pop with order repeat prescriptions online enabled	Patients Online: Total no. prescriptions ordered via online pt transaction service (Jan 22)	Extended Access: Category Full / Partial / No	Extended Access: No. of extended access days	Extended Access: Directed Enhanced Services (Extended Access payment)
1	F83002	99.3%	9.7%	10,517	5.8%	92%	89%	83%	78%	£148	✓	42%	0	✓	40%	380	FULL	7	✓
2	F83004	94.8%	12.2%	18,057	23.3%	87%	78%	78%	72%	£126	✓	0%	0	✓	37%	175	FULL	7	✓
3	F83007	97.4%	4.5%	3,488	1.9%	no data	89%	82%	80%	£136	✓	33%	0	✓	33%	89	FULL	7	
4	F83008	95.6%	7.8%	12,471	6.7%	no data	88%	83%	89%	£140	✓	54%	0	✓	54%	584	FULL	7	✓
5	F83010	95.9%	5.9%	20,574	2.4%	no data	86%	56%	81%	£136	✓	73%	0	✓	73%	494	FULL	7	✓
6	F83012	98.5%	7.1%	7,455	-0.5%	100%	87%	72%	92%	£159	✓	57%	0	✓	57%	335	FULL	7	✓
7	F83015	97.3%	7.0%	12,082	-1.5%	80%	86%	79%	80%	£145	✓	0%	0	✓	43%	533	FULL	7	✓
8	F83021	95.5%	5.8%	18,213	-0.6%	no data	77%	60%	82%	£135	✓	53%	0	✓	52%	567	FULL	7	✓
9	F83027	96.4%	8.7%	#N/A	#N/A	no data	86%	59%	71%	£131	✓	26%	7	✓	26%	91	FULL	7	✓
10	F83032	98.4%	5.4%	12,041	0.8%	70%	82%	83%	88%	£136	✓	44%	2	✓	31%	328	FULL	7	✓
11	F83033	89.3%	9.6%	3,897	13.3%	no data	80%	71%	79%	£136	✓	24%	0	✓	24%	65	*no data*	-	
12	F83034	90.0%	13.4%	1,599	-0.9%	no data	88%	98%	92%	£168	✓	0%	0	✓	33%	22	FULL	7	✓
13	F83039	94.6%	4.6%	4,828	-1.6%	70%	80%	66%	69%	£150	✓	37%	0	✓	37%	159	FULL	7	✓
14	F83045	97.6%	4.6%	9,959	-2.8%	100%	90%	83%	87%	£139	✓	62%	2	✓	62%	585	FULL	7	✓
15	F83053	94.3%	5.6%	6,785	8.3%	90%	82%	81%	75%	£190	✓	43%	0	✓	43%	158	FULL	7	✓
16	F83056	100.0%	11.4%	8,241	21.2%	*	87%	86%	90%	£155	✓	0%	0	✓	50%	179	FULL	7	
17	F83060	99.5%	9.2%	9,151	0.9%	no data	83%	81%	76%	£141	✓	42%	0	✓	42%	157	FULL	7	✓
18	F83063	99.6%	11.2%	12,476	3.0%	97%	93%	84%	87%	£166	✓	37%	0	✓	37%	398	FULL	7	✓
19	F83064	90.5%	8.3%	9,416	18.1%	90%	84%	81%	92%	£158	✓	46%	0	✓	46%	204	FULL	7	✓
20	F83624	96.8%	9.2%	16,675	12.5%	95%	88%	95%	78%	£128	✓	54%	7	✓	53%	346	FULL	7	
21	F83652	98.1%	6.9%	10,731	5.9%	NA	88%	83%	87%	£178	✓	51%	98	✓	51%	354	FULL	7	✓
22	F83660	95.9%	5.9%	9,363	0.1%	no data	76%	69%	70%	£125	✓	36%	9	✓	36%	258	FULL	7	✓
23	F83664	94.0%	7.0%	10,480	9.8%	no data	81%	83%	80%	£154	✓	49%	0	✓	49%	316	FULL	7	✓
24	F83666	95.3%	10.3%	6,034	-1.6%	no data	80%	64%	76%	£146	✓	0%	0	✓	38%	188	FULL	7	✓
25	F83671	96.6%	9.2%	3,298	6.9%	no data	90%	89%	90%	£147	✓	41%	0	✓	43%	70	FULL	7	✓
26	F83673	99.5%	3.1%	5,856	3.8%	no data	86%	88%	96%	£145	✓	40%	0	✓	40%	172	FULL	7	✓
27	F83674	97.9%	6.4%	9,431	-1.9%	no data	79%	66%	69%	£161	✓	38%	97	✓	38%	401	FULL	7	✓
28	F83678	97.1%	10.5%	2,351	-2.0%	no data	85%	84%	78%	£136	✓	35%	28	✓	35%	44	*no data*	-	✓
29	F83680	90.1%	9.0%	4,231	-1.1%	87%	82%	81%	73%	£134	✓	34%	0	✓	34%	75	FULL	7	✓
30	F83681	98.6%	13.3%	9,207	129.5%	100%	76%	76%	65%	£165	✓	34%	63	✓	34%	132	FULL	7	
31	F83686	95.2%	4.6%	6,594	0.1%	88%	96%	98%	84%	£130	✓	50%	203	✓	50%	195	FULL	7	✓
32	Y01066	100.0%	11.8%	11,375	15.4%	96%	74%	82%	78%	£169	✓	46%	0	✓	46%	308	FULL	7	

Comments:

No. 27 - List size change reflects merger with Dr. Ko and partner (F83051) in October 2018.

General Practice Sustainability and Resilience
References

Purpose of document, and source data

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, such as the General Practice Indicators, along with data from CQC ratings, GPPS and practice demographics. In January 2016, £10m was allocated for a pilot programme to support practices in difficulty, and a further £40m was made available over four years (to 2020) under the General Practice Resilience Programme. Local teams were asked to identify those practices which are considered vulnerable* and those which would benefit from Resilience Programme support. These practices have been highlighted in the regional and DCO tables.

Area	Indicator	Detail	Brief Description	Source	Time period	Published
Summary	Total Practices	Main practices	Data for GPs and GP Surgeries is supplied by the NHS Prescription Service of the NHS Business Services Authority. Medical Practices classed as Active and with a GP Practice prescribing setting are included.	NHS Digital	Jan-19	✓ Feb-19
	Registered Population	Number of Patients Registered at a GP Practice	Data extracted as a quarterly snapshot in time from the GP Payments system maintained by NHS Digital.	NHS Digital	Feb-19	✓ Feb-19
Primary Care Co-Commissioning	Delegated commissioning Greater involvement Joint commissioning		Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning aims to support the development of integrated out-of-hospital services based around the needs of local people. It is part of a wider strategy to join up care in and out of hospital. **Delegated commissioning:** CCGs assume full responsibility for the commissioning of general practice services. **Greater involvement:** an invitation to CCGs to collaborate more closely with their local NHS England teams in decisions about primary care services. **Joint commissioning:** enables one or more CCGs to jointly commission general practice services with NHS England through a joint committee.	NHS England	Apr-18	✓ Apr-18
Practice Information & Demographics	Contract Type Dispensing Practice		Displays the contract type and if the practice is authorised to dispense drugs. Sourced from NHS Payments to General Practices in England for 2017/18 by individual General Practice	NHS Digital	2017-18	✓ Dec-18
	Deprivation	Practice patient level deprivation	Patient level IMD has been calculated from IMD 2015 data. For each practice, NHS Digital gives the number of registered patients in each LLSOA (based on their registered address). Kings College London then calculate a weighted mean based on the mean IMD-2015 scores for all patients (in turn, based on LLSOA residency) registered at the practice.	Kings College London, Department for Communities and Local Government	2015	✓ Sep-16
	% Aged 75+		Data extracted from the NHS Digital's GP Payments system.	NHS Digital	Feb-19	✓ Feb-19
	% Non-BME		Estimated proportion of non-BME ethnic groups in the practice population (weighted average over the contributing LSOAs).	English Indices of Deprivation, Department for Communities and Local Government	2015	✓ Jul-16
Quality	CQC Rating	Outstanding Good Requires improvement Inadequate No published rating	The CQC rates General Practices to give an overall judgement of the quality of care. There are four ratings that we give to health and social care services. The rating examines five key areas for the quality of care: Caring, Effective, Responsive, Safe, Well-led. When no rating is shown, no published rating is available.	CQC	Feb-19	✓ Feb-19
	Written Complaints (total for practice) Written Complaints (directed to NHS England)		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. This shows the counts of the number of written complaints made by (or on behalf of) patients, received between 1 April 2017 and 31 March 2018. Data are collected via two forms, the KO41a (NHS Hospital and Community Health Service (HCHS)) and KO41b (Family Health Service (GP including Dental) (FHS)). Please note this is experimental information.	NHS Digital	2017-18	✓ Sep-18
Workforce	Practice Size (Based on FTE GPs)	Single-handed (=<1 FTE GP) Small-medium (>1 and =<3) Medium-large (>3 and =<6) Large (>6 FTE GPs)	The primary data source for General and Personal Medical statistics is the workforce Minimum Data Set (wMDS) collected via the Primary Care Web Tool (PCWT) Workforce Census module and the workforce Minimum Data Set Collection Vehicle (wMDSCV). These statistics are labelled Experimental so care needs to be taken when interpreting the figures. Note that all indicators are based on Full Time Equivalent (FTE) staffing and not numbers of staff. The number of patients registered at the GP practice is also taken from the wMDS return.	NHS Digital	Mar-18	✓ Sep-18
	% FTE GPs aged 55 and over % FTE Locum GPs % FTE Nurses aged 55 and over Number of patients per FTE GP Number of patients per FTE Nurse					
Efficiency	QOF Achievement QOF Exception Rate		The QOF was introduced as part of the new General Medical Services (GMS) contract on 1 April 2004. The objective of the QOF is to improve the quality of care patients are given by rewarding practices for the quality of care they provide to their patients. Participation in QOF is voluntary, though participation rates are very high (94.8% in 17/18).	NHS Digital	2017-18	✓ Oct-18
	List size		Number of patients registered to the GP Practice. Data extracted as a monthly snapshot in time from the GP Payments system.	NHS Digital	Feb-19	✓ Feb-19
	List Size Change	+/- 5-10%	Available quarterly, the annual percentage change of list size of all practices in England.	NHS Digital	Jan-19	✓ Jan-19
Patient Experience	% likely to recommend the GP service to friends and family		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. This indicator presents the percentage of those 'Likely' or 'Extremely likely' to recommend their practice.	NHS England	Dec-18	✓ Feb-19
	Good overall experience of GP practice Easy to get through on the phone Satisfied with the type of appointment offered		The GP Patient Survey, an independent survey run by Ipsos MORI on behalf of NHS England, is sent to over a million people across the UK. The results (weighted) show how people feel about their GP practice. The survey was extensively redesigned for 2018. Due to this, and the inclusion of 16-17 year olds, comparisons cannot be made with previous years' results even where question wording remains similar. Note that two of the questions reported have changed in 2018: - Good overall experience of GP practice (% very or fairly good) - Ease of getting through by phone (% very or fairly easy) - Satisfied with the type of appointment offered (% yes)	NHS England	Jan - Mar 18	✓ Aug-18
Finance	Average payment per weighted patient		This figure is taken from the NHS Digital report 'NHS Payments to General Practice, England'. It represents the total payments figure divided by the number of weighted patients. Values are included only where a full year of data is available. The number of weighted patients is calculated by the Global Sum process. Global Sum Payments are a contribution towards the contractor's costs in delivering essential and additional services, including its staff costs. For more information, please visit NHS Digital's website.	NHS Digital	2017-18	✓ Dec-18
Patients Online	Online Appointments Enabled		GP practices provide functionality for patients to book/cancel appointments electronically	NHS Digital	Jan-19	✓ Feb-19
	% Of Reg Population with online appointment enabled		Number of patients enabled to electronically book or cancel an appointment divided by the practice list size			
	Total no. pt transactions using online appointments service		Total number of appointment scheduling or cancelling transactions using an Online Patient Transaction Service.			
	Order Repeat Prescriptions Online Enabled		GP practices provide functionality for patients to view/order repeat prescriptions electronically.			
	% Of Reg Population with order repeat prescriptions online enabled		Number of patients enabled to electronically view/order repeat prescriptions divided by the practice list size			
	Total no. prescriptions ordered via online pt transaction service		Total number of prescriptions ordered using an Online Patient Transaction Service. (Note that ordering several items at once to be counted as one prescription).			
Extended Access	Category Full/Partial/No extended access No. of extended access days		Bi-annual data collection monitors availability of pre-bookable appointments in practices at evenings and weekends. Launched in Oct 2016 in response to the government's mandate to NHS England "to ensure everyone has easier and more convenient access to GP services, including appointments at evenings and weekends", data are published as experimental statistics as they are new and undergoing evaluation.	NHS England	Sep-18	✓ Nov-18
	Directed Enhanced Services (Extended Access payment)		Whether or not a practice received a Directed Enhanced Services payment for Extended Hours Access in 2016/17	NHS Digital	2016-17	✓ Sep-17

https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/final-30-september-2019

* National criteria has been created to be used as a screening tool by local commissioners to guide their assessment with local stakeholders on offers of support to improve sustainability and resilience. This criteria includes 9 data indicators out of the 16 identified examining areas such as Safety, Workforce, Efficiency and Patient Experience/Access.

Sustainability and Resilience Reports - Conditions on Forward Use

Sustainability and Resilience reports provide NHS England Management Information at an individual practice level, including potentially sensitive information relating to practices status in the Vulnerable Practice Programme, GP Resilience Programme and Personal Medical Services Reviews.

This information therefore needs to be managed accordingly and should be held in strict confidence, **not for onward transmission** to any other individual or organisation (other than CCGs), or the details of any practice disclosed publicly. Measures should therefore be taken locally to guard against unauthorised access or sharing of the data.

NHS England local teams will need to be satisfied these conditions and controls are equally understood and applied by CCGs when sharing any reports under co-commissioning arrangements.

North Central London
Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee Meeting
21 April 2022

<table>
<tr><td>Report Title</td><td>Planning for 2022/23</td><td>Date of report</td><td>12 April 2022</td><td>Agenda Item</td><td>2.3</td></tr>
<tr><td>Lead Director / Manager</td><td>Paul Sinden,
Chief Operating Officer</td><td>Email / Tel</td><td colspan="3">p.sinden@nhs.net</td></tr>
<tr><td>GB Member Sponsor</td><td colspan="5"></td></tr>
<tr><td>Report Author</td><td>Paul Sinden,
Chief Operating Officer

Sarah Mcilwaine,
Director of Primary Care

Caroline Rowe
Head of Communications and Engagement</td><td>Email / Tel</td><td colspan="3">p.sinden@nhs.net

sarah.mcilwaine@nhs.net

caroline.rowe3@nhs.net</td></tr>
<tr><td>Name of Authorising Finance Lead</td><td>Not Applicable</td><td colspan="4">Summary of Financial Implications

Not Applicable</td></tr>
<tr><td>Report Summary</td><td colspan="5">Introduction
This paper builds on the report presented to the Committee in February 2022, and sets out:
• Local priorities for primary care, including those identified through local work with Healthwatch through the winter resilience communications and engagement update.
• Summary of primary care workforce modelling and narrative, developed for the Operating Plan process 2022/23</td></tr>
<tr><td>Recommendation</td><td colspan="5">The Committee is asked to:

• COMMENT ON the identified national and local priorities for 2022/23; and
• COMMENT ON the workforce narrative for 2022/23</td></tr>
<tr><td>Identified Risks and Risk Management Actions</td><td colspan="5">Risks to delivering our priorities are:
• Workforce to deliver service developments, with priorities to expand capacity through the Additional Roles Reimbursement Scheme and GP recruitment and retention;
• Workforce resilience following the two-year response to the covid pandemic, with the operating plan having a focus on wellbeing;
• Recovery of services including addressing the planned care backlog;
• Availability of funding to deliver the range of national and local priorities.</td></tr>
</table>

Conflicts of Interest	Conflicts of interest are managed robustly and in accordance with the CCG's conflict of interest policy.
Resource Implications	Primary care development plans for 2022/23 will be developed in accordance with planning guidance and local resources.
Engagement	The report sets out the engagement work undertaken to identify local priorities alongside the national priorities set out in the national guidance; there is a strong overlap between national and local priorities.
Equality Impact Analysis	This report was written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	Operating Plan priorities - None The winter resilience update includes a distillation of Healthwatch reports on access to primary care and the impact of the covid pandemic.
Next Steps	Operating plans for 2022/23 are being developed to the following timetable (that is consistent with the national planning timetable): • First draft of Operating Plan narrative and activity / performance trajectories – 25th February 2022; • Interim submission to NHS England / Improvement - 17th March 2022; • Second draft of Operating Plan narrative and activity / performance trajectories – 8th April 2022; • Final submission to NHS England / Improvement - 28th April 2022.
Appendices	1. Operating Plan Report Primary Care and Workforce Priorities

Operating Plan Report for 2022/23 – Appendix 1

1. Introduction

This paper builds on the report presented to the Committee in February 2022, providing more detail on the priorities for primary care, as set out in the draft NCL Operating Plan submission. It also includes more detail on the assumptions and modelling for primary care workforce, as part of the Operating Plan process.

2. North Central London Primary Care Priorities

The last Committee report described the work undertaken by the five Healthwatches, including a focus on access to primary care services. In addition, the following primary care priorities have been identified for 2022/23:

1) Working towards a more consistent approach to the delivery of care for those with long term conditions (LTC). The focus in primary care in 2022/23 is the continued development of and preparation for the NCL locally commissioned service LTCs.
2) Supporting PCNs to deliver the incoming PCN DES specifications including anticipatory and personalised care and extended access services.
3) Optimising capacity in existing services, via schemes mobilised as part of the winter access fund (in 2021/22) e.g. community pharmacy consultation scheme.
4) Development of the provider model, via the GP Provider Alliance.
5) A more data-driven approach to primary care (strategic and operational), with underpinning work on estates, digital and workforce, including maximising the use of the Additional Roles Reimbursement Scheme (PCN DES) and clear and consistent communications.
6) Preparation for delegation of dental, optometry and pharmacy commissioning (expected no earlier than 2023/24).

Primary care continues to experience intense pressure, following two years of rapid and mass adaptation of the general practices (and wider primary care) service model as the pandemic unfolded. Patient contacts rose back to and surpassed pre-pandemic levels in 2021, and GP, pharmacy and others in primary care are consistently managing 20-30% more patient contacts than before the pandemic (covering same day access and planned care), with no significant increase in baseline allocations. Demand, as opposed to need, continues to outstrip supply. This is alongside growing staff absences and calls for workforce to support additional primary care activity, acute and 111 pressures.

3. Primary Care Workforce Modelling

The following is based on the NCL Operating Plan draft submission for primary care workforce.

Role	Operating Plan Modelling
GPs excluding registrars	**TOTAL increase 3.7%** Based on calculated inflow/outflow (GP trainees against retiring and other leavers, full calculations available). 20/21 - 21/22 %increase was 7.2% however this was within the context of a dip in GP numbers in 20/21 and overall the increase for the last 4 years has been 3.9%
Nurses	**TOTAL decrease 0.5%.** 7% decline in last 5 years however growth from 16/17 to 18/20 then 10% decline, with 0.5% decline from 20/21 to 21/22. Assume rate of decline remains at 0.5% given GPN interventions to improve inflow & retention but outflow due to retirement high with 43% of workforce aged 55+
Direct Patient Care roles (ARRS funded)	**TOTAL increase 25.6%.** NCL has higher than national average claims against ARRS to date and it is predicted that this will continue to increase.

Direct Patient Care roles (not ARRS funded)	**TOTAL increase 13.5%.** 100% increase in last 5 years. NCL highest rate of increase nationally but %increase is slowing as 54% increase 19/20 - 20/21 and 27.7% increase 20/21 - 21/22. Assume pattern of %increase halving (demonstrated last 2 years competition with PCNs) and thus use %increase of 13.5%
Other – admin and non-clinical	**TOTAL increase 8.1%.** 12.9% increase in last 5 years but increase slowing at 8.1% increase between 20/21 -21/22 and decline between 19/20 and 20/21. Assumed growth of 8.1%.

4. Primary Care Workforce Narrative

<table>
<tr><td colspan="2">Invest in our workforce – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.</td></tr>
<tr><td>Assumptions</td><td>The changing face of Primary Care is matched by a changing and rapidly expanding range of roles reaching far beyond the roles we traditionally associate with General practice. General Practice in NCL has embraced the opportunity to diversify the workforce, introducing new ways of working through Direct Patient Care (DPC) facing roles at both a practice and PCN level. In the last 5 years we have doubled our DPC workforce employed at a practice level – the highest % increase nationally. We have seen similar successes though our DPC roles employed at a PCN level through the ARRS Scheme and in 2020/21, NCL successfully recruited the second highest number of ARRS roles per 100,000 patients in London and 37% higher than the national average.

Within this context we have also continued to see both a growth in GP numbers and Reception and Admin numbers but our Nursing numbers have continued to decline, although at a slower rate of decline in the last 12 months.

Our workforce assumptions are based on continuing to successfully recruit and diversity our workforce in NCL but with a slow down on the trajectory for increase of DPC roles as the ARRS scheme expands and we are in direct competition with system partners and neighbouring ICSs.

Our ability to increase our Clinical Placements will be key in increasing educational opportunities to attract new people to NCL and our direct actions against the Workforce Ambitions of the Operating Plan are detailed below.</td></tr>
<tr><td>Actions</td><td>Central to the delivery of the 22/23 strategic priorities is the North Central London Integrated Care System Primary Care Training Hub (The Training Hub). The Training Hub brings together a strong, locally rooted, collaboration to ensure that the diverse needs of the workforce from all five Boroughs of North Central London can be met.

<u>Look after our people</u>: improve retention, support health and wellbeing, improve attendance

• The GP and GP Nursing (GPN) Fellowship and Mentoring Scheme provides a supported transition into Primary Care for newly qualified GPs and GPNs and the offer provides 100% coverage to all GPs and GPNs wishing to join the scheme in NCL. In NCL we have built in flexibility to our scheme to allow recruitment outside of the graduating cohorts and to increase the range of fellowships we are able to offer by working closely with system partners to co-fund placements.
• The success of our Mentoring Scheme has allowed us to expand the offer in 22/23 to pair mentors/mentees with a wider range of roles in the General Practice workforce recruited through ARRS and practice level DPC recruitment
• Utilising Local GP Retention Funding we have established 12 GP Retention Schemes designed to meet local borough retention needs which will continue delivery into 22/23. These schemes focus on the support, retention and</td></tr>
</table>

development of mid-career GPs to meet the changing needs of Primary Care and to also expand our Fellowship offer to newly qualifying GPs.
- **Delivery of GPN initiatives for preceptorship, wellbeing, masterclasses, leadership development** – Recruiting, retaining and expanding our GPN workforce remains a key priority for NCL. Priorities and funded activity for 22/23 cover 4 key areas – securing leadership, establishing structure, career pathways, and continuous professional development – all of which aim to retain and develop our GP Nurses and make Primary Care Nursing a first destination career.
- Building on the successes and foundations laid by our 21/22 **Wellbeing Pilot** support to practices will continue in to 22/23 with the development of a Primary Care Wellbeing Lead post and targeted training and resilience building workshops across our Primary Care Providers.
- **Boosting the resilience of Reception & Admin staff** through bespoke training on managing difficult conversations and customer service as well as a wellbeing support offer regarding difficult conversations and managing violent patients in Q1.

Improve belonging in the NHS: *improve BAME disparity ratios, and promote equality across all protected characteristics.*

- Primary Care, via the Training Hubs, are linking this into **EDI Leadership Networks** being set up across London following the launch of the Primary Care London Workforce Race Equality Strategy. To supplement this, they are recruiting **local EDI Primary Care Leads** and a Practice Manager to complement the work of the wider ICS EDI Group

Work differently: *accelerate the introduction of new roles, develop the workforce required to deliver multidisciplinary care closer to home, optimise the capacity of the current workforce, and establish, or become part of, volunteer services such as the NHS cadets and NHS reservists.*

- Under the **Additional Roles Reimbursement Scheme** Primary Care Networks are able to draw down **full funding** for 15 new Primary Care roles. In NCL we have already recruited 327 FTE staff under this scheme in 20/21 with plans to recruit a further 114 in 21/22 and 112 in 22/23, and have a ARRS to patient ration significantly higher than the national average. 22/23 activity will support PCNs to continue to develop their workforce plans and focus on retention initiatives for this expanding workforce.
- Valuing the **contribution of our Volunteer Workforce** to the Covid Vaccination programme and retaining their skills in general practice we will deliver an Introductory Training to General Practice targeting 25+ volunteers to increase the long-term number of primary care administrators available in NCL by creating routes into employment for local residents and volunteers.
- Training Hubs continue to support the **deployment of new ways of working** including video group consultation training, funding for **PCN Digital Ambassadors** to support Primary Care Networks making the most of the Digital First agenda & **bespoke local training** on new emerging pathways such as BP@Home or Long Covid pathways.
- NCL has developed a **Primary Care Flexible Staff Pool** to connect practices and clinicians to a workforce who wish to work more flexibly and to retain and support our locum workforce in NCL. The pool will initially focus on GP and GPN Locums in 22/23 but will expand in future years to include the full General Practice workforce.
- In early 22/23 we will be piloting an **NCL face to face group consultation offer to the parents of young children** training facilitators and back-filling staff in high-need PCNs to run pilot group consultations for up to 12 – 15 parents of young children with the aim of reducing presentations in local Emergency Departments and release workforce capacity.

	• **Personalised Care training -** working to ensure all staff can access the Personalised Care Institute e-learning and training an additional 675 staff per annum. • **Shared recruitment for entry point roles –** working with ICS partners to work collaboratively to fill reception and admin roles across the system, reducing competition and supporting local residents to make the most of employment opportunities. **Grow for the future:** *expand international recruitment, leverage the role of NHS organisations as anchor institutions/networks, make effective use of temporary staffing, ensure training of postgraduate doctors continues, and to ensure sufficient clinical placement capacity*. • NCL is working hard to maximise opportunities to recruit, retain and develop our Primary Care Workforce to meet the changing face of Primary Care. • The NCL Training Hub are leading a programme of work focused on the **Promotion & expansion of clinical placements in NCL** – attracting clinician's in to Primary Care as part of their placements. • **Expansion & promotion of Apprenticeship roles in Primary & Social Care** – developing our future workforce and providing a stepping stone into a career in primary care • **HCA Training Programme Recruitment** – Cohort 2 starting to recruit a further 25 new staff and train them to be health care assistants. • **NA / TNA Training Programme** – Ongoing recruitment twice yearly as part of a joint ICS initiative led through work of the Training Hub. • **Careers Fair for 16–17-year-olds in** partnership with Middlesex University with over 300 attendees.
Risks, issues and mitigation	**Direct Patient Care** There is a risk that roles available for reimbursement within PCNs are in short supply and could be recruited from elsewhere in the system with the risk to destabilise system partners. This is being mitigated through partnership rotation recruitment such as joint recruitment with LAS for PCN Paramedic roles. **GP Nursing** There is a risk that our GP Nursing numbers continue to decline, further affecting our GPN to patient ration. This is mitigated by significant recruitment to other DPC roles to ensure patient needs continue to be met whilst our NCL Training Hub Primary Care Nursing Strategy and NCL Primary Care Nursing Programme Priorities 22-23 actions work to address our recruitment and retention initiatives to rebuild our GPN workforce in NCL.

North Central London
Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee Meeting
21 April 2022

Report Title	NCL Long Term Conditions Locally Commissioned Service (NCL LTC LCS) DRAFT Specification	**Date of report**	11 April 2022	**Agenda Item**	2.4
Lead Director / Manager	Sarah McIlwaine	**Email / Tel**	Sarah.mcilwaine.nhs.net		
GB Member Sponsor	*N/A*				
Report Author	Melissa Donnelly and Sarah McIlwaine	**Email / Tel**	Sarah.mcilwaine.nhs.net		
Name of Authorising Finance Lead	*N/A*	**Summary of Financial Implications** Risk stratification work continues in order to confirm financial implications in full. To be presented to PCCC at a future date once confirmed.			
Report Summary	This report is for information and includes the current draft of the specification that will form the foundation of the new, NCL long term conditions locally commissioned service. This draft LCS specification has been developed in collaboration with clinical and programme leads from across North Central London CCG, and with input from Londonwide LMC. It supports a more consistent approach to the delivery of care and support for people with long term conditions (LTCs) within general practices and primary care networks (PCNs). This LCS seeks to identify people who are at risk of developing a LTC through active case finding, and to deliver care to people who are already diagnosed with a LTC. The model of care is based around the Year of Care approach that uses the House of Care[1] as a framework to ensure essential components are in place to deliver person-centred care. The specification: • supports delivery of national models of LTC care,				

[1] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

	• recognises and gives central importance to personalisation[2], • is outcomes-focussed, • supports a holistic approach to care, particularly for people with multi-morbidity, and • delivers personalised care and support planning over a year of care, ensuring patients are central to care and support decisions and goals. This specification is designed to promote equity of access, outcome and experience for patients with LTCs from communities across North Central London. The specification acknowledges the differential effort needed to achieve outcomes for different communities and contributes to the Integrated Care System (ICS) effort to reduce health inequalities, by reducing morbidity and mortality amongst our most deprived communities. The service specification covers a minimum period of three years, with a potential further two year extension, and with annual updates, to enable systems, processes and outcomes to be embedded and in order for them to become business as usual. The proposed payment model is based on a block payment to practices, and an element of payment based on achievement of outcomes. The intention is to allow practices and PCNs a preparatory period during 2022/23, with the specification mobilised across NCL once this preparation is complete. A comprehensive training programme will be provided as part of the preparatory period, using a mix of existing expert programmes and bespoke content to support all practice staff, clinical and administrative, to understand and carry out their role in delivering the model of care. Work continues on: • Risk stratification and size of patient cohort • Financial implications; pending risk stratification data • Weighted and outcomes elements of the payment model • The childhood asthma model; in development by CYP Clinical Lead/Model of Care task and finish group • The finalised timeframe for the preparatory year, agreed set of milestones, including training and GP IT infrastructure and a practice readiness checklist. • The case finding detail to support practices. The areas above will be incorporated into the next iteration.
Recommendation	The Committee is asked to **NOTE** the current version of the specification, including the model and outcomes framework.
Identified Risks and Risk Management Actions	The NCL LTC LCS has its own risk log.

[2] https://www.england.nhs.uk/personalised care/upc/

Conflicts of Interest	The NCL LTC LCS has its own Declaration of Interest Register and requests for members to raise potential interests are invited at each meeting. There are no known conflicts.
Resource Implications	tbc – on completion of risk stratification and patient cohort work.
Engagement	The NCL LTC LCS model of care is based on the Year of Care approach that uses House of Care as a framework to ensure essential components are in place to deliver person centred care. Clinical input from all boroughs has been part of the development of the model of care with programme updates occurring at borough level to further socialise the intention of the new LCS in development. Borough clinical and management leads are in the process of engaging with their respective borough partnerships and GP fora, with more engagement planned with practices over the next months, including the use of GP webinars and newsletters. Co-production with residents who live with one or more LTC is planned to understand what support/information/self-management approaches they need to proactively engage with this new model of care that all GP practices across NCL will have the chance to offer from April 2022.
Equality Impact Analysis	An EQIA is in development.
Report History and Key Decisions	The Committee has received updates on the development of this work on: • 17th June 2021 • 19th August 2021 • 21st October 2021 • 16th December 2021 • 17th February 2022 Similar updates have also been to: • Community Operational Group on 9th November 2021 • Governing Body Seminar on 18th November 2021, 3rd February 2022 • Clinical Leaders on 9th December 2021 • Enfield Borough Partnership on 10th December 2021, 25th January 2022 • Barnet Borough Partnership on 12th January 2022 • Islington Primary Care Strategy Group on 21st January 2022 • Haringey Clinical Directors on 24th January 2022 • Islington Integrated Care Board on 11th February 2022 • Barnet PCN Open Board 23rd February 2022 • Haringey Strategic Operational Group 3rd March 2022 • NCL Community Partnership 4th March 2022 • NCL Heads of Medicines Management 30th March 22
Next Steps	Completion of the items identified above (in Report Summary). Committee to review the model and specification against the core contract, QoF and incoming national PCN DES specifications, as part of formal governance.
Appendices	Draft specification included.

SCHEDULE 2 – THE SERVICES

A. DRAFT Service Specification

Service specification Number	
Commissioner Lead	*NCL Integrated Care Board (ICB)*
Provider Lead	NCL GP Practices and Primary Care Networks
Period	To be confirmed
Date of review	

1. Introduction

This Locally Commissioned Service (LCS) specification has been developed in collaboration with clinical and programme leads from across North Central London CCG, and with input from Londonwide LMC. It supports a more consistent approach to the delivery of care and support for people with long term conditions (LTCs) within general practices and primary care networks (PCNs).

This LCS seeks to identify people who are at risk of developing a LTC through active case finding, and to deliver care to people who are already diagnosed with a LTC. The model of care is based around the Year of Care approach that uses the House of Care[1] as a framework to ensure essential components are in place to deliver person-centred care.

The specification:

- supports delivery of national models of LTC care,
- recognises and gives central importance to personalisation[2],
- is outcomes-focussed,
- supports a holistic approach to care, particularly for people with multi-morbidity, and
- delivers personalised care and support planning over a year of care, ensuring patients are central to care and support decisions and goals.

This specification is designed to promote equity of access, outcome and experience for patients with LTCs from communities across North Central London. The specification acknowledges the differential effort needed to achieve outcomes for different communities and contributes to the Integrated Care System (ICS) effort to reduce health inequalities, by reducing morbidity and mortality amongst our most deprived communities.

The service specification covers a minimum period of three years, with a potential further two year extension, and with annual updates, to enable systems, processes and outcomes to be embedded and in order for them to become business as usual.

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[1] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

[2] https://www.england.nhs.uk/personalised care/upc/

Over the lifetime of the specification, its impact will be kept under review, ensuring coordination with other key specifications, particularly the PCN DES personalised care/anticipatory care specification, to ensure patients are at the centre of effective and coordinated care, and that resources are deployed in the most optimal way.

The specification describes a consistent and holistic approach to LTC care delivered through general practices and Primary Care Networks (PCNs) and builds on the Quality and Outcomes Framework (QOF). The specification supports delivery of the model of care, with risk stratification of all those in scope, and a defined frequency of contacts, in order to support effective primary care workforce planning over the year of care. The model of care includes diagnosis as well as optimal treatment, supporting practices to close their prevalence gap through case finding.

The specification includes an outcomes framework, aligned to the NCL ICS population health outcomes and with a comprehensive set of indicators to help practices and PCNs track progress toward equitable achievement.

Personalised care and support planning and proactive care are at the heart of the model of care. The model of care draws on existing evidence-based approaches that will enable practice staff to collaborate with patients to define and work towards their individual care goals and to plan and coordinate care, particularly for those higher risk patients, living with complex health and care needs. Higher risk individuals may require coordinated case management, working with community and voluntary services across health and care. The stratification, on which the specification is based, will support improved identification of these higher risk individuals, which can be aligned with other services and can form the basis for developing an anticipatory care model, expected to be outlined in the forthcoming Directed Enhanced Service (DES). The model of care supports greater emphasis on a strengths-based approach, focussing on the wider determinants of health and their impact on individuals.

For information on the National LTC data, see Appendix 1 – National LTC data.

2. Population needs

2.1 The National Context

For information on the National Context, see Appendix 2 – National Context.

2.2 The Local Context

Prior to the merger of the five CCGs, the pandemic and the development of this specification, LCSs were largely commissioned by borough-based CCGs, which meant variation in the commissioning and delivery of services, ranging from a universal offer designed around achieving outcomes, to multiple individual specifications. There was also variation in the scope and focus of LCS in NCL.

The holistic approach to the disease clusters in scope of this specification will deliver a better patient experience, common outcomes, and better use of system resources, while supporting greater consistency across NCL. The specification builds upon the excellent examples of NCL LTC care that already exist.

For further information on the Local Context, see Appendix 3 - The Local Context.

3. The Case for Change

Appendix 4 – The Case for change.

4. Scope

4.1 Aims and objectives of service

The health conditions agreed in scope, and those considered (but agreed as out of scope) are:

In scope	Out of scope
1. Cardiovascular Disease (CVD (covering Ischaemic Heart Disease (IHD), Stroke, TIA, Peripheral Vascular Disease (PVD), Heart Failure (HF))) 2. Arial Fibrillation (AF) 3. Hypertension 4. Hyperlipaemia 5. Diabetes (Type 2) 6. Chronic Kidney Disease (CKD) 7. Non-Alcoholic Fatty Liver Disease (NAFLD) 8. Chronic Obstructive Pulmonary Disease (COPD) 9. Asthma – adults and childhood	10. MS 11. Parkinson's 12. Migraine syndromes 13. Dementia (particularly vascular dementia given overlap with CVD, and factors that can be managed to slow progression) 14. Rheumatoid Arthritis (and other arthropathies associated with poorer quality of life and health outcomes e.g. Psoriatic arthritis, osteoarthritis and osteoporosis/multiple fractures) 15. Thyroid Disease 16. Inflammatory Bowel Disease (possibly including coeliac's and IBS) 17. Hepatic diseases (including auto-immune Hepatitis, other Hepatitis aetiologies) 18. HIV 19. Lupus 20. Sarcoidosis 21. Sickle cell disease 22. Fibrotic Lung Disease 23. Cystic fibrosis 24. Obesity 25. Type 1 Diabetes

For NCL patients with LTCs in scope of this LCS, the aim of the service is to:

- Replace existing LCS for the LTCs that are in scope for the new NCL specification.
- Support the delivery of a holistic approach to long-term conditions management including the delivery of related QOF activity.
- Offer a service that focusses on prevention, detection and management of metabolic and respiratory conditions in scope.
- Proactively identify patients at risk of developing a LTC and help close the prevalence gap for those with an undiagnosed LTC.
- Systematically deliver personalised care and support planning for in scope LTC patients over a year of care ensuring patients and staff are prepared for shared decision making and goal setting conversations.
- Support patients at risk of, or confirmed living with, LTCs to self-manage their condition(s), enabling them to achieve their personalised health and lifestyle goals.

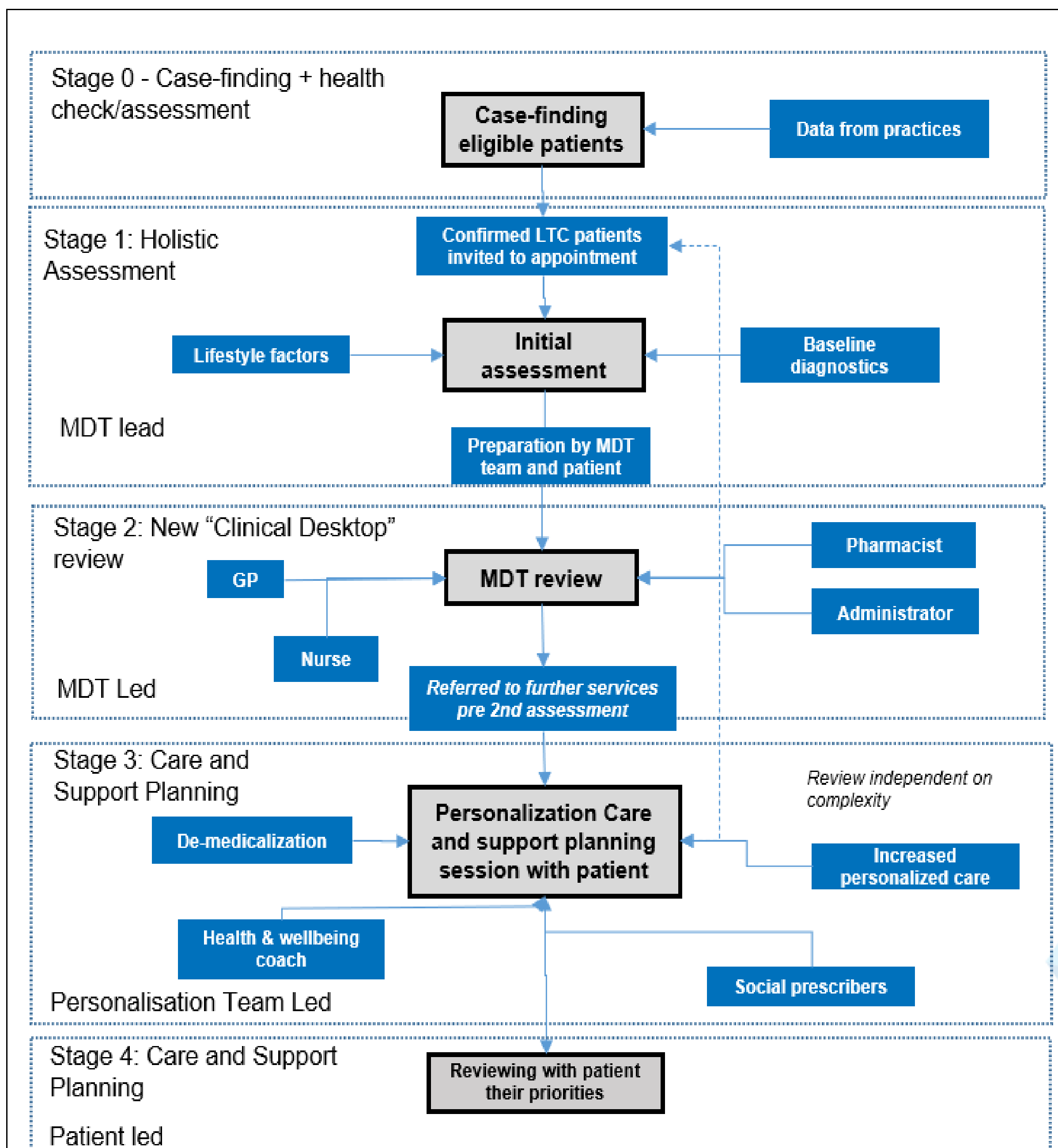
- Encourage a proactive multidisciplinary team (MDT) approach to the care of people with the greatest need and maximise the MDT impact.

4.2 Service description/operational delivery of the care pathway

This LTC LCS is based on both delivery of a set of outcome measures and key indicators and a model of care with an established evidence base. The model of care is set out below and is based on the "*Year of Care"* and the *"House of Care"* approach widely implemented across the UK. Providers will be commissioned on an outcomes-based approach. The launch of the LCS will be preceded by a *preparatory* period, when practices will receive training, change business process and move towards a state of readiness for delivery of the full model to all cohorts to achieve the outcomes. It is intended to enable providers to have flexibility as to how the model of care is delivered and the outcomes are achieved e.g. using quality improvement methodology, having aspects of delivery at PCN level etc.

4.3 Model of Care

The outline model of care is shown in the diagram below:



A further, more simplified, graphic of the model of care, which shows the pathway from the patient's perspective, is provided in Appendix 6 - NCL's Long-term conditions model of care.

4.3.1 Stage 0 – Patient Identification/Case Finding

- Usage of templates/risk stratification tools, etc.
- SNOMED codes

Ensuring that patients at risk of developing a LTC are identified so that they can be provided with a health assessment and support them to reduce the risk of developing a LTC later on. In addition, patients diagnosed with a long-term condition will be added to the appropriate disease register so helping to reduce the prevalence gap and provide access to the full model of care.

The proposed case finding list includes:

- People at high risk of COPD
- People at high risk of Diabetes
- People with raised BP >140/90 but no code of hypertension
- People at high risk of CVD
- Opportunistic AF case finding
- People at risk of familial hyperlipaemia
- People at risk of asthma –adults
- Children and young people with a possible diagnosis of asthma
- People at risk of Chronic Kidney Disease (CKD) (low eGFR and no code for CKD).

See Appendix 5 - Case Finding for further information on the case finding processes.

4.3.2 Stage 1 – Holistic Assessment

Patients identified with a LTC in scope for the LCS will be invited to a holistic assessment appointment led by a multidisciplinary team member (e.g. suitably skilled Health Care Assistant (HCA)) or nurse or pharmacist if required) for an initial review and discussion on concerns and lifestyle factors that may affect their health and well-being.

At this assessment, relevant baseline ***diagnostics*** (e.g. blood pressure, pulse, weight, height BMI, foot check (for diabetics), diet assessment, bloods, spirometry (potentially from another provider) will be collected. Practices may wish to consider a 'one stop shop' approach to improve convenience for patients and consider how this relates to options for at scale delivery.

At the end of the assessment, the clinician conducting the holistic assessment will explain the personalised care and support planning process to the patient and begin drafting a care plan. This can include any referrals to system partners including voluntary and community services. The patient will receive next steps guidance in the form of a letter or email, outlining what will happen next, including being sent the results from their diagnostic tests.

4.3.3 Stage 2 – Clinical Desktop Review

Patients' test results from Stage 1 are collated and reviewed by a suitably skilled healthcare professional, highlighting 'out of range' values. For those at high risk of complications an MDT discussion is suggested (practice or PCN-based) in order to agree which member of the MDT is best placed to work in partnership with the patient for personalised care and support planning (Stage 3) and whether any further care coordination may be required.

4.3.4 Stage 3 – Personalised Care and Support Planning

The patient will be invited back to the GP practice to have a personal care and support planning conversation. This appointment should be a minimum of 30 minutes to ensure the patient has time to consider what matters to them and is supported to agree achievable goals and outcomes. The conversation should be led by the appropriate clinician for the patient's level of risk. High risk patients will be seen by a GP, Advanced Nurse Practitioner (ANP), nurse, pharmacist or other suitably qualified member of the team. Moderate risk patients may be seen by a member of the wider multidisciplinary team (HCA, nurse, GP or pharmacist) and low risk patients will be seen by a suitably trained HCA, nurse or pharmacist.
The personalised care and support planning conversation will focus on what is important to the patient and agree goals with the patient to support them to achieve better clinical outcomes and their self-management goals, as well as any lifestyle ambitions. To help

patients achieve their goals, the plan may include referral to additional roles in primary care, such as social prescribing link workers, voluntary and community services, local authority services. A timeframe for next review will be agreed.

It is recognised that new innovative approaches to support personalised care and support planning and goal setting have been trialled within general practice e.g. group consultations, and this specification supports new ways of working if they help to deliver improved outcomes.

4.3.5 Stage 4 – Ongoing Review

The patient's goals, as identified through the care and support planning conversation, will be reviewed to identify if any further support is needed or to identify new goals. For those patients at higher risk, the model includes multiple touch-points over the year to help patients stay on track with their goals. Practices/PCNs will need to develop processes to ensure robust call and recall is established to ensure patient's care is systematically reviewed.

4.4 Staff Training

Three areas of training, to be commissioned separately, are required to deliver the specification:

- **Overview of the model of care**
  - (Core, free e-Learning via Personalised Care Institute).
- **Enhanced Personalised Care & Support Planning**
  - (For clinicians, needs to be PCI accredited provider – e.g. OSCA / Year of Care via individual course and train the trainers).
- **Change Management support**
  - (Support practices with business planning, call/recall, searches, use of templates etc).

4.5 Eligibility to provide the service

In order to implement this LCS, practices must:

- Have completed the practice checklist by [DN: date tbc in 22/23], which will confirm the practice's readiness to deliver the service. The checklist will have two main sections:
  1. Staff training
  2. Practice change management project, including templates, searches, alerts, call/recall and monitoring dashboard (provided by the CCG).
- The relevant borough team (or a contracted provider) will liaise with the practice on progress with the practice checklist and provide support to overcome any problems.
- Add practice readiness checklist once confirmed.

4.6 Interdependence with other services/providers

The specification will be offered to GP practices who are free to choose to provide some or all of the scope of this work at PCN level, depending on local population need. There will need to be further discussion with the PCN about overall delivery, including where an individual practice opts out.

There are a number of interdependencies which have been mapped out against the model of care and outcomes framework to ensure no duplication and to align and enhance to.

These include:

- DES (Anticipatory care, personalisation, CVD prevention and health inequalities)
- Impact and Investment Fund
- Community Services Review
- Mental Health Services Review
- Remote monitoring and care @ home
- QOF.

At time of writing this specification, a review is underway to determine the core offer for community and mental health services across North Central London. As the results of those reviews become available, practices and PCNs will be updated on how this relates to the LTC LCS. This will be of particular relevance to higher risk/more complex patients.

Given the importance of taking a holistic, strength-based approach in the model of care, practices and PCNs may want to engage community and voluntary sector resources, especially to address the wider determinants of health.

4.7 Record Keeping

All records will be kept as required by the NHS Records Management Code of Practice.[3]

Identifiable data relating to patients will be used for direct care only, with the sole exception of matching across different services to produce correlation evidence.

Sharing agreements are already in place across NCL allowing much of this sharing to occur, However a formal Purpose-Specific Schedule to the sharing agreement, along with an assessment of risks (DPIA) will be performed to ensure that data handling is fully compliant with law.

Aggregate statistical data will be used for measurements of delivery and outcomes.

4.8 Location and venues

The service will be offered locally to patients from locations within each borough, either from a practice or PCN base, with consideration given to travel distances.

5. Outcomes

5.1 NHS Outcome Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	X
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	X

[3] https://www.nhsx.nhs.uk/information-governance/guidance/records-management-code/

5.2 Locally-defined Outcomes

The table below details the Primary Care LTC Outcomes that have been developed collaboratively across NCL and their associated indicators for measurement. The outcomes have been grouped according to the two disease concordant clusters in scope and across four domains: detection, prevention, treatment and personalisation. The outcomes have strong attribution to primary care and so form a solid foundation for the outcomes-based payment. The outcomes have also been mapped to the draft NCL ICS population health outcomes.

5.2.1 Version 21

Domain	Population Health Outcome	Primary Care LTC Outcome	Indicators
Prevention	Live Well Reduced early deaths from cancer, cardiovascular disease and respiratory disease Indicator: Reduced prevalence of key risk factors: smoking, alcohol, obesity Age Well Older people live health and independent lives for as long as possible Indicator: Prevent development of frailty with active ageing	% of LTC population referred to a lifestyle intervention and/or social prescribing **plus** Diabetes % increase in referral to NDPP NAFLD % of patients <75 years of age with a Fib 4 result >2.6 that have had an ELF test Lipids % increase in number of patients with a QRisk > 10% on a statin (QRisk over 10% to be offered lifestyle intervention) (Risk over 10% to be offered statin)	increase in people with LTCs with alcohol intake recorded increase in people with LTCs with diet advice recorded increase in people with LTCs with activity advice recorded increase in people with LTCs with depression screening recorded increase in people with LTCs with drug use recorded increase in people with LTCs with smoking status recorded childhood asthma - increase in households with smoking status recorded Diabetes decrease in those who ever had gestational diabetes with no HbA1c recorded increase in those with second consecutive raised HbA1c =42-47 coded as NDH NAFLD increase in referral to weight management services % of patients with NAFLD with a Fib 4 level calculated Lipids Increase in proportion of eligible population who have a documented QRisk score
Detection	Start Well All children and young people are supported to have good physical and mental health Indicator: Improved outcomes for children with long term conditions Live Well Reduced early deaths from cancer, cardiovascular disease and respiratory disease Indicator: Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease Age Well Older people live health and independent lives for as long as possible Indicator: Improved outcomes for older people with long-term conditions, including dementia	% increase in prevalence compared to RightCare PCN similar 10 AF, CHD, HTN, PAD, COPD (conditions which are not covered include IHD, Stroke, TIA, Hyperlipaemia, Diabetes (T2), Asthma) **except** CKD % patients with accurate CKD staging code Childhood and Adult Asthma Reduction in children and adults with a coded diagnosis of asthma with no measures of airflow obstruction variability COPD Reduction in adults with a coded diagnosis of COPD with no measures of airflow obstruction	Increase in NHS Health Checks **plus** Diabetes Referral to NDPP Childhood and Adult Asthma A register created with recorded spirometry and FeNO or PEAK COPD Recorded Spirometry
Personalisation	-	% of overall LTC population with a completed personalisation outcome measure	% LTC population with a recorded personalised care plan

6. National/ Local and Applicable Standards

6.1 Applicable national standards (e.g. NICE)

The outcomes framework and indicators have been informed by NICE and local NCL clinical pathways which can be accessed through the NCL GP website.[4]

7. Quality

7.1 Applicable quality requirements

[4] Home - North Central London GP Website (northcentrallondonccg.nhs.uk)

The ICB will monitor the LCS on a quarterly basis:

- Practices must use appropriate escalation procedures to ensure matters arising are recorded and appropriately managed.
- Where necessary and appropriate, timely escalation of concerns should be made to the ICB.
- Practices must use the EMIS clinical template to code any activities carried out under the contract.

There are no further additional quality elements over and above the outcomes framework and those within the contract expected at this time.

8. Outcomes and Key Performance Indicators – Version 21

An outcomes framework for the conditions in scope has been developed with input from clinical and programme leads from across NCL through a dedicated task and finish group. Each outcome has an associated set of indicators. The process for outcomes-based payment, including baselining, goal-setting and the eligibility criteria and distribution of that payment between practices and PCN is currently in development by the task and finish group and the specification will be updated once the process is finalised and agreed.

The outcomes framework and indicators are presented below:

Domain	Population Health Outcome	Primary Care LTC Outcome	Indicators
Prevention	Live Well Reduced early deaths from cancer, cardiovascular disease and respiratory disease Indicator: Reduced prevalence of key risk factors: smoking, alcohol, obesity Age Well Older people live health and independent lives for as long as possible Indicator: Prevent development of frailty with active ageing	% of LTC population referred to a lifestyle intervention and/or social prescribing **plus** Diabetes % increase in referral to NDPP NAFLD % of patients <75 years of age with a Fib 4 result >2.6 that have had an ELF test Lipids % increase in number of patients with a QRisk > 10% on a statin (QRisk over 10% to be offered lifestyle intervention) (Risk over 10% to be offered statin)	increase in people with LTCs with alcohol intake recorded increase in people with LTCs with diet advice recorded increase in people with LTCs with activity advice recorded increase in people with LTCs with depression screening recorded increase in people with LTCs with drug use recorded increase in people with LTCs with smoking status recorded childhood asthma - increase in households with smoking status recorded Diabetes decrease in those who ever had gestational diabetes with no HbA1c recorded increase in those with second consecutive raised HbA1c =42-47 coded as NDH NAFLD increase in referral to weight management services % of patients with NAFLD with a Fib 4 level calculated Lipids Increase in proportion of eligible population who have a documented QRisk score
Detection	Start Well All children and young people are supported to have good physical and mental health Indicator: Improved outcomes for children with long term conditions Live Well Reduced early deaths from cancer, cardiovascular disease and respiratory disease Indicator: Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease Age Well Older people live health and independent lives for as long as possible Indicator: Improved outcomes for older people with long-term conditions, including dementia	% increase in prevalence compared to RightCare PCN similar 10 AF, CHD, HTN, PAD, COPD (conditions which are not covered include IHD, Stroke, TIA, Hyperlipaemia, Diabetes (T2), Asthma) **except** CKD % patients with accurate CKD staging code Childhood and Adult Asthma Reduction in children and adults with a coded diagnosis of asthma with no measures of airflow obstruction variability COPD Reduction in adults with a coded diagnosis of COPD with no measures of airflow obstruction	Increase in NHS Health Checks **plus** Diabetes Referral to NDPP Childhood and Adult Asthma A register created with recorded spirometry and FeNO or PEAK COPD Recorded Spirometry
Personalisation	-	% of overall LTC population with a completed personalisation outcome measure	% LTC population with a recorded personalised care plan

Population Health Outcomes	Respiratory Cluster Outcomes	Indicators
Start Well All children and young people are supported to have good physical and mental health Indicator: Improved outcomes for children with long term conditions Live Well Reduced early deaths from cancer, cardiovascular disease and respiratory disease Indicator: Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease Age Well Older people live health and independent lives for as long as possible Indicator: Improved outcomes for older people with long-term conditions, including dementia	Childhood Asthma (Under 16 years old) % increase of children diagnosed with asthma with good control (no more than 6 salbutamol inhalers prescribed per year **and** prescription of an ICS)	% decrease in children with asthma with more than 6 salbutamol inhalers prescribed in a 12 month period
		% increase in children with asthma with an ICS prescribed
		% decrease in the number of courses of oral prednisolone prescribed to children with asthma
		% increase of children with asthma with a completed post attack review
	Adult Asthma % increase in adults with asthma with good control (no more than five salbutamol inhalers prescribed per year **and** prescription of an ICS)	% decrease in adults with asthma with more than 5 salbutamol inhalers prescribed in a 12 month period
		% increase in adults with asthma with an ICS prescribed
		% decrease in the number of courses of oral prednisolone prescribed to adults with asthma
		% increase of adults with asthma with a completed post attack review
		All adults prescribed with an oral steroid for an exacerbation to receive a review and medicines optimisation within one month.
	COPD % increase in patients with COPD at MRC 3-5 referred to pulmonary rehab in last 12 months	% increase in patients with a recorded MRC
		% increase in patients with a recorded MRC of 3-5 who are provided with information about PR
		% increase in patients with a recorded MRC of 3-5 who consent to referral to PR
	increase in patients with COPD with optimised inhaled therapy prescriptions (reduction in salbutamol use **and** reduced prescribing of ICS alone **and** increased prescribing of LABA/LAMA combinations)	% decrease in adults with COPD with more than three salbutamol inhalers prescribed in a 12 month period
		% decrease in the number of courses of oral prednisolone prescribed to adults with COPD in a 12 month period
		% increase in prescribing of dry inhalers
		% decrease in prescribing of an ICS alone
		% increase of patients with COPD being prescribed LABA/LAMA combinations

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Population Health Outcomes	Metabolic Cluster Outcomes	Indicators
Start Well All children and young people are supported to have good physical and mental health Indicator: Improved outcomes for children with long term conditions Live Well Reduced early deaths from cancer, cardiovascular disease and respiratory disease Indicator: Early identification and improved treatment of cancer, diabetres, high blood pressure, cardiovascular disease and respiratory disease Age Well Older people live health and idependent lives for as long as possible Indicator: Improved outcomes for older people with long-term conditions, including dementia	AF % high risk AF on optimal anticoagulation, excluding contraindicated	% increase in people with known AF who have a recorded CHADSVASC score
		%increase in people with AF with CHADSVASC ≥ 1 (unless female < 65 years old) on anticoagulant
		% patients on DOACs who have had weight and renal function measured in last 12 months
	Diabetes Percentage on Type 2 Diabetes register with good diabetes control: Hba1c <= 58, AND TC=<5, AND BP<=140/80 % patients who have had all 8 care processes complete in last 12 months	% high risk diabetic patients reviewed annually
		% decrease in number that hadn't had an HbA1c in last two years
		% increase in people with diabetes who have had an HbA1c recorded in last 24 months
		% increase in people with an HbA1c of >70 who have had an HbA1c measured within the last 12 months.
		% decrease of people with HbA1c>70 who haven't had a repeat HbA1c in the past six months
	CKD % patients with CKD prescribed Renin-angiotensin antagonist: CKD and ACR over ≥70 CKD with HT and ACR over ≥30 CKD with DM and ACR over ≥3 % of patients with CKD with BP in target range. <140/90 (ACR<70) < 130/80 (ACR ≥70) <150/90 (>80yrs) % patients with CKD 3a plus (meaning 3b, 4 and 5) prescribed a statin	% patients with CKD reviewed annually
	Hypertension % increase in patients with good blood pressure control -79yrs and under <=140/90 and 80 and above <=150/90	**QOF plus** 140/90 under 80 150/90 over 80
	Lipids % of patients with both hypertension and CVD who are on optimal lipid lowering therapy	% people with hypertension and CVD who are on high dose high intensity statin
		% patients with hypertension and CVD who have cholesterol measured in the last 12 months
	Heart Failure % patients with a diagnosis of heart failure with a management plan	% of patients with NYHA class recorded

9. Finance/Value

To be added later once financial/costing work is completed.

9.1 There are two elements to the payment model:

9.1.1 Block

1. Covers delivery of the costed model of care based on the number of patients in scope and within each risk strata. Paid quarterly prospectively.
2. Weighted-element dependent on an agreed set of factors present in the practice population in scope for the LCS. These are factors that reflect the differential effort needed to achieve the outcome. The factors will be beyond those captured in the risk stratification. Paid quarterly prospectively.

9.1.2 Outcomes-based

1. Based on PCN achievement of goals from a baseline (re-calculated annually) *NB baseline is tbc.*
2. Based on improvement goals set as a % for each PCN, calculated from individual baselines; tiered so that PCNs will be able to receive payment for partial achievement.
3. Paid annually retrospectively.

9.2 Further block payment detail

- The financial model has been aligned to the five stages of the model of care, which has identified;
  - the activities required in each stage;
  - the workforce required to deliver the activities;
  - the time required to complete each activity.
- The cost of the model of care per patient increases in line with the risk severity of patient cohorts; high risk patients receive up to four annual reviews, compared to low risk patients who receive one. The additional time for higher risk patients also allows for improved coordination with community, voluntary and acute services, which are involved in supporting our population with more complex needs.
- The risk stratification data will identify which patients are considered low, moderate or high risk based on criteria collectively produced by NCL LTC Clinical Leads and existing UCLP risk stratification work. The criteria are complex and nuanced for the health conditions in scope; a patient with multiple LTCs is not automatically high risk, conversely one LTC does not automatically mean low risk.
- All GP practices will receive a payment based on the number of registered patients with one or more LTCs in scope of the specification, aligned to their level of risk severity.

9.3 Financial model development- assumptions:

- Alignment with core contract and QoF to ensure there is no overlap/ duplication with the existing core contract and/or QoF, or that the LCS is creating any gaps.
  There is the potential for overlap with the NCL LTC LCS and some of the activities delivered in stage 1 and the QoF. E.g. Run searches to identify patients, sending out letters of invite/follow-up contact with patient, complete holistic assessment, baseline diagnostics and collate results and send to patient.
- Remuneration – use of agenda for change. No adjustment for any inflationary uplift has been made for 22/23 for any contracts in NCL in 22/23).
- Model uses consistent GP costs in all boroughs (£85/hr inclusive of NI and pensions).

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- Children and Young People (CYP) asthma model is still in development (as of April 2022).
- Work is underway to create a variation of the model of care to reflect the different approach to CYP care, once completed, the block finance model will be updated.

Appendix 1 – National LTC data

NHS England, Long-term conditions (LTCs) infographic:[5]
https://www.england.nhs.uk/wp-content/uploads/2014/09/ltc-infographic.pdf

The below are national statistics for England taken for period 2014/19 and are designed to give a flavour of the national issue (working age adults).

- People living with a long-term condition are more likely to use health and care services.
- Of the people who report that they live with long term conditions, 24% have two LTCs and 20% live with three or more LTCs.
- 72% of people with long term conditions use their care plan to manage everyday health.
- 18% of people living with a long-term condition smoke.
- Long-term conditions account for:
    - 50% of all GP appointments;
    - 64% of all hospital outpatients appointments;
    - 70% of all hospital bed days; and
    - 70% of health and care spend.
- 64% of people living with long-term conditions, at present say they feel supported, so there is room for improvement.
- 5.4% of people with long-term conditions have a written care plan.

.2.5.i Employment of people with mental illness (formerly indicator 2.5):[6]

- People living with mental illness are less likely to be working, 51.6%, compared to the general population in employment, 77.1% (data for 2020 Q1).

.2.2 Employment of people with long-term conditions:[7]

- People living with a long-term condition are less likely to be working, 66.3%, compared to the general population in employment, 77.1% (data for 2020 Q1).

Smoking prevalence in adults with a long-term mental health condition (18+) – current smokers (GPPS):[8]

- The smoking prevalence in adults with a long-term mental health condition (18+) was 26% (Data for 2019/20).

[5] https://www.england.nhs.uk/wp-content/uploads/2014/09/ltc-infographic.pdf
[6] 2.5.i Employment of people with mental illness (formerly indicator 2.5) - NHS Digital
[7] 2.2 Employment of people with long-term conditions - NHS Digital
[8] Public health profiles - OHID (phe.org.uk)

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Appendix 2 – National Context

NHS England, Enhancing the Quality of Life for People Living with Long-Term Conditions (LTCs):[9]

- About 26 million people in England have at least one LTC.
- Ten million have two or more LTCs, 1 million with frailty, 0.5 million at end of life.
- There's a three-fold increase in cost of health care for those with frailty.
- 15% of young adults aged 11-15 have an LTC.
- Only 59% of people living with LTCs are in work, compared with 72% of the general population.

Institute for Public Policy Research, Patients in Control – Why people with long-term conditions must be empowered (September 2014):[10]

- Over three-quarters of respondents (77%) from a survey of over 2,500 people with long-term conditions thought that more of their ongoing health problems could and should be managed independently at home – including more than seven in 10 people who use clinical services frequently. Only 3% rejected the idea.
- Three-quarters (75%) of respondents agreed or somewhat agreed with the proposition that if they had better information and support they could become more expert at self-managing more of their care independently at home. People under 40 were more likely to agree with this statement than people over 40, and people on lower incomes more likely to strongly agree than others.

Department of Health, Long-term conditions: compendium of information: Third Edition (May 2012):[11]

- Fifteen million people in England have one or more long-term health conditions, and the number of people with multiple conditions is rising.
- The Department of Health states that 'around 70% of the total healthcare spend in England is attributed to caring for people with long-term conditions' and 'people with long-term conditions account for 50 per cent of all GP appointments.
- The majority of people aged over 65 have two or more long-term conditions; the majority of over 75s have three of more; and overall, the number of people with multiple conditions is rising.

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[9] PowerPoint Presentation (psnc.org.uk)
[10] patients-in-control_Sept2014.pdf (ippr.org)
[11] Long Term Conditions Compendium of Information: Third Edition - GOV.UK (www.gov.uk)

Appendix 3 - The Local Context

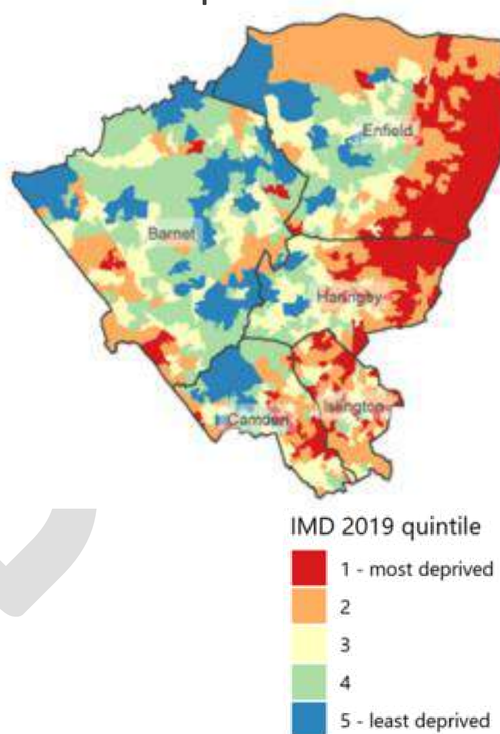
North Central London has a population of about 1.5 million people which pre-Covid was expected to increase by 3% by 2026, with the largest growth among those over 65. The population is relatively young, with more adults under 30 than other areas. Historically there has been a lot of migration, nationally and internationally. Population estimates will have been impacted by Covid-19 and Brexit. The 2021 Census will be able to provide some assessment of this impact.

Haringey, Islington and Enfield have on average, higher rates of deprivation compared to London, but the patterns of deprivation are different. While more affluent on average, there are areas of deprivation in Camden and Barnet too.

More than half of NCL residents are White, with around 20% Asian and 20% Black. Barnet and Camden have larger Asian communities, whereas Haringey and Enfield have larger Black communities.

Across North Central London there is a high level of population health needs and inequalities. This is driven by a high level of deprivation among some communities, affecting all aspects of people's lives from their childhood, education, employment, income, and housing. For some communities, the intersectionality between ethnicity and deprivation can be important too with an additional impact on health and wellbeing.

Deprivation



MHCLG, IMD 2019

Main underlying causes of early death in NCL are cardiovascular disease, cancer and respiratory diseases, with those living in the most deprived communities in NCL have a 50% higher death rate from avoidable causes of death compared to the NCL average. For cardiovascular disease, there are also clear ethnic inequalities with Black communities more

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likely to die prematurely from preventable (e.g. smoking cessation) or treatable (e.g. atrial fibrillation detection) causes.

Those living with serious mental health illnesses and learning disabilities also experience large inequalities, as do the homeless. For example, the death rate for those with serious mental illness in Camden and Islington is three times higher than the rest of the population. The direct and indirect impacts of Covid-19 have starkly highlighted these inequalities, including the inequities in access to health services and patient experience through the Covid vaccination programme - uptake is lower for some ethnicities and areas of higher deprivation.

Across NCL there are about 88,000 people living with diabetes, 33,000 with heart disease and 21,000 with serious respiratory disease (COPD). Nearly 6,000 new cancers are diagnosed each year. Unadjusted for age, Enfield has higher prevalence of long-term conditions and a higher incidence of cancer. Barnet has a higher prevalence of chronic kidney disease and heart disease.

The wider determinants of health are critical for health and wellbeing too. Islington, Haringey and Enfield have higher rates of unemployment. Air pollution levels are high in Camden, Haringey and Islington. Homelessness rates are highest in Haringey and Barnet.

	Long-term Conditions						
	England Average	London Average	Barnet	Camden	Enfield	Haringey	Islington
Diabetes (17+)	7.1%	6.8%	6.6%	4.0%	10.0%	6.5%	4.8%
Chronic Kidney Disease (18+)	4.0%	2.4%	3.3%	1.9%	3.3%	2.0%	1.7%
Hypertension	14.0%	11.0%	12.0%	9.5%	16.0%	11.0%	8.8%
Coronary Heart Disease	3.1%	1.9%	2.4%	1.4%	2.8%	1.6%	1.4%

Fingertips 2018-2020

Significantly BETTER than London average
Significantly WORSE that London average

Proportionately more older people live alone in Barnet, which may mean they are more likely to be socially isolated.

Fuel poverty is highest in Haringey and Enfield, making it difficult for older people to keep warm and well in colder months.

Moderate or severe frailty prevalence is highest in Islington and Camden, with Islington also having higher rates of alcohol admissions among older people.

So what is the above telling us

1. Variation in demographics, ethnicity and deprivation means the workload for implementation of this specification will vary across general practices, PCNs and boroughs
2. Inequalities need to be reduced through consistency of implementation of this specification across general practices, PCNs and boroughs
3. Need to reduce both morbidity and mortality for those in most deprived areas of NCL through systematic implementation and delivery of the specification.

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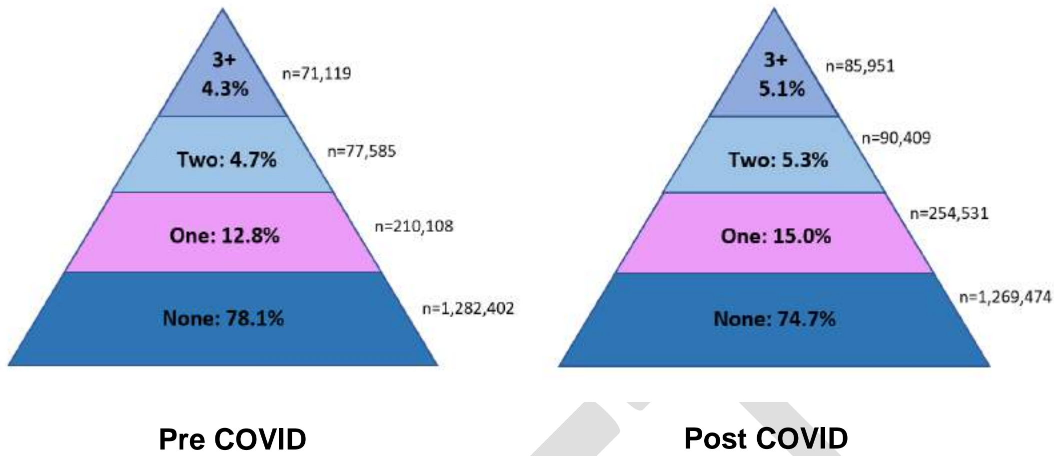
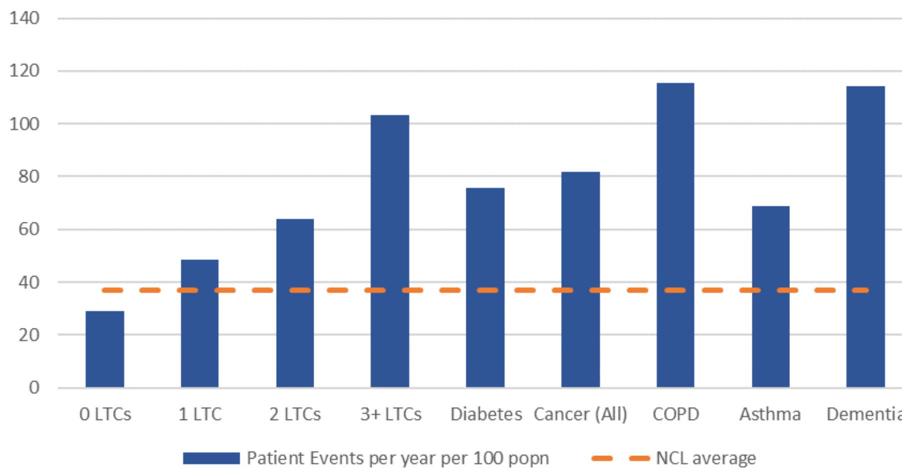
Changing patterns in health and care utilisation in North Central London:[12]

- Across NCL there has been a 3.4% increase in the percentage of people with long term conditions.



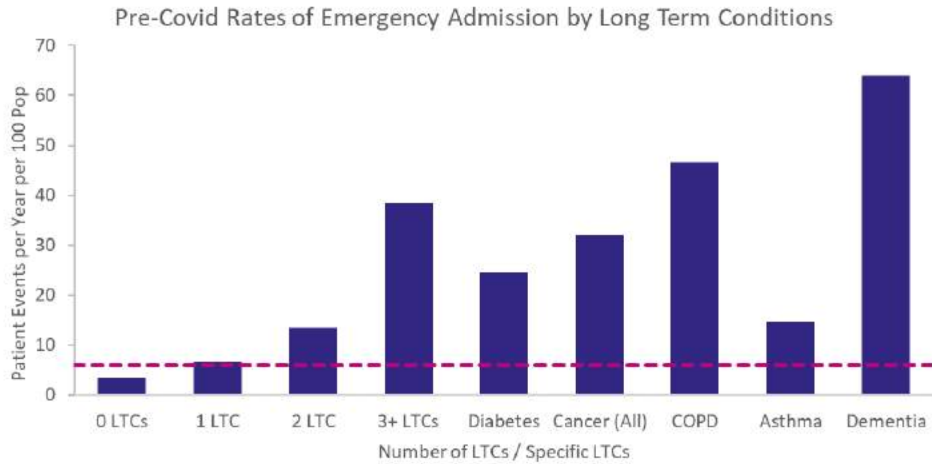
Pre COVID **Post COVID**

- Average numbers of A&E attendances substantially increases with increasing levels of morbidity, reaching 1 attendance for every person with 3 or more long-term conditions each year.
- Attendances are particularly high for those with COPD and dementia.

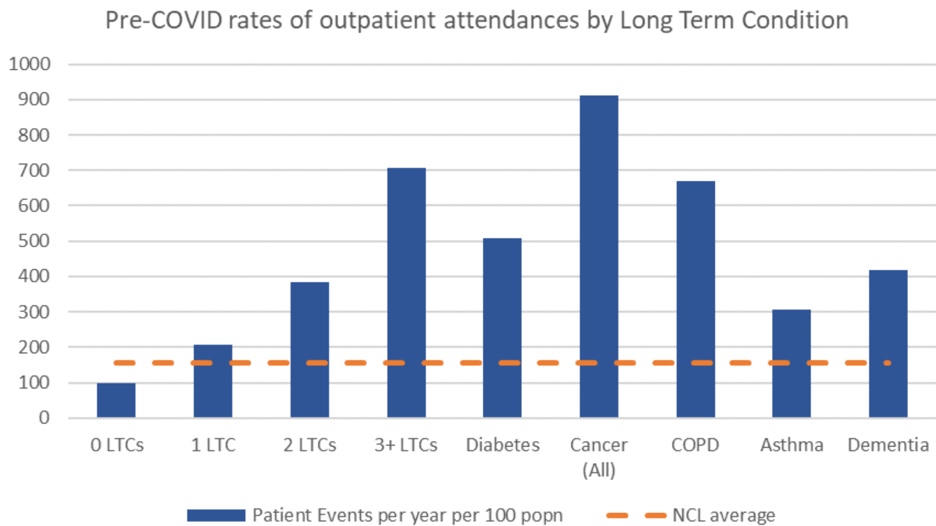


- The number of long-term conditions a patient has is a strong predictor of healthcare utilisation: the emergency admission rate for those with no long-term conditions in the pre-Covid period was 3.5, compared with 38.5 for those 3 or more long term conditions.
- Among patients with specific long-term conditions, those with dementia have very high admission rates, of over 60 per 100.

[12] Healthcareutilisation_FIRSTOUTPUT_FINAL



- The number of long-term conditions a patient has is a strong predictor of healthcare utilisation, the outpatient appointment rate almost doubling for each condition a patient has, reaching 7 appointments per annum for those with 3+ long term conditions.
- Of the specific conditions reviewed, highest appointment rates were for Cancer and COPD. For every person with cancer (on GP disease registers) there were an average of 9 appointments per annum pre Covid.



Appendix 4 – The Case for change

Within NCL, LCSs were largely commissioned by borough-based CCGs, prior to the CCGs merging and before the pandemic. There is variation in the commissioning and delivery of the services, from a universal offer designed around achieving outcomes, to multiple individual specifications, and in the scope and focus of LCS in NCL. Nationally, QOF has demonstrated the improvements in the management of people with long-term conditions however it is increasingly recognised that we need to review this approach. https://www.england.nhs.uk/wp-content/uploads/2018/07/quality-outcome-framework-report-of-the-review.pdf

Over the past decade we have seen a considerable focus on the proactive management of long-term conditions and personalisation nationally, moving away from the 'medical model' of illness towards a model of care which takes into account the expertise and resources of the people with LTCs and their communities. This will help to provide a holistic approach to their care and lives and help them achieve the best outcomes possible (***Year of Care. Report from the Findings of the Pilot Programme, DoH, 2011, Delivering Better Service for People with Long-Term Conditions. Building the House of Care, Kings Fund, 2013***).

One of the barriers recognised to changing the paradigm of long-term conditions care and support has been the lack of personalised care and support planning where patients are regarded as central to the planning process and where that planning process builds on what's important to them in their lives.
https://www.england.nhs.uk/ourwork/patient-participation/patient-centred/planning/
https://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/What-is-personalised-care-and-support-planning/

Personalisation and Personal Care and Support Planning has been further emphasised in the 2022/23 priorities and operational planning guidance NHSE/I 2021.
https://www.england.nhs.uk/wp-content/uploads/2021/12/B1160-2022-23-priorities-and-operational-planning-guidance.pdf

It sets out how, working with people with lived experience and partners in local government and the voluntary and community sector, we will systematically implement the Comprehensive Model for Personalised Care to reach 2.5 million people by 2023/24 and then aiming to double that again within a decade(by 2028/29)".

Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences. It recognises that personalised care is central to a new service model for the NHS, including working through primary care networks, in which people have more options, better support, and properly joined-up care at the right time in the optimal care setting.

This shift represents a new relationship between people, professionals and the health and care system. It provides a positive change in power and decision-making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities.

The ***Comprehensive Model for Personalised Care*** has been co-produced with people with lived experience and a wide range of stakeholders and brings together six evidence-

based and inter-linked components, each of which is defined by a standard, replicable delivery model. The components are:

1. *Shared decision making*
2. *Personalised care and support planning*
3. *Enabling choice, including legal rights to choice*
4. *Social prescribing and community-based support*
5. *Supported self-management*
6. *Personal health budgets and integrated personal budgets.*

The evidence base for personalised care demonstrates a positive impact on people, professionals and the system. Shared decision making about tests, treatments and support options leads to more realistic expectations, a better match between individuals' values and treatment choices, and fewer unnecessary interventions.
From tracking over 9,000 people with long-term conditions across a health and care system, evidence has shown that people who are more confident and able to manage their health conditions (that is, people with higher levels of activation) have 18% fewer GP contacts and 38% fewer emergency admissions than people with the least confidence. The evidence of the impact of personalised care continues to grow. Personalised care also has a positive impact on health inequalities, taking account of people's different backgrounds and preferences, with people from lower socio- economic groups able to benefit the most from personalised care (***Universal Personalised Care. Implementing the Comprehensive Model, NHSE 2019)***

There is therefore a national driver for personalised care and support planning to be mainstreamed in primary care, and personalised care and support plans to be rapidly expanded to 2.5 million people with long-term conditions and complex needs and that this is very much sited in the integration agenda for Integrated Care Boards.

The BMJ have stated that personalised care and support planning is

a reproducible and practical model of planned care applicable to all LTCs, with the capacity to be transformative for people with LTCs and health care professionals. It recaptures relational dimensions of care with transactional elements in the background.

and that

Care planning is a systematic approach which can help reshape current routine care and address these issues. Focused on supporting a more productive conversation between the person and the healthcare professional, it emphasises preparation work by both as an important enabler. The conversation is forward looking, solution focused, starts with 'what matters' to the person and values their role within it. It brings together traditional clinical issues and the person's lived experience as a 'meeting between experts'. It can also provide links to health supporting activities within the wider community. This new way of working involves changes to attitudes, roles, consultation skills, clinic administration and infrastructure being introduced simultaneously.

Across Scotland approximately 15% of general practices are now adopting care and support planning as their usual way to deliver care for people with long-term conditions. Practices have stated that " w*e embedded the approach pre-pandemic and the ethos stood us in good stead throughout. It has also given us structure as we move forward out of the pandemic. It aligns well with the new roles in primary care and the 'more than medicine' focus offers opportunities to work with our link workers* (The House of Care. The newsletter of the Year of Care Community of Practice, Oct 2021).https://www.yearofcare.co.uk/newsletters

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Appendix 5 - Case Finding

Details of the case finding element to be included once finalised.

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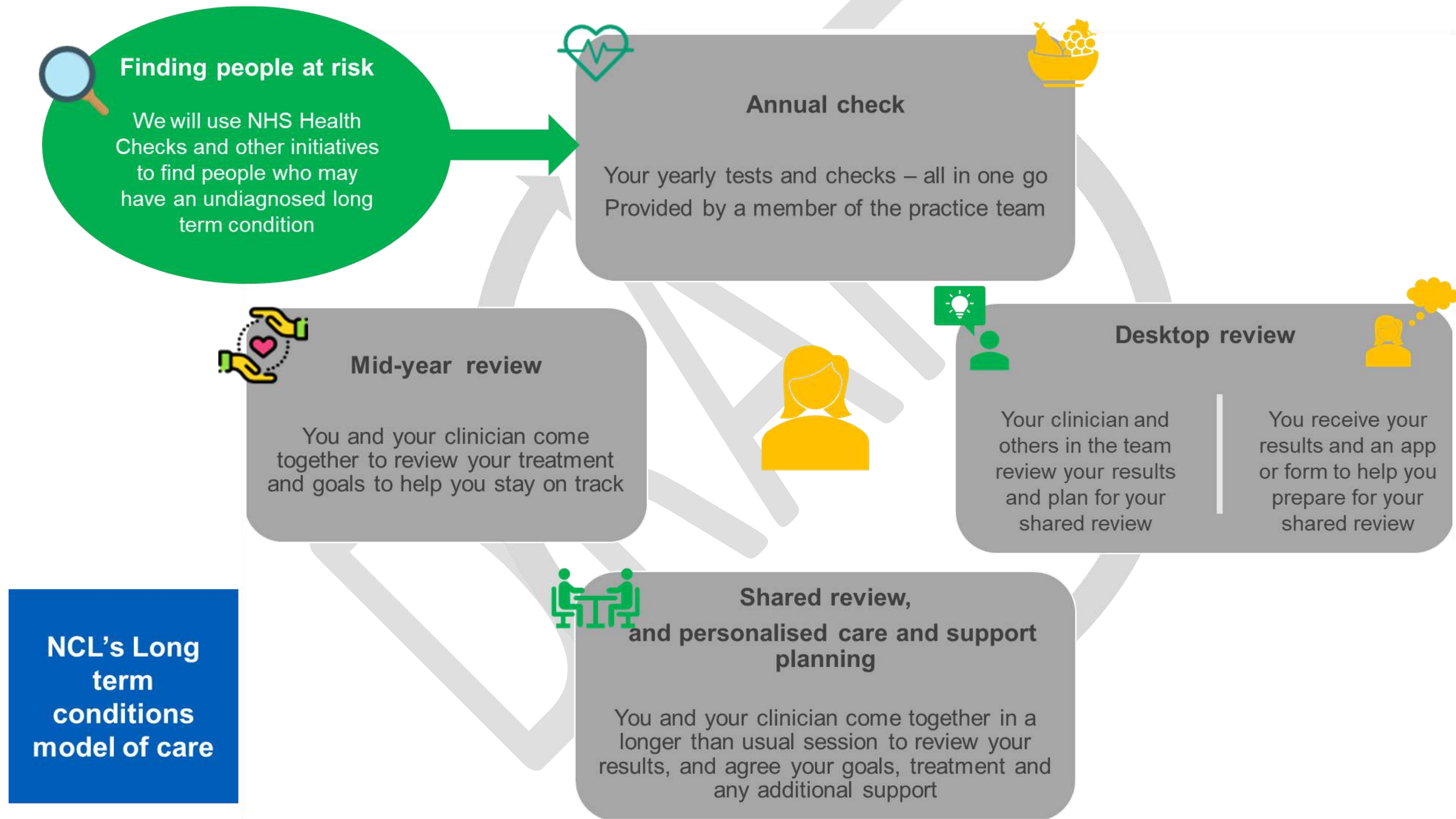
Appendix 6 - NCL's Long-term conditions model of care

The model of care from the patient's perspective:



North Central London
Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee
21 April 2022

Report Title	Commissioning Decisions on PMS Agreement Changes	**Date of report**	28 March 2022	**Agenda Item**	3.1
Lead Director / Manager	Paul Sinden, NCL Chief Operating Officer	**Email / Tel**	p.sinden@nhs.net		
GB Member Sponsor					
Report Author	GP Commissioning & Contracting Team	**Email / Tel**	nlphc.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	The Committee is asked to **NOTE** one change and where indicated to **APPROVE** 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*				

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1 Executive summary

The below table summarises the Agreement Changes requested by PMS Practices in NCL. Committee members are 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 01/01/2022	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
E83039 Ravenscroft Medical Centre	Barnet	5642	Barnet PCN 5 with a combined list size of 58153	24 hour retirement of Dr Barry Subel	Practice has requested the 24 hour retirement of Dr Barry Subel leaving 1 contractor on the agreement during the 24 hour retirement **Practice provision** GP appointments 408 GP sessions 22 Nurse appointments 173 Nurse sessions 9 **Recommended guide** GP appointments 407 GP sessions 22 Nurse appointments 181 Nurse sessions 10 There is a small shortfall in nursing provision and the practice has advised they are currently in the process of trying to recruit an additional nurse. The practice have also advised they employ a practice Pharmacist for 3 sessions per week.	To approve
F85640 Cheshire Road Surgery	Haringey	6323	Haringey North Central with a combined list size of 40793	Addition of Dr Thomas	Practice has requested the addition of Dr James Thomas increasing the total contractors to 3 on the agreement. **Practice provision** GP appointments 365 GP sessions 22 Nurse appointments 208	To approve

Practice	Borough location	List Size 01/01/2022	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
					Nurse sessions 16 **Recommended guide** GP appointments 456 GP sessions 24 Nurse appointments 203 Nurse sessions 11 There is a shortfall in GP provision the practice have advised Dr Thomas is currently providing 4 sessions and will be increased to 6 when he joins the contract. The practice also offer 40 Physician Associate and 32 Pharmacist appointments per week. The practice is also in the process of recruiting a full time prescribing pharmacist in May who is completing the ANP course to help assist with urgent care access.	
F85688 Rutland House Surgery	Haringey	11,243		Removal of Dr John Demades	Practice has requested the removal of Dr John Demades leaving 2 individuals on the PMS agreement. **Practice provision** GP appointments 867 GP sessions 51 Nurse appointments 116 Nurse sessions 11 **Recommended guide** GP appointments 810	

Practice	Borough location	List Size 01/01/2022	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
					GP sessions 43 Nurse appointments 360 Nurse sessions 19 There is a shortfall in nursing provision the practice have advised they are in the process of recruiting a full time nurse to increase provision.	

North Central London
Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee Meeting
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Report Title	Lichfield Grove Surgery- Request to revert from a PMS agreement to a GMS contract	**Date of report**	6 April 2022	**Agenda Item**	3.2
Lead Director / Manager	Colette Wood – Director of Integration for Barnet	**Email / Tel**		Colette.wood1@nhs.net	
GB Member Sponsor					
Report Author	GP Commissioning & Contracting Team	**Email / Tel**		nlphc.lon-nc-pcc@nhs.net	
Name of Authorising Finance Lead	*Not Applicable*	**Summary of Financial Implications** *Not Applicable*			
Report Summary	Lichfield Grove Surgery in Barnet have requested to revert their PMS agreement to a GMS contract from 01 July 2022. Under the PMS Regulations (2015) part 7, PMS contract holders can exercise their right to request to revert their PMS agreement to a GMS contract. They are required to provide 3 months' notice from the date, they wish the GMS contract to commence. The practice has requested the GMS contract commence from 01 July 2022. Under the regulations the CCG is required to ensure the individual's signatories to the contract are eligible to hold the GMS contract (Section 86 of the NHS Act 2006 and Regulations 4 & 5 of the NHS GMS Regulations), including the requirement to provide essential services. In summary the eligibility criteria to hold the GMS contract is; - Individual (signal hander) - Partnership (with one partner being a medical practitioner) - Company limited by shares (with at least one share being beneficially owned by a medical practitioner) - Contractor must provide essential services				

	- Subject to national disqualification or suspension - Dismissal from any employment by a health service body - Any convictions - Bankruptcy - Fraud The above is not the full list of eligibility as set out in the GMS regulations and NHS Act, this is assessed as part of the due diligence carried out by the primary care contracting team. Further assurance has also been sought on the following and appendix A contains the template due diligence form, the practice was to asked to complete; 1. Individuals who wish to be signatory to the GMS contract 2. Contracting form the individuals wish to hold the contract (i.e. partnership, company etc) 3. Partnership agreement will be in place (not operating as a partnership at will) 4. Details of the company and shares (if opting to be a company limited by shares) 5. Confirmation that the relevant insurance and indemnity is in place prior to the change 6. Confirmation whether the contract will be held as a Health Service body (provides an option for disputes to be referred to NHS Resolution) 7. If applicable, any contractual performance notices issued under the PMS agreement will be transferred to the GMS contract Where it is found that the individual (s) do not satisfy the conditions to hold a GMS contract under the NHS Act and GMS Regulations, the CCG is required to notify the practice in writing, and the contract holders are entitled to appeal the decision. The process to revert the PMS agreement to a GMS contract requires the CCG to terminate the existing PMS agreement and issue a new GMS Contract. There will be no significant material or financial difference by issuing the new GMS contract, the only changes will be the annual national regulation / contract changes, included in the new GMS contract. PMS agreements are varied annually to include the national regulation changes. The practices also have to confirm that they will deliver the essential services as set out within the new GMS contract. The Primary Care Finance team have confirmed that there are no financial difference from a PMS to a GMS contract. The contract budgets will be based on Global Sum, plus payments for the Quality outcome Framework (QOF), Directed Enhanced Services (DES's), Localised Commissioned Services (LCS) etc. Lichfield Grove Surgery currently has two signatories to the PMS agreement with a patient list of 6496 at January 2022. They will hold a contract as a Partnership and have provided confirmation that a partnership agreement will be in place at the time of reversion. The practice has also provided

	relevant insurance and indemnity insurance information. From the practice declaration there were no concerns identified regarding the eligibility to hold the GMS contract.
Recommendation	The Committee members are requested to **NOTE** and **APPROVE**; 1. The due diligence that has been carried out 2. Individual(s) signatory to the PMS agreement meet the eligibility criteria to hold the GMS contract 3. The PMS agreements will be terminated 4. New GMS contracts will be issued with no material or financial changes
Identified Risks and Risk Management Actions	There have been no concerns identified and contract holders meet the eligibility criteria to hold the GMS contract. The contract budget and service delivered will not be changed during the process of terminating the PMS agreement and issuing a new GMS contract.
Conflicts of Interest	*Not Applicable*
Resource Implications	*Not Applicable*
Engagement	There will be no service change, therefore patient and stakeholder engagement has not been carried out
Equality Impact Analysis	There will be no service change, therefore an equality impact assessment has not been carried out
Report History and Key Decisions	*Not Applicable*
Next Steps	If approved the PMS agreements will be terminated and a new GMS contract issued.
Appendices	

Appendix A

REQUEST TO TRANSFER FROM A PMS AGREEMENT TO A GMS CONTRACT

Under the **PMS Agreement Regulations (2015), Part 7,** the contractor may request to transfer to a GMS contract by sending a notification to the CCG in writing at least **THREE MONTHS** before the date on which it wishes the general medical services contract to be entered into. Please complete all parts of the form below

1. Contract holder details

1.1 **Please list the names of the contract holders under the existing PMS agreement**

Applicant Name (s):	

1.2 **Practice Details**

Practice Name	
Practice Code	

2. Impact on Contract

2.1 **Date of change**

Please state the date below you wish to terminate your existing PMS Agreement and exercise your right to enter in to a GMS contact ***(Effective date must be at least three months from the date of notice)***

2.2 **Type of contract - Please mark 'x' in the appropriate box:**

Partnership		Singlehanded	

2.3 **Please give the name of the person(s) with whom the contractor wishes the Commissioner to enter into a GMS contract (a person's name may only be given in a notice if that person is a party to the PMS agreement) *Please refer to Appendix 1 (2.12.3) 5. Conditions relating to solely to medical practitioners*.**

	General /Limited
	General /Limited
	General /Limited
	General /Limited
	General /Limited

2.4 **Please confirm that the person(s) named in question 2.3 above meet the conditions set out in Section 86 of the NHS Act 2006 (persons eligible to enter into GMS contracts) and Regulations 4 & 5 of the NHS GMS Contract Regulations 2015 (appendix A) or, where the contractor is not able to confirm, the reason why it is not able to do so and confirmation that the person(s) immediately prior to entering into the GMS contract will meet those conditions.**

Details	

2.5 **Please confirm the contracting form that the individual(s) will hold the GMS contract (i.e. partnership, company limited by shares etc)**

2.6 **If a partnership, confirm that an agreed signed partnership agreement will be in place, prior to or on commencement of the GMS contract.**

2.7 **If the proposed contracting body will be a company limited by shares, please provide a complete breakdown of share ownership.**

Names of Shareholder:	Signature	% of shares held:

2.8 **Has the company been registered on companies house, if yes provide the registration number**

2.9 **Do you wish to be considered as a 'Health Service Body'? For the purpose of populating the new GMS Contract. (Please see appendix 2) Please mark 'x' in the appropriate box:**

Yes				No	

2.10 **Practices are required to have a nominated lead for Clinical Governance (IG). Could you please provide details of your nominated Clinical Governance Lead?**

Details	

2.11 **Please confirm you have or will have (for the proposed new entity) all relevant insurance and indemnity requirements in place prior to contract signature – please mark ‘x’ in the appropriate box:**

Insurance category:	Name of insurance company	Policy no.	Expiry Date	Amount of cover (£)	Name of staff member
Professional indemnity					
Employers liability					N/A
Public liability					N/A

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Report Title	The Town Surgery – Request to Novate a PMS Agreement	**Date of report**	5 April 2022	**Agenda Item**	3.3
Lead Director / Manager	Deborah McBeal, Director of Integration, Enfield	**Email / Tel**		d.mcbeal@nhs.net	
GB Member Sponsor					
Report Author	Usha Banga	**Email / Tel**		u.banga@nhs.net	
Name of Authorising Finance Lead	*Not Applicable*	**Summary of Financial Implications** *Not Applicable*			
Report Summary	The Town Surgery PMS Agreement is held by three GPs. The practice has a list size of 4,525 patients (January 2022). The contract holders have requested to Novate their PMS Agreement to a company limited by shares. The current contract holders are directors of the company who propose to hold the contract, under the name The Town Surgery Limited – which is a company limited by shared and will trade as The Town Surgery. The process of a contract novation requires commissioners to terminate the current PMS contract and issue a new PMS Agreement under a direct award to the three existing contract holders, who will hold the new company limited by shares. The CCG as part of this process is required to demonstrate that the direct award of the new PMS Agreement is not breaching procurement regulations. There will not be a change to the terms and value of the new contract. There will not be a reduction in service provision The CCG have undertaken due diligence of the application and supporting documentation provided and there were no concerns were identified. The practice have carried out engagement with patients registered on the list and the CCG has written to stakeholders. A full summary of results and analysis of the outcome from the patient engagement will be presented to the June 2022 committee to note.				

Recommendation	The Committee members are requested to **APPROVE** the; 1. Termination of the PMS Agreement 2. Issue a new PMS Agreement by direct award to The Town Surgery Limited - a company limited by shares.
Identified Risks and Risk Management Actions	*Not Applicable*
Conflicts of Interest	*Not Applicable*
Resource Implications	*Not Applicable*
Engagement	The practices engaged with their patients and full summary results and analysis of the outcome from the patient engagement shall be presented to the June committee to note.
Equality Impact Analysis	An EIA was undertaken, the results of which will be presented to the June PCCC to note.
Report History and Key Decisions	*Not Applicable*
Next Steps	If approved by PCCC the PMS Agreement will be terminated and a new PMS Agreement will be issued to The Town Surgery Limited.
Appendices	*Not Applicable*

Recommendation

Committee members are requested to approve the;

1. Termination of The Town Surgery PMS Agreement
2. Issue a new PMS Agreement by direct award to The Town Surgery Limited - a company limited by shares.

Background and Due diligence - Contract Novation

The process of contract novation requires the CCG to terminate the existing PMS Agreement and issue a new PMS Agreement to the Town Surgery Limited, which is a company limited by shares, and whose directors and shareholders are the 3 GPs who hold the current PMS Agreement.

As part of the due diligence the contract holders submitted an application to novate their PMS Agreement and provide supplementary evidence for the following, of which no concerns were identified.

- Companies House certification detailing all the directors
- Articles of association
- Breakdown of the share ownership
- Details of the proposed contractor
- Name of Indemnity Insurer and the policy number
- Whether any of the Directors had been convicted of;
    - Conspiracy
    - Corruption
    - Bribery
    - Fraud
    - Money laundering
    - Any other offences

- Whether any of the medical practitioners employed have, during the last three years had their professional registration removed or suspended, including whether they were under investigations
- Benefits to patients
- Confirmation there will be no change to services provided to patients.

To not breach procurement regulations as part of the contract novation process the CCG has to ensure that there is no material change to the PMS Agreement, services delivered and its current value. The new PMS Agreement will contain all the National regulations amendments from 2004, there will be no other amendments and changes added by the CCG.

Benefits following the contract novation

As part of the due diligence process the contract holders were required to confirm how they will maintain and improve access for existing and new patients. A summary of some of the key themes and points from the practices application have been provided below:

- All the clinicians, reception staff and administrators will remain at the practice to support patients.
- The practice will continue to provide the same level of GP access and opening times with view to increase this in the future.
- The practice will seek to expand access to more allied health professionals (AHP) such as Paramedic, Pharmacist, Physician Associates and social prescribing service.
- The practice boundary will remain the same.
- The Practice will offer specialist services such as coil removals, weight management and long-term condition reviews.
- Provide telephone consultations to support patients who are unable to attend the practice during normal working hours.
- All patients will have a named GP who supports them in whatever setting they live, whether it is at home or in a care home or supported living scheme.
- Provide home visits and urgent appointments for those with enhanced needs.
- There will be a medicines delivery service for housebound patients via local specific pharmacists.
- Patients with a long-term condition will receive an annual review to check their health and medicines needs are being appropriately met.
- The practice will offer transparent information on service it offers including prescribing policy, opening hours and limitations of the service.
- To enhance consultation pathways and access to the surgery via the eConsultation service, AccuRx text and video messaging service as well as providing regular face to face consultations.
- To enhance the phlebotomy services for the benefit of our patients, especially the elderly or disabled who cannot access the hospital service easily.
- To enhance the paramedic home visiting service, Smoking cessation clinics, medication reviews by Pharmacists and Care co-ordination via a dedicated member of staff.

Patient and Stakeholder Engagement

The Practice have engaged with patients, including letters being sent to vulnerable groups to seek their views.

The contract holders prepared the engagement questionnaire and EIA and shared the information via:

- Practices’ website
- Posters in waiting areas and entrance
- Paper surveys
- Text messages
- Letters to housebound, over 65’s and learning disabilities register
- Dedicated time to take calls

- PPG

In addition Commissioners had engagement with stakeholders on the practice's proposal to novate their PMS Agreement.

A full summary of results and analysis of the outcome from the patient engagement will be presented to the June 2022 committee to note.

Next Steps

If approved by PCCC the PMS Agreement will be terminated and a new PMS Agreement will be issued to The Town Surgery Limited.

North Central London
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Report Title	Belsize Priory Medical Practice - relocation	**Date of report**	12 April 2022	**Agenda Item**	3.4
Lead Director / Manager	Simon Wheatley Director of Integration - Camden Directorate	**Email / Tel**	simon.wheatley2@nhs.net		
GB Member Sponsor					
Report Author	Anthony Marks	**Email / Tel**	anthony.marks@nhs.net		
Name of Authorising Finance Lead	Tracey Lewis, Head of Finance Anthony Browne, Director of Finance Strategic Commissioning	**Summary of Financial Implications** The current practice rent of £68,050 will reduce to £21,167 (subject to occupancy space negotiated and District Valuer confirmation) Associated legal and Stamp duty costs do not fall to the CCG.			
Report Summary	The report sets out the case for the relocation of a GMS contract, Belsize Priory Medical Practice from 208 Belsize Road, London, NW6 4DX, to a new build development approximately 100 metres away on Belsize Road. The list size for Belsize Priory Medical Practice is 4,941 as of 1 January 2022 As part of the Abbey development, Camden council is developing a new health centre in order that the surgery can move out of the current location which will demolished for housing units as part of a wider council regeneration scheme. The Abbey development phase 3 will bring further living accommodation and commercial units which will cause an increase in local population, expected to be 141 additional homes. The new building has no space allocation to store the patient's paper notes. Funding has been secured for offsite storage, but the practice will need full digitisation as soon as possible as the new facility was designed without paper notes storage. The building will be used to house the GP practice and community services provided by CNWL. The practice currently operates from 6 clinical and treatment rooms and has been allocated 5 clinical and treatment rooms in the new building. The Department of Health (DH) Health Building Notes Estimator (HBN) tool calculates at (1) 80% utilisation of the patient list, (2) 6 contacts per annum, (3) 15 minute consultations and (4) number of appointments per week, which exceeds the BMA guidance of 72 GP and 32 nursing appointments per week, which allows for a wider workforce operating in the practice.				

	The DH HBN tool indicates that the combined practice size requires 5 clinical and treatment rooms. This gives a patient to room ratio would be 1:989. The practice is expected to occupy 31% of the new building. The practice has secured an NHS grant from central funds to cover the cost of: - Specialist healthcare surveyors to advise on the new lease - Legal fees - Stamp duty land tax - Contribution towards locum costs - Moving to the new building - Equipment - Transferring patients' paper notes into digital format as there is no space to store the notes at all. In addition the fit out costs for the new building will be covered by the ETTF grant secured. The current rent is £68,050 with the new proposed rent for the entire building to be £67,500. Based on the current proposed practice occupancy this would be an annual rent of £21,167. The final figure will be subject to confirmation of the floor are split between the practice and CNWL. The head-lease in the current building is held by CNWL however the practice will sign a lease directly with Camden Council (the overall landlord) in the new building. Leases are in the process of being drafted and rent reimbursement will be subject to District Valuer confirmation.
Recommendation	The Committee is asked to **APPROVE** the 1. Relocation of Belsize Priory Medical Practice to the new Belsize Road site 2. Provisional rent of £21,167 per annum premises reimbursement subject lease and DV confirmation)
Identified Risks and Risk Management Actions	Patient resistance to moving to new health centre Mitigation: 1. New health centre is 100 metres away from current site 2. Engagement with patients who raise any issues 3. Improved physical access and facilities at the new site
Conflicts of Interest	*Not Applicable*
Resource Implications	Reimbursable premises costs of £21,167 pa subject to lease and DV confirmation above costs for the current site
Engagement	Initial engagement undertaken as part of the Abbey redevelopment scheme. Patient engagement to follow commencing 9 May 2022 for 4 weeks
Equality Impact Analysis	The practice to conduct prior to relocation
Report History and Key Decisions	*Not Applicable*

Next Steps	Practice to undertake patient engagement with results presented to committee in June 2022. Form a task and finish group to complete the mobilisation of the practice to the new location. Issue contract variation notice
Appendices	*Not Applicable*

1.0 Recommendation

The committee is asked to approve the

- Relocation of Belsize Priory Medical Practice to the new Belsize Road site
- Provisional rent of £21,167 per annum premises reimbursement subject lease and DV confirmation)

2.0 Background

The practice is located in a purpose built health centre on Belsize Road constructed in 1976. It is on the first floor of a building with a ramp and external separate lift access into the floor plate. The practice is above retail units with high rise residential accommodation above.

The GMS contract has 4,941 registered patients (as at 1 January 2022) and uses 6 consultation and treatment rooms. The CCG has been in discussion with Camden Council about plans to redevelop the local area and to provide a new modern health centre.

The Department of Health (DH) Health Building (HBN) space estimator notes that the practice requires 4 clinical and treatment rooms giving a room to patient ratio of 1:1236

3.0 Abbey Road redevelopment

The Abbey Road development centred on the junction of Abbey Road and Belsize Road was approved by Camden council in 2013. The development was planned in three phases:

Phase 1: 141 new homes completed in March 2019
Phase 2: building a new two storey health and community services centre, open spaces, car parking, and road layout changes (currently underway due for completion in July 2022)
Phase 3: the existing health centre site will be demolished, replaced with housing and the project completed.

Currently the practice has been allocated 5 clinical rooms in the new health centre. The practice is attempting to renegotiate this to 6 rooms so that they can continue to be a training practice. The registered list size has increased since the initial designs.

In the new building, no space has been allocated for the storage of patient's paper notes. Funding has been secured for offsite storage, but the practice will need full digitisation.

4.0 Engagement

As part of the Abbey Road development Camden Council has undertaken engagement. Engagement with patients will happen prior to the practice relocation. The practice will begin engagement 9 May 2022 for 4 weeks and the results of the engagement and equality impact

assessment will be presented to committee in June 2022. Commissioners will work with the practice to ensure that any patient issues that are raised are addressed.

4.0 Rental change

The current rent reimbursement is £68,050 per annum and the new facility will have an overall rental charge of £67,500. This figure will divided between the tenants CNWL (69% occupancy) and Belsize Priory Medical Practice (31%). The new annual rent will be £21,167

The rent is subject to lease and confirmation by the District Valuer (DV). Associated legal and Stamp Duty Land Tax liabilities are covered by a grant from the NHS which will not fall to the CCG. Further to this the £350,000 fit out costs for the new building have been secured under ETTF funding route.

5.0 Next steps

A task and finish group will be formed to complete the mobilisation of the practice to the new location.

Contract variation notice will be issued with the new site address.

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Report Title	Direct Payments for practices for reimbursable premises costs	**Date of report**	12 April 2022	**Agenda Item**	3.5
Lead Director / Manager	Deborah McBeal, Director of Integration, Enfield Simon Wheatley, Director of Integration, Camden	**Email / Tel**		d.mcbeal@nhs.net simon.wheatley2@nhs.net	
GB Member Sponsor					
Report Author	Vanessa Piper	**Email / Tel**		vanessa.piper@nhs.net	
Name of Authorising Finance Lead		**Summary of Financial Implications** No financial implications The practices will continue to be reimbursed under the existing agreed premises costs			
Report Summary	Community Health Partnership (CHP) is a landlord of primary and community health buildings and NCL CCG currently has 12 practices whom are tenants within CHP buildings. CHP has approached NCL CCG to request if the CCG can consider paying the reimbursable costs via Direct Payments, to address the issue of the funds not being received on a regular monthly basis and to prevent practice debts from accumulating. The terms of the NHS Premises Costs Directions (2004) amended 2013, the regulations for primary care premises, states in summary that Direct payments can be considered if the contractor and the CCG agrees. Direct payments though can only be applied to practices whom have no debts and have a signed lease in place and the three practices listed below fall into this category. • Chalfont Medical Practice – Enfield • Boundary Court Surgery – Enfield • James Wigg Practice – Camden By setting up direct payments the CCG does not take on any liability for the following;				

	- Non reimbursable costs charged by CHP - Lease or any of its terms - Practice accounting with CHP for the reimbursable costs The three practices have been written too and have been requested to share their views on whether they are in agreement for direct payments to commence pending referral to the NCL PCCC. A copy of the signed lease has also been provided by the practices. The practices were also notified that the CCG would not become liable for the non-reimbursable costs, lease terms and the practice accounting relating to the reimbursable costs. If the PCCC members were in agreement to direct payments, then the contract holders will be required to sign a Section 52 agreement which is the terms of the NHS Premises Directions related to the Direct Payments.
Recommendation	Request committee members to **APPROVE** the setup of Direct payments for the following practices; 1. Chalfont Medical Practice – Enfield 2. Boundary Court Surgery – Enfield 3. James Wigg Practice – Camden
Identified Risks and Risk Management Actions	The practices have been notified that the CCG would not become liable for the lease, non-reimbursable costs and the practice accounting with CHP for the reimbursable costs
Conflicts of Interest	*Non Applicable*
Resource Implications	The practices will continue to be reimbursed under the existing agreed premises costs
Engagement	*Not Applicable*
Equality Impact Analysis	*Not Applicable*
Report History and Key Decisions	The PCCC members approved in April 2021 for the four practices below to be reimbursed by Direct payments; • Hanley Road Primary Care Centre – Islington • The Partnership Practice – Islington • Queenswood Medical Practice – Haringey • The Morris House Group Practice – Haringey
Next Steps	If PCCC members approve the commencement of direct payments, then the practices will be notified of the following; 1. PCCC approval of direct payments 2. When the reimbursement costs payments will cease to the Practice 3. The commencement and method of direct payments to CHP 4. Request each contract holder to sign a section 52 agreement which relates to the terms set out in the NHS Premises Costs Directions
Appendices	None

Background

Community Health Partnership (CHP) has approached North Central London (NCL) Clinical Commissioning Group (CCG), to request if the CCG can consider paying the reimbursable costs via a Direct Payment to CHP, for all practices who occupy their buildings.

The reason for the request from CHP is to ensure reimbursable costs are received regularly on a monthly basis and to prevent a practice debt accumulating, which has been occurring for some NCL and other practices across London.

Direct payments for reimbursable costs can only be agreed for practices that have no debts and have a signed lease with CHP.

The reimbursable costs relate to the following;

- Lease Rent
- Non-Domestic Rates
- Water and sewage
- Clinical waste

Under the Premises Cost Directions 2004 (amended 2013), it allows for Direct Payments to be considered but must be agreed by the contractor and the Board (NCL Primary Care Commissioning Committee).

Part 6, section 52, of the Directions states the following;

52. (1) Where a contractor and the Board agree, the Board must pay any amount that is due to the contractor as financial assistance under these Directions to a third party instead of the contractor, subject to a condition that the contractor ensures that it treats the payment for accounting purposes as a payment to it.

(2) If, (a) the payment from the Board to the third party is less than the amount that is due from the contractor to the third party; and

(b) The contractor is due other payments from the Board as financial assistance under these Directions which are greater than or equal to the amount of the shortfall,

Where the contractor and the Board agree, the Board must pay all or part of those other payments to the third party instead of to the contractor, subject to a condition that the contractor ensures that it treats the payment for accounting purposes as a payment to it.

NCL Practices - Tenants of CHP buildings

NCL currently has 12 practices that occupy CHP buildings and committee members in April 2021 approved four practices to commence Direct payments. The 3 practices below have requested to proceed to Direct payments and the remaining 5 practices are where there are debts or no lease in place and the CCG primary care, estates and finance leads have been working with CHP to resolve these issues.

Practices referred to the April 2022 PCCC meeting for Direct payments

- Chalfont Road Surgery – Enfield
- Boundary Court Surgery – Enfield
- James Wigg Practice – Camden

Responsibility for non-reimbursable costs

The CCG is not liable to pay the non-reimbursable costs. Therefore the contract holders have been notified that they will be required to continue to liaise with CHP to receive a copy of their annual statement, so they are aware of the non-reimbursable costs required to be paid to CHP.

Liability of the Lease and its terms

If the contract holders and PCCC members agree to the process of direct payments, the contract holders have been notified that the CCG does not take on any liability for the lease held between the practice (tenant) and CHP.

The practice will still need to meet its obligations under the lease terms. Negotiate a new lease if it is due to expire and to ensure all non-reimbursable costs are paid to CHP.

The practice will be able to view the direct payments of the reimbursable costs on Exeter. Therefore under the lease terms the practice will be responsible for maintaining is own accounts and ensuring the premises charges are settled by year end with CHP. Any irregularities in the payments for reimbursable costs the practice will then be required to liaise with the CCG.

Next steps

If PCCC members approve the commencement of direct payments, then practices will be notified of the following;

- PCCC approval
- When the reimbursement costs payments will cease to the Practice
- The commencement and method of direct payments to CHP
- Request each contract holder to sign a section 52 agreement which relates to the terms set out in the NHS Premises Costs Directions

North Central London
Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee
21 April 2022

Report Title	Lawrence House Practice & Spur Road Surgery Merger	**Date of report**	12 April 2022	**Agenda Item**	3.6
Considered at	**Part 1**☒ Part 2 ☐ Urgent decision ☐				
Lead Director / Manager	Rachel Lissauer	**Email / Tel**	r.lissauer@nhs.net		
GB Member Sponsor					
Report Author	Honorine Focho, – Senior Primary Care Commissioning Manager	**Email / Tel**	Honorine.focho@nhs.net		
Name of Authorising Finance Lead		**Summary of Financial Implications** *Not Applicable*			
Report Summary	This paper sets out the case for Committee members to approve the merger of a Primary Medical Service (PMS) Agreement at Lawrence House Surgery (list size 15,523) and a General Medical Service (GMS) Contract, at Spur Road Surgery (list size 2,116). The proposed merger will take effect from 01 July 2022. The Lawrence House Surgery (107 Philip Lane, London N15 4JR) Agreement would continue while the Spur Road Surgery (1 Spur Road, London, N15 4AA) contract terminate. The Spur Road Surgery's premises will become a branch of Lawrence House Surgery. The PMS practice is in Primary Care Network (PCN) 6 (Haringey-Welbourne) while the GMS practice is in PCN 5 (Haringey N15/South East Haringey). The merger of these practices will mean a change of PCN core membership. PCN 5 will formally apply for the change in core membership and this will be presented to committee in June 2022. The merging practices combined list size is 17,639 as at 1 January 2022. The practices will operate from 13 clinical rooms across the two sites and the distance between the practices is 0.5miles (9 minutes walking distance). The providers have informed commissioners that in future, they will explore the feasibility to relocate operations from the Spur Road to 107 Philip Lane and close the Spur Road branch. Commissioners will be working closely with the providers to give required support to explore this option. **Benefits of the merger to patients** The providers have proposed that the merger will have a wider range of services for patients to choose from, improved access with extended hours services				

	provided on an additional day a week, as well as increased GP and nurses appointments. Patients will be able to access GP services from both sites. **Practices' Catchment Areas** The Partners have confirmed that the practices' catchment areas will not change post-merger. **GPIT Costs** There are no GPIT costs associate with this merger. **Patient engagement and Equality Impact Assessment** The Partners have engaged with patients, including vulnerable groups to seek their views about the merger through the various ways: • Putting up posters at the reception about the merger; • Online and paper based surveys; • Via the practice's websites; • Text messages and letters have been sent to patients about the merger; and • The partners have also been working with the Patient Participation Groups from both practices to listen, answer any queries and take in account patients' views and opinions. A full summary and analysis of the outcome from the patient engagement and equality impact assessment will be presented at June 2022 committee to note.
Recommendation	Committee members are asked to **APPROVE** the: • Merger of a PMS Agreement (Lawrence House Surgery) with GMS Contract (Spur Road Surgery) and terminating the GMS contract.
Identified Risks and Risk Management Actions	*Not Applicable*
Conflicts of Interest	*Not Applicable*
Resource Implications	*Not Applicable*
Engagement	The practices have engaged with their patients and results and analysis of the outcome from the patient engagement will be presented at June committee to note.
Equality Impact Analysis	An equality impact assessment has been carried out. Analysis will be presented at June committee to note.
Report History and Key Decisions	*Not Applicable*
Next Steps	If PCCC members approve the case, commissioners will meet with both practices to plan the merger.
Appendices	None

Recommendation

Committee members are asked to approve commissioners' recommendation for the merger of a PMS Agreement (Lawrence House Surgery) with GMS Contract (Spur Road Surgery). The PMS Agreement will be varied and the GMS contract terminated.

Background

Lawrence House Surgery (PMS) and Spur Road Surgery (GMS) Partners have requested to merge their agreement/contract, with the GMS contract terminating. Two of the Lawrence House Surgery's partners are the contract holders of the GMS contract and both partners will continue with the new merged Agreement. The practices propose the merger takes place 01 July 2022.

The Lawrence House Surgery is located at 107 Philip Lane, London N15 4JR and Spur Road Surgery is at 1 Spur Road, London, N15 A44. Both practices are situated in Tottenham Green ward in the London Borough of Haringey with a distance of 0.5 miles (9 minutes walking) between the sites.

After the merger, the partners propose that GP services will be provided from both sites with Spur Road Surgery site becoming a branch of Lawrence house Surgery.

The partners have informed commissioners that in future, they will explore the feasibility to relocate operations from the 1 Spur Road to 107 Philip Lane and close the 1 Spur Road branch. Commissioners will be working closely with the partners to provide required support to explore this option. The practices currently operate out of 13 combined clinical rooms as presented on the table below:

Category	Lawrence House Surgery	Spur Road Surgery	Combined Analysis
Total Clinical rooms	11	2	13
Total list sizes at January 2022	15,523	2,116	17,639

The last Care Quality Commission (CQC) inspections rated both practices overall 'Good'.

Strategic case for the merger

The practices' catchment areas will not change as a result of the merger.

The patients currently registered at both practices will benefit from:

- Improved Access to more GPs and nurses appointments; an additional extended hours clinic; and access to GP services from both sites;
- Longer opening hours from 8am - 8:30pm on Tuesdays and Wednesdays;
- A wider range of services ranging from Chronic disease clinics to baby clinics, family planning, diabetes, Asthma clinics etc.;
- A training practice with education and training ethos; which allows for recruitment and retention.

Clinical capacity and appointments offered

The practices currently offer the following:

<table>
<tr><td colspan="2">Category</td><td>Lawrence House Surgery</td><td>Spur Road Surgery</td><td>Combined Analysis</td></tr>
<tr><td rowspan="3">Appointments</td><td>GPs</td><td>1160</td><td>170</td><td>1330</td></tr>
<tr><td>Nurses</td><td>680</td><td>70</td><td>750</td></tr>
<tr><td colspan="3">Total Appointments Offered from both sites</td><td>2,080</td></tr>
<tr><td rowspan="3">Sessions</td><td>GPs</td><td>102</td><td>11</td><td>113</td></tr>
<tr><td>Nurses</td><td>57</td><td>5</td><td>63</td></tr>
<tr><td colspan="3">Total Sessions Offers from both sites</td><td>176</td></tr>
</table>

- Lawrence House Surgery: 1160 GP and 680 Nurse appointments per week = 1840 ppointments per week
- Lawrence House Surgery: 102 GP and Nurse 57 sessions per week = 159 sessions per week

- Spur Road Surgery: 170 GP and 70 Nurse appointments per week = 240 appointments per week
- Spur Road Surgery : 11 GP and 5 Nurse sessions per week = 16 sessions per week

The combined list size is 17,639 (as at January 2022). Based on the list size and the BMA guidance of 72 GP and 32 nurse appointments per 1000 patients. The practices are required to offer the following recommended appointments for the combined list size:

- 1271 GP appointments, 67 sessions per week
- 583 Nurse appointments, 31 session per week
- Total number GP & Nurse per week = 1854 appointments and 98 sessions per week

The Partners are proposing that they will offer the following to the merged list:

- 1350 GP appointments, 123 sessions per week
- 800 Nurse appointments, 70 session per week
- Total number GP & Nurse per week = 2150 appointments and 193 sessions per week.

On review of the number of appointments being offered, commissioners can confirm this in line with and above the BMA recommended guidance of 72 GP and 32 nursing appointments per 1000 patients /week

Patient Engagement

An equality impact assessment and patient survey has been carried out by both practices.

The Partners have engaged with patients, including vulnerable groups to seek their views prior to the merger. Both practices worked together to prepare communication to patients, including:

1. PPG Chairs to prepare patient questionnaire for the merger and to produce Equality Impact Assessment (EIA).
2. Disseminate/signpost the merger questionnaire and EIA to patients via:

    - Posters in waiting rooms
    - Online and paper surveys;
    - Links the practice's websites;
    - Letters sent to vulnerable patients;
    - Text messages;
    - The partners have also been working with the Patient Participation Groups from both practices to listen, answer any queries and take in account patients' views and opinions.

A full summary results and analysis of the outcome from the patient engagement shall be presented to the June 2022 committee to note.

Next Steps

If committee members approve the merger, commissioners will meet with the practices to convene a project group to complete actions and facilitate the merger.

Results of the engagement and equality impact asse4ssment will be presented to committee in June 2022.

North Central London Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee Meeting
21 April 2022

<table>
<tr><td>Report Title</td><td>Additional facility in Somerset Gardens health centre</td><td>Date of report</td><td>4st April 2022</td><td>Agenda Item</td><td>3.7</td></tr>
<tr><td>Lead Director / Manager</td><td>Rachel Lissauer</td><td>Email / Tel</td><td colspan="3">r.lissauer2@nhs.net

07967 312224</td></tr>
<tr><td>GB Member Sponsor</td><td colspan="5"></td></tr>
<tr><td>Report Author</td><td>Owen Sloman</td><td>Email / Tel</td><td colspan="3">owen.sloman@nhs.net
0203 688 2728</td></tr>
<tr><td>Name of Authorising Finance Lead</td><td>Bahi Jayadevan

bahi.jayadevan1@nhs.net</td><td colspan="4">Summary of Financial Implications

Minimal:
• The Elective Programme Recovery Board, EMT and System Management Board have approved a grant of £91k for the development of Somerset Gardens in support of the Proactive Integrated Teams initiative.
• Practice will provide a further £46k in line with NHS Premises Cost Directions.
• The GP Partners and landlord have confirmed they would not seek rent reimbursement for the first ten years.
• The likely cost of the space after those ten years is £18k based on the rental value of the rest of the health centre.</td></tr>
<tr><td>Report Summary</td><td colspan="5">The Elective Recovery Programme Board, EMT and System Management Board has given Somerset Gardens practice £91k to develop unused loft space into a meeting facility for the Proactive Integrated Teams (PIT) initiative. PITs bring together a wide range of professionals to go through the elective waiting list and identify patients who require specific initiatives. East Haringey has been seen as the vanguard area for the PIT work. Once built, the facility will also be used for practice and other visiting staff as a base for administrative and telephone work and be available for other practices. The capital investment also includes a lift from the ground to the first and second floor and will support disabled staff access.

The proposed development is part of a number of investments in the planned Somerset Gardens building. Winter Access Funding will allow for a staff room to be converted into two booths for telephone consultations. The Haringey team has also prioritised Somerset Gardens in the Improvement Grant process, and this would bring in further investment to modernise the estate.</td></tr>
</table>

Recommendation	The Committee is asked to **APPROVE** that Somerset Gardens practice can develop and then operate from the space.
Identified Risks and Risk Management Actions	Risk of not securing Improvement Grant funding; This would impact on the overall modernisation of the practice but not on this initiative which is stand alone.
Conflicts of Interest	None.
Resource Implications	Capital allocation already given and has been transferred to practice. No rental increase for the first ten years. Likely rental increase of £18k a year subsequently.
Engagement	None - though consistent feedback from patients that access to this practice is challenging. Developing the estate to improve access is critical.
Equality Impact Analysis	Somerset Gardens is located in North East Haringey, one of the most deprived areas in North Central London. Improving access through the development of the practice building is incredibly important. Haringey has been shaping the Proactive Integrated Teams initiative around the needs of its most vulnerable patients. The PIT funding also includes provision for a lift from the ground floor to the first and new second floor, and this will make it easier for disabled staff to work for the practice.
Report History and Key Decisions	Elective Recovery Programme Board approved £91k from Proactive Integrated Team funding to support this facility on 28st February. The decision was confirmed in EMT on 1st March and System Management Board on 2nd March 2022.
Next Steps	Building works to start, linked to confirmation of approval of Improvement Grant funding.
Appendices	Practice PID

Appendix 1

NCL

Project Initiation Document for Procurement & Development of Primary Care Premises by GP Contractors

PRACTICE NAME & CODE	F85030 SOMERSET GARDENS FAMILY HELTH CARE CENTRE
PRACTICE ADDESS	4 CRIEGHTON ROAD LONDON N17 8NW
BRANCH SITE **If the practice has a branch site provide the** - Address - Distance from the main site - Number of clinical and consulting rooms in the branch site	N/A
BRIEF SCHEME DESCRIPTION	This is to provide a new room in the loft area to provide space across the borough. In the first instance this will be used to continue to develop the Proactive Integrated Team initiative. Locally driven supporting and problem solving across a multidisciplinary team This will also provide a modern digital space for local training and development.
LOCATION & ADDRESS OF THE NEW PREMISES Please confirm the travel distance to the new site (if applicable)	N/A
CURRENT SPACE OCCUPIED Include the total number of clinical rooms (consultation and treatment rooms) Total square metres occupied	17 treatment rooms 203.5sq.m 2nd floor extension 31.3sq.m
CURRENT RENT REIMBURSED	£116250

Include the current rent that is being reimbursed	
ADDITIONAL SPACE REQUESTED If additional space or rooms are being requested please set this out	This is a new space by using wasted space in the loft. The building was built to be able to hold another working area in the loft.
BRANCH & MAIN SITE If the practice has a branch site confirm if the additional space is being requested in the main and / or branch site	N/A
CURRENT PRACTICE LIST SIZE Include the current raw list size	13400
PRACTICE AREAS Please confirm if there will be any change in the practices catchment area	We are very sympathetic to patients who wish to register that live outside our Tottenham catchment area.
NUMBER OF GPS AND CLINICAL SESSIONS Include the WTE GPs employed, number of sessions and appointments offered per week	WTE GPs- 6.5
NUMBER OF NURSES AND CLINICAL SESSIONS Include the WTE of nurses employed, number of sessions and appointments offered per week	1.5 Advanced Clinical Practitioner 6 sessions 50 appts. 2 WTE Practice Nurses 20 sessions 360 appts. 1 WTE Trainee Nurse Associate 10 Sessions 150 appts. 0.5 Health Care Assistant 6 sessions 90 appts
NUMBER OF OTHER PRACTICE STAFF Include the WTE of other practice staff employed, number of sessions and appointments offered per	20 WTE

week	
TYPE OF APPOINTMENTS OFFERED Provide the percentage of appointments that are offered remotely and face to face per week	Remotely 50% We use dr. First system F2F 70%
Remote working across staff Provide the percentage of the practice workforce that will be required and has the ability to work remotely	5 (OFF SITE) All staff to have option
CONFIRM IF THERE IS LEASE IN PLACE Include the length of the lease and term remaining	N/A
STRATEGIC NEED Set out if there is a strategic case for this change	A modern with multimedia space is required to review patients as part of an MDT to ensure that patients on an active waiting list with LTC & SMI are appropriately reviewed. This will provide space across the borough. In the first instance this will be used to continue to develop the Proactive Integrated Team initiative. Locally driven supporting and problem solving across a multidisciplinary team This will also provide a modern digital space for local training and development
BENEFIT TO PATIENTS Set out the benefits to patients from the change	Patients on the active waiting list will have an holistic assessment by the MDT Each patient will be discussed and medication optimised if required. Delay in appts can be addressed. Patients with language barriers will have access to trained interpreters. Any special requirements such as hearing or speech extra needs will be supported.
CONFIRM THE PRACTICE OPENING HOURS If the practices closes during or ½ day what access improvements will be made, to bring the	Monday 8.00-18.30 Extended Hours7-8 am Extended Access 18.30-20.30 Tuesday 8.00-18.30 Extended Hours 7-8 am Extended Hours 7-8 am Extended

opening hours in line with core hours Revision of the workforce could be include here	Access 18.30-20.30 Wednesday 8.00-18.30 Extended Hours 7-8 am Extended Hours 7-8 am Extended Access 18.30-20.30 Thursday Extended Access 18.30-20.30ursday 8.00-18.30 Extended Hours 7-8 am Extended Hours 7-8 am Friday 8.00-18.30 Extended Hours 7-8 am Extended Hours 7-8 am Extended Access 18.30-20.30 Saturday Extended Access 8.00- 20.00 Sunday Extended Access 8.00-20.00
BENEFIT OR IMPACT TO OTHER LOCAL PRACTICES / PCN Factors to take into consideration are if there will be any changes to the practice boundary, where the practice will be located too, changes PCN payments etc	N/A
BENEFIT TO COMMMISSIONERS Set out what strategic, financial and other benefits will be realised	Reduction of DNAs from hospital appts. This will reduce the burden in hospitals and create better value. Available to other practices

COST ESTIMATES (Inc. VAT) If capital is required and the practice has already sought quotes submit a copy of any costs	90K Plus vat and architects costs.
CAPITAL COSTS Set out whether there is any capital implications for	90K

the request For example - Building work - Compliance improvements - Equipment - IT equipment - Cabling	
REVENUE Confirm what the change in rent will be - Existing - Expected new rent	Existing= Rent £116250 New rent for new space of 31.3sq.m will have rent of £17,880 per annum abated for 10 years
KEY RISKS	

ENDORSED BY:		
LEAD GP(s) **(As Business case Applicant)**	**Organisation**	**Somerset Gardens Family Health Care Centre**
	Name	**Dr Bastianpillai** **Marion Lombardelli Managing Partner**
	Signature	*Dr Bastianpillai* *Marion Lombardelli*
	Date	**11/03/2022**
FOR COMMISSIONER USE ONLY		
CCG DIRECTOR OF FINANCE / CHIEF FINANCIAL OFFICER	**Organisation**	
	Name	
	Signature	

	Date	
NCL HEAD OF PRIMARY CARE	**Organisation**	
	Name	
	Signature	
	Date	
NHS PROPERTY SERVICES REGIONAL DIRECTOR **(Assuring technical content of the Business case)**	**Name**	
	Signature	
	Date	
OTHER (Please specify)	**Organisation**	
	Name	
	Signature	
	Date	

PRIORITISATION (For Contracting Team use only)	

North Central London
Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee
21 April 2022

Report Title	Change to Islington PCN composition	**Date of report**	6 April 2022	**Agenda Item**	3.8
Lead Director / Manager	Clare Henderson	**Email / Tel**	clare.henderson4@nhs.net 020 3688 2945		
GB Member Sponsor					
Report Author	Phil Wrigley	**Email / Tel**	pwrigley@nhs.net 07736 298 633		
Name of Authorising Finance Lead	Tracey Lewis tracey.lewis9@nhs.net 020 3688 1728	**Summary of Financial Implications** No additional expenditure. However, the Finance and borough primary care teams will need to align budgets and staff to new PCN footprints.			

Report Summary

Islington has had five PCNs since May 2021 when the largest grouping, North PCN, split into two. At that point the two new PCNs were named North 1 PCN and North 2 PCN.

- Andover Medical Practice has now signalled its intention to leave North 1 PCN in order to join North 2 PCN
- 1st of May is requested as the date of transition. The split is amicable and has been agreed by all practices in North 1 and North 2.
- Islington Primary Care team is working closely with the two North PCNs, the LMC and Primary Care contracting colleagues, to support this transition
- Whilst Islington overall has an even combination of affluence and deprivation across the whole borough, it is generally considered that the North locality has the greatest deprivation across a wide footprint
- Changes to the PCN will even out the list sizes between the PCNS:

	Currently (weighted)	Post transition (weighted)
North 1	63,434	56,958
North 2	54,242	60,719

Recommendation

PCCC is asked to confirm **APPROVAL** of the new PCN structure which will take effect from 1st May 2022.

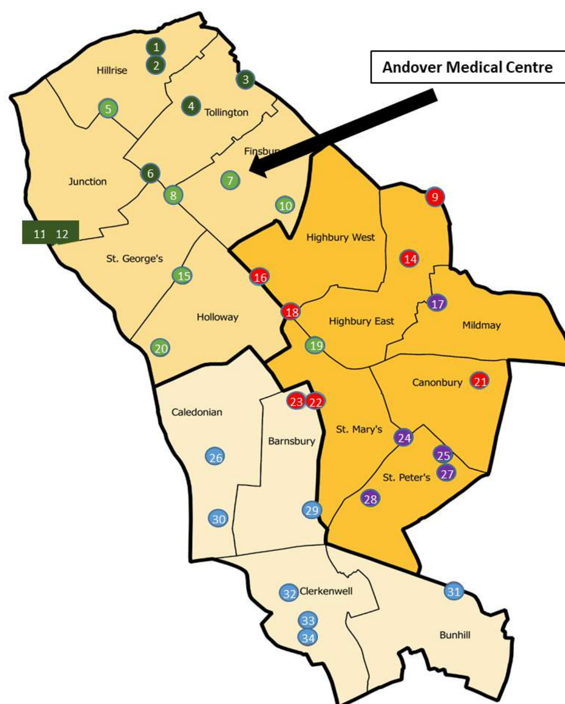
Identified Risks and Risk Management Actions

The primary care team will work with the LMC and practices on a "breakaway settlement" that addresses any historical issues (finance, workforce, etc.) with regard to the transition. An MOU outlining all elements of the change will be drafted to ensure a smooth transition

In addition, the Islington Primary Care team will work with Finance and contracting colleagues to revise budget statements for the new year.

Conflicts of Interest	None
Resource Implications	Need to confirm split of additional roles team members and adjust budget envelopes for 2022/23.
Engagement	• LMC • Andover Patient And Public Participation Group • North 1 and North 2 member practices
Equality Impact Analysis	Patients in both PCNs should not be aware of any change in service provision. Patients in all practices will continue to benefit from the additional roles that have been in place within each PCN. The withdrawal of Andover from North 1 PCN will have no impact on allocation of ARRS roles within the PCN as there is currently an underspend on ARRS in this PCN N1 patients will continue to be covered by the existing ARRS roles – no change for patients in the remaining practices. Andover patients may potentially benefit from a differing variety of ARRS roles in North 2 PCN.
Report History and Key Decisions	15th March – Andover Medical Practice confirmed to the North 1 Clinical director its intention to leave the PCN from 1st April 2022 (the practice was informed that the deadline was not achievable and a new deadline was agreed later subject to PCCC approval) 6th April – Transition meeting between N1, N2, Federation and CCG to discuss mitigation of contracting, funding and workforce risks and issues. Separate finance meetings to be scheduled with finance leads later in April and May.
Next Steps	Primary Care Network change form to be completed by both parties and submitted to contracting team.
Appendices	None

Map of Islington showing current PCN composition. North PCN details within table.



Key	Islington North Locality Practices	Practice List Size (March 2022)	Current PCN structure
10	The Village Practice	10480	North 1
5	St John's Way Medical Centre	12082	North 1
8	The Northern Medical Centre	9151	North 1
7	Andover Medical Centre	6034	North 1
20	Goodinge Group Practice	12471	North 1
19	The Family Practice (now merged with PPCC)	N/A	North 1
15	The Partnership Primary Care Centre	9207	North 1
6	Archway Medical Centre	18057	North 2
1	The Rise Group Practice	4828	North 2
3	Stroud Green Medical Clinic	6594	North 2
4	Hanley Primary Care Centre	11375	North 2
2	The Beaumont Practice	3298	North 2
11/12	The Junction Medical Practice	9431	North 2

The following table shows the changes in PCN composition

PCN	Current member practices	Weighted list size Jan 22	Change from 1st May 2022	Weighted list size Jan 22
North 1	Goodinge, St John's Way, Partnership Primary Care Centre, Northern, Village, Andover	63,434	Goodinge, St John's Way, Partnership Primary Care Centre, Northern, Village,	56,958
North 2	Archway, The Rise, Beaumont, Junction, Stroud Green, Hanley	54,242	Archway, The Rise, Beaumont, Junction, Stroud Green, Hanley, Andover	60,719

Other Islington PCNs: South PCN (list size 74,023), Central 1 (list size 59,877) and Central 2 (list size 43,820) are not affected by this proposal.

North Central London
Clinical Commissioning Group

North Central London CCG
Primary Care in Common Committee
21 April 2022

Report Title	Finsbury Leisure Centre/City Road Medical Centre - Islington Relocation Project	**Date of report**	12 April 2022	**Agenda Item**	3.9
Lead Director / Manager	Clare Henderson	**Email / Tel**	Clare.henderson@nhs.net		
GB Member Sponsor					
Report Author	Becky Kingsnorth, AD Primary Care - Islington Mike Stone, NCL Strategic Estates Lead – Haringey & Islington	**Email / Tel**	Rebeccakingsnorth@nhs.net Mike.stone@mstonepropertysolutions.co.uk		
Name of Authorising Finance Lead	Anthony Browne	**Summary of Financial Implications** PCCC are asked to approve: the conclusions of the Affordability model in relation to Islington which identifies that Finsbury Leisure Centre/City Road Medical Centre project is affordable, subject to the surplus revenue budget being utilised when the recipient borough has achieved the agreed voids reduction target. Finsbury Leisure Centre/City Road Medical Centre project is a proposed revenue only project, no NHS capital is required for construction works. There is a requirement for non-recurrent revenue to cover the items detailed below. To note the projected reduction in rent due to the injection of £1m+ S106 monies allocated to the project.				
Report Summary	In February 2022, the Committee received a paper on the affordability of planned estates developments across North Central London. The Committee approved the following Budget Principles: 1. Void reduction savings in the Primary Care budget will be retained within the Primary Care budget 2. Void reduction savings that reside in the Corporate Budget to be transferred to the Primary Care Budget 3. GP rationalisation savings that reside in the Primary Care budget to be retained within the Primary Care budget				

	4. Surplus revenue budget can only be utilised when the recipient borough has achieved the voids reduction targets agreed as pre-requisite for any funding to be made available to them 5. Surplus revenue budget in one borough within NCL may be deployed in another borough where there is a deliverable scheme and need for healthcare Next steps were to follow up with a more detailed separate financial paper which is being brought to April PCCC for sign off, of the financial implications of this policy at both NCL and local level. This more detailed affordability paper identifies the Finsbury Leisure Centre/City Road Medical Centre is affordable, subject to the surplus revenue budget being utilised when the recipient borough has achieved the agreed voids reduction target. The Affordability paper for Islington identifies there are three priority projects to be progressed and a fourth that has previously been approved by the Committee (Vorley Road). This covering paper relates to o the Finsbury Leisure Centre/City Road Medical Centre A separate April PCCC paper relates to o the Andover Medical Centre project Another paper will be developed for PCCC in June 2022 covering o the Highbury New Park/the Miller Practice scheme
Recommendation	The Primary Care Commissioning Committee is asked to: • **APPROVE** the relocation of City Road Medical Centre to the Finsbury Leisure Centre Development, noting the patient engagement that has been undertaken and a projected reduction in revenue costs due to the injection of £1m+ S106 monies allocated to the project. • **NOTE** the current rent reimbursed for City Road Medical Centre is £192,700 per annum (extracted from the CCG's affordability model data). The estimated rental value (ERV) for the new surgery within Finsbury Leisure Centre is £182,000 per annum. However, with the use of the Section 106 healthcare allocation, it will reduce the annual rental. The overall rent and reduction will be assessed by the District Valuer. • **NOTE** the CCG will undertake further design development with the Council (as developer and landlord), including a District Valuer sign off for the final rent and clarification of other reimbursements. • The GP IT costs have been estimated, based on a recent project within the ICS. The total GP IT capital costs are estimated to be £65,000 and the total revenue costs £7,500. These will be funded through separate budgets within the CCG. • Other estimated costs will include: - SDLT – say £25,000. - GP legal costs – £20,000 plus VAT - GP Project Manager - £30,000 plus VAT - GP Surveyor/engineer - £50,000 plus VAT

	• It is proposed that the SDLT and the other estimated costs above are funded from the Primary Care Delegated Budget. In total approx. £125,000 plus VAT. • The NHS NCL CCG PCCC is recommended to approve this Project Initiation Document for the planned investment and for the relocation of City Road Medical Centre practice to Finsbury Leisure Centre as part of LBI's planned redevelopment of this site.
Identified Risks and Risk Management Actions	• The practice's lease expires in 2024. The relocation project described in this paper are intended to secure accommodation for the future. • A short-term lease extension is being sought to align with the timelines of the developments, which is due to complete in 2025.
Conflicts of Interest	• None
Resource Implications	• Implications for projected capital and revenue spend are described above and in more detail in the papers.
Engagement	• Patient engagement has been undertaken in relation to the City Road relocation.
Equality Impact Analysis	• This relocation would see City Road move by 0.3 miles. Modelling shows that most patients will remain with the practice.
Report History and Key Decisions	• In February 2022, the Committee received a paper on the affordability of planned estates developments across North Central London and approved Budget Principles and next steps. • A more detailed financial paper is being brought to April 2022 PCCC for sign off of the financial implications of this policy at both NCL and local level. • This covering paper also for April 2022 PCC, links the Finsbury Leisure Centre/City Road Medical Centre to the Budget Principles paper approved in February 2022 and the more detailed financial paper also being presented at PCCC April 2022.
Next Steps	• To actively engage with the Practice and Council to progress these two projects. • To appoint the DV to negotiate the rental • Practices to appoint lawyers to negotiate heads of terms, prior to Agreements to Lease. • Design development so the Council can submit planning applications.
Appendices	• Finsbury leisure Centre/City Road Medical Centre

NHS England

TITLE OF SCHEME	RE-PROVISION OF CITY ROAD MEDICAL PRACTICE, ISLINGTON

SPONSORING ORGANISATIONS		NHS NCL CCG – Islington Directorate
CONTACT DETAILS		Becky Kingsnorth, AD Primary Care rebeccakingsnorth@nhs.net Mike Stone, NCL Strategic Estates Lead – Haringey & Islington Mike.stone@mstonepropertysolutions.co.uk

A. SCHEME DESCRIPTION

1. Service Needs for New GP Practice Premises

City Road Medical Centre (practice code F83064) is a high performing mid-sized GP practice, rated Good by CQC. Based at 190-196 City Road, EC1V 2QH, the practice is one of 7 delivering primary care services to the population of Islington South Primary Care Network (PCN).

The current GP premises are based on the ground floor of a leased property with residential units above. The GP premises are:

- Assessed as having insufficient capacity to accommodate current demand and projected increase in list size as a consequence of planned local housing developments.
- Not fit for purpose and not meeting current NHS design standards e.g., Health Building Notes (HBNs) and Health Technical Memoranda (HTMs);
- A 2016 six facet survey concluded overall condition rating and functionality rating as both being Category C[1]; and
- Not able to address future primary care needs or to accommodate the wider multidisciplinary team including Additional Roles Reimbursement Scheme (ARRS) roles (as assessed by the current PCN consultants Howarth Litchfield).

The City Road Medical Centre premises are located on a site owned by a Monopro Limited, a private landlord. City Road Medical Centre's lease for its occupation of these premises is due to expire in March 2024. As a consequence, there is a fundamental need to re-provide suitable accommodation, in order to maintain continuity of primary care service provision within the locality.

The vision for the practice's accommodation is to be large, flexible, modern, accessible and secure, to enable integration within the voluntary sector, peer support groups, employment and housing. Developing a new City Road Medical Centre would enable the vision by creating a modern hub to support multidisciplinary working and the integration of health and social care.

[1] For condition a 'C' rating is defined as operational but major repair or replacement will be needed soon (ie. within 3 years). For functional suitability a 'C' rating is defined as operational but major repair or replacement will be needed soon (ie. within 3 years)

The service needs for the new GP practice premises are fully aligned with national, regional and local strategic direction.

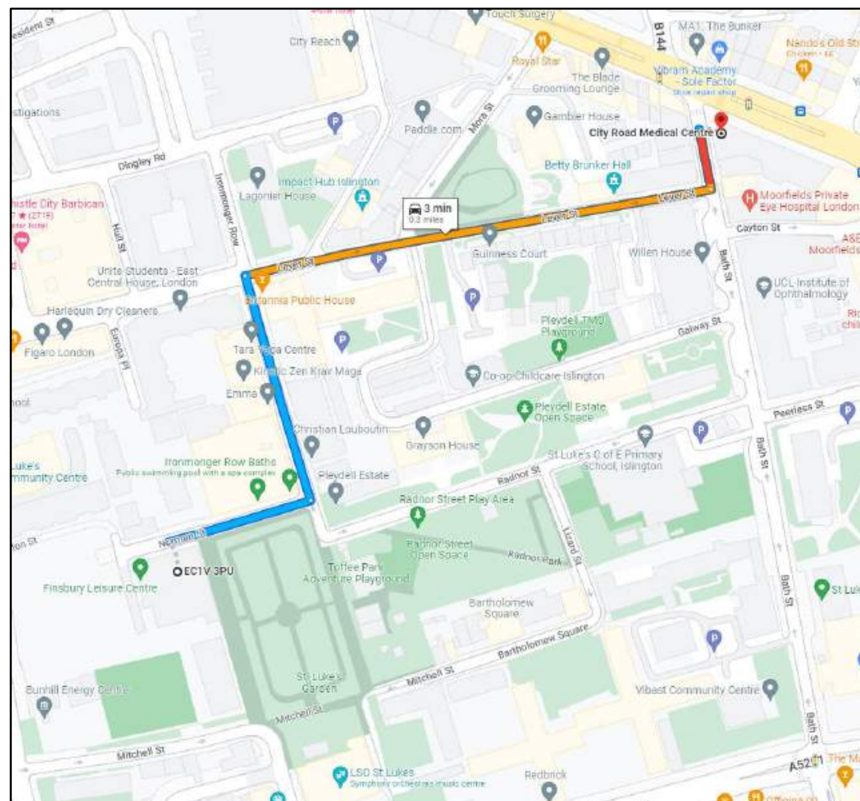
2. Preferred Option

Affordable land or existing buildings that can be adapted in Islington are extremely scarce and there are limited options to re-provide City Road Medical Centre. The preferred option is to re-provide the practice as part of London Borough of Islington (LBI)'s Finsbury Leisure Centre regeneration project. This regeneration project will comprise housing, a new leisure element and a GP surgery. This opportunity was identified in July 2015 and an expression of interest process identified City Road Medical Centre as the priority practice to move there. The planned works had been delayed however LBI are now ready to proceed with the process of developing the site.

Finsbury Leisure Centre is a Council owned building. The proposal is for LBI to retain the freehold and act as developer to redevelop the existing premises. LBI will retain the building and become City Road Medical Centre's landlord.

Figure 1 provides a map showing the existing location of the City Road Medical Centre, and the proposed new site. The proposed site is located 0.3 mile from the existing site and is within a 6 minute walk. The proposed relocation of City Road Medical Practice to Finsbury Leisure Centre would move the practice more towards the geographical heart of where the registered list resides with minimal expected negative impact from the relocation. This is graphically shown in Fig 7 on Page 8.

Figure 1: Site Map – Current and Proposed Locations



There is a potential timing issue as the GP practice's lease expires in March 2024 and the new surgery will not be complete until at least May 2025. The CCG will request the Practice negotiates a lease extension with its landlord to cover the additional lease term required. The terms of the extension will be signed off through the normal CCG process. Initial indications are the landlord would be conducive to an extension and negotiations have started.

The Council has appointed a consultant to procure on its behalf a design team to undertake initial site investigations, due diligence and to develop a feasibility study. This work will take place over the summer of 2022 with a view to applying for planning consent around December 2022. Following receipt of planning consent, a procurement process will

commence to appoint a Design & Build Contractor with a view to starting construction works around the autumn of 2023.

3. Stakeholder Engagement

The project has the in-principle support of:

- City Road Medical Centre contract holders
- City Road Medical Centre Patient Participation Group[2]
- NHS NCL CCG, Primary Care – Islington team
- LB Islington

4. Conclusions, Recommendations and Next Steps

The current rent reimbursed for City Road Medical Centre is £192,700 per annum (extracted from the CCG's affordability model data). The estimated rental value (ERV) for the new surgery within Finsbury Leisure Centre is £182,000 per annum. However, with the use of the Section 106 healthcare allocation, it will reduce the annual rental. The overall rent and reduction will be assessed by the District Valuer.

Other reimbursement costs to be business rates and clinical waste are to be determined.

The CCG will undertake further design development with the Council (as developer and landlord), including a District Valuer sign off for the final rent and clarification of other reimbursements.

Based on the ERV rental figure above, the Stamp Duty Land Tax (SDLT) calculation is £24,500.

The GP IT costs have been estimated, based on a recent project within the ICS. The total GP IT capital costs are estimated to be £65,000 and the total revenue costs £7,500. These will be funded through separate budgets within the CCG.

Other estimated costs will include:

- GP legal costs – £20,000 plus VAT
- GP Project Manager - £30,000 plus VAT (covering pre- and post-financial close work for the GPs and interfacing with Council's design team and contractor)
- GP Surveyor/engineer - £50,000 plus VAT (checking quality and assuring compliance and fit-for-purpose)

It is proposed that the SDLT and the other estimated costs above are funded from the Primary Care Delegated Budget. In total approx. £125,000 plus VAT.

The NHS NCL CCG PCCC is recommended to approve this Project Initiation Document for the planned investment and for the relocation of City Road Medical Centre practice to Finsbury Leisure Centre as part of LBI's planned redevelopment of this site.

[2] City Road Medical Practice ran a full engagement with patients from 11 March to 8 April 2022.

The practice received over 750 responses from patients. Over 75% of patients who responded supported the proposed relocation with over 80% willing to travel 0.3 miles from the current location to the proposed new site. Patient responses were positive with several welcoming the expanded space and new facilities which would be better than the current building. Some were happy that it would be off of the busy City Road, others wanted additional parking. A small number of patients wanted to know more about why the relocation was necessary and Commissioners will work with the Practice to ensure patients are informed and updated about the relocation.

B. STRATEGIC NEED

1. National Strategic Context

Key national strategies have been developed supporting new models of care, including those in primary care, the overarching aims of which are to:

- Dissolve the divide between primary care and community health services through the development of population-based care. Primary Care Networks (PCNs) are a unit of delivery for population-based care whereby groups of GP practices work together with other primary and community care staff and health and care organisations to provide integrated services to local population of between 30-50,000 people.
- Increase the role of digital in enabling improved delivery of primary care in association with other providers.
- Develop new workforce models and roles. By working at scale in local networks, and through improved digital systems, a wider range of professionals (e.g., GPs, nurse practitioners, pharmacists, mental health workers, social prescribing link workers and secondary care specialists) can work in an integrated way.
- Reducing pressure on acute urgent and planned care services. Increasing access to specialist care, diagnostic testing and care management within community settings. The ability to enable this will be assisted through a critical mass of professionals delivering care to a population, rather than single GPs delivering from small scale premises.

The planned investment is consistent with national drivers and guidance, as summarised at Figure 2.

Figure 2: National Strategic Direction

Guidance / Policy	Description and Alignment
NHS Long Term Plan (January 2019)	Ten Year programme of phased improvements to NHS services and outcomes. Principles that are relevant to this scheme: • Networks of GP practices to deliver services to a population of 30-50,000 people, and integrate primary care, community health and social care services to deliver a wider range of services (PCNs) • Step change in the provision of out of hospital care, to significantly reduce the need to attend acute hospital sites • Provide capacity to support the expansion of clinical offering at a primary care level. • Wider action on ill-health prevention, and reduce health inequalities and unwarranted variation • Broaden NHS' priorities for care quality and outcomes improvement • Delivery of upgraded technology and digitally-enabled care across the NHS • Support training opportunities across primary care, community and local authority to improve service delivery, recruitment and retention. • Development of PCNs, which will build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care
General Practice Forward View (NHS England, April 2016)	Commitment to improve patient care and access and invest in new ways of providing primary care through a major expansion of the primary care workforce. To meet rising demand, members of the primary care team, including nurses, pharmacists, mental health therapists and physician associates will play an increasing role in providing day to day co-ordination and delivery of care. Includes the General Practice Nurses 10 point plan: • increase the number of pre-registration nurse placements • improve retention of the existing nursing workforce • support for return to work schemes for practice nurses and • improve the training capacity in general practice.

Guidance / Policy	Description and Alignment
Investment and Evolution: A 5 Year Framework for GP contract reform to implement the NHS Long Term Plan (2019)	GP contract reform which supports delivery of the NHS Long Term Plan. Key components of the contract changes: • PCNs to work closely with ICSs as a formal basis for collaborating with other system partners including community services • Initiatives such as enhanced health in care homes scheme, and anticipatory care services implemented by local systems led by PCNs in collaboration with community providers. • PCNs to work multidisciplinary teams comprising clinical pharmacists, physician associates, first contract physiotherapists, social prescribing link workers and first contact community paramedics to support GPs and nurses in general practice and assist in providing joined up care.
Health and Social, Care Integration: joining up care for people, places and populations (2022)	Integration White Paper aimed at bringing together the NHS and local government to jointly deliver for local communities. It supports person-centred care, improving population health and reducing health disparities across place.
The Future of Primary Care: Creating teams for tomorrow (Primary Care Workforce Commission, 2015)	Strategy to identify models of primary care to meet the future needs of the NHS. Four key recommendations of the strategy include: 1. Expanded multidisciplinary primary care teams 2. Larger primary care organisations: networks, federations and associations of primary care practices 3. Better collaboration between primary, secondary and community care, and between health and social services 4. Better use of information technology

2. Regional and Local Strategic Context

The NCL Integrated Care System (ICS), 'North London Partners in Health and Care', is a collaboration between CCGs, local authorities and NHS providers in NCL. As a single, merged CCG, NCL is now better placed to drive progress forward towards a single NCL Integrated Care Board.

The STP/ICS Estates Strategy (July 2018 and March 2020) identifies key enablers to the successful delivery of the strategy including digital and estates, and this project is on the STP investment pipeline. The priorities for developing the North London Partners Estates Strategy are:

1. Developing a place-based approach to allow NLP to optimise the use of estate in each locality to support service delivery, drawing on One Public Estate principles
2. To respond to care requirements and changes in demand by putting in place a fit for purpose estate
3. To increase the operational efficiency of the estate
4. To enhance delivery capability
5. To enable the delivery of a portfolio of estate transformation projects

The North London Partners in Health and Care ICS is building on its latest a strategy for primary care, '*General Practice as the foundation of the NHS: A North Central London Strategy for General Practice 2018-2021*'. The four overarching aims of the primary care strategy are summarised at Figure 3. The strategy also acknowledges that, in order to achieve these aims, no single intervention will alone be able to deliver them; rather, a whole system approach is required. Figure 3 also summarises the contribution this project will make to meeting ICS primary care aims.

Figure 3: North London Partners in Health Care STP Primary Care Aims

No.	Aim Description	Contribution of the Proposed Scheme on NCL Position
1	Resilient, sustainable and thriving general practice	• Appropriate capacity to be able to cater for future demand for primary care services • Improved recruitment and retention due to improved environment
2	High quality, equitable and person-centred safe care	• Additional capacity to be able to cater for growing and ageing population • Improved access to primary care
3	Proactive, accessible and co-ordinated care	• Fit for purpose premises • Place-based delivery of a wider range of co-ordinated services
4	Integrated services that respond to the needs of the patient and the population	• Ability to extend the service offering within the PCN • Improved ability to deliver PCN initiatives • Improved ability to address health inequalities within deprived Bunhill ward

The NCL position is underscored by the pan-London strategic direction, including that as set out in 'Journey to a New Health and Care System' (NHSE/ I, April 2020). This strategy assesses the implications of Covid on the delivery of health and care services and identifies the fundamental need to shift the way services are delivered. Eight tests are identified within the strategy; of relevance to this project is the need to maintain the total system infrastructure including capacity and surge capability in primary care and to deliver innovative solutions e.g. virtual primary care and outpatients.

3. Demographics and Population

There are 295,396 weighted registered patients in Islington (285,993 unweighted) (source: NHS Digital). Camden & Islington Public Health estimate the total population of Islington is projected to increase by 41,500 people by 2026 and that a number of planned new developments will occur (before 2026).

The current demographic and population for Islington South PCN is summarised at Figure 4.

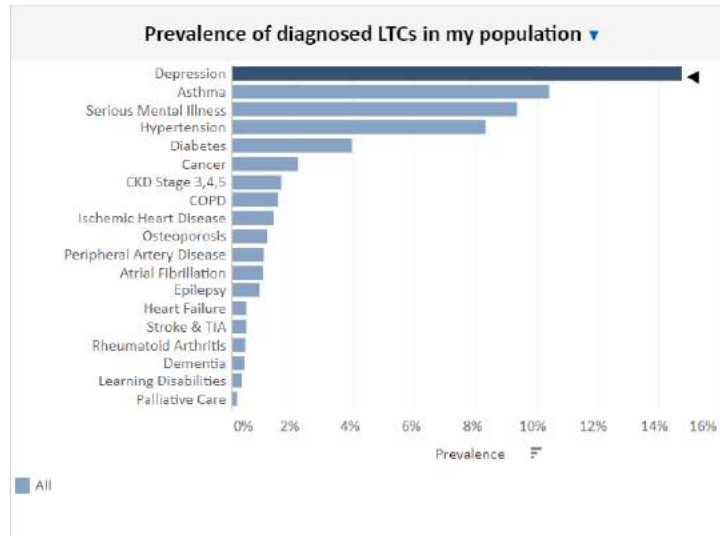
Figure 4: Islington South PCN

	South PCN
Registered population size	75,600
Ethnicity	33% are from a Black, Asian or Other (excluding White other) ethnic background 55% White 12% Unknown
Age	14% aged 0-18 years 7% aged 65+ Slightly younger population with a higher proportion of patients aged 20-34 years compared to Borough average
Life expectancy at birth	Male = 80 years Female = 84 years
Social deprivation	72% in the most deprived or second most deprived quintile out of which 34% live in the most deprived quintile
Obesity	Significantly better than borough average
Smoking	Significantly better than borough average
Alcohol dependency	Significantly worse than borough average
Asthma	Significantly better than borough average
Depression	Better than borough average
Serious mental illness	Better than borough average
Hypertension	Significantly better than borough average
Diabetes	Significantly better than borough average
Cancer	Better than borough average
COPD	Better than borough average
Heart failure	Significantly better than borough average

Dementia	Significantly better than borough average
Stoke / TIA	Significantly better than borough average

Figure 5 summarises the prevalence of long term conditions within Islington South PCN.

Figure 5: Islington South PCN



The most common long term condition is depression (15%). 68% of patients with 2 or more long term conditions have depression.

4. Strategic Need

Strategic Direction

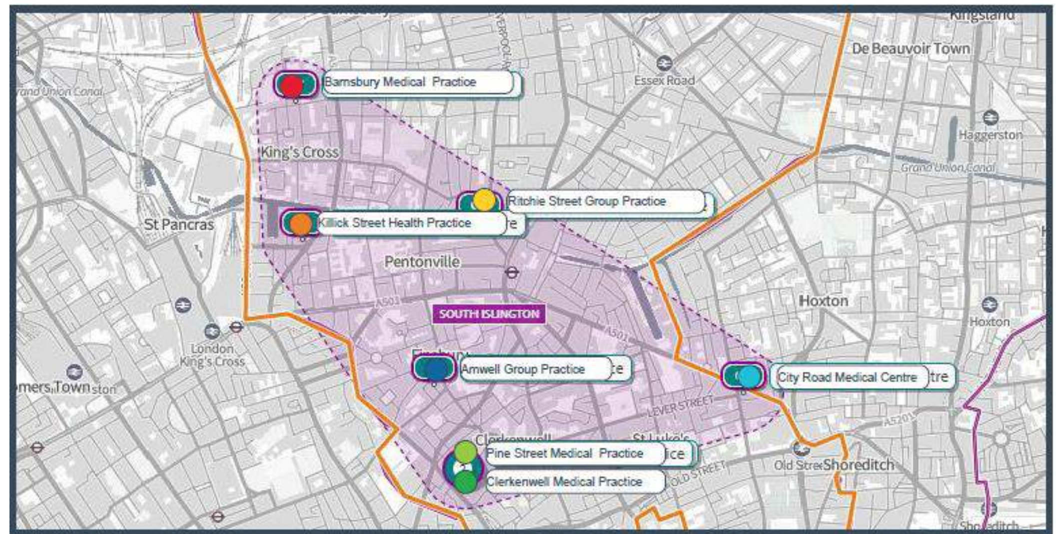
The Islington Primary Care Directorate of NHS NCL CCG, through its locality planning work which was completed in 2019, appraised the infrastructure at a PCN level. Through this plan, priorities and projects were identified within Islington that would support its ambitions for delivery of integrated care. The projects align with and support the overall NCL Estates Strategy. As part of the strategic planning process, NHS NCL CCG has prepared a 5-year revenue affordability forecast to model the revenue implications of the primary care pipeline, which was presented to EMT / PCCC in February 2022. This forecast position shows affordability of the following key priority projects:

- Archway/Vorley Road;
- City Road/Finsbury Leisure Centre;
- Andover redevelopment/relocation

Islington Directorate has identified a critical need for the re-provision of City Road Medical Centre, 190-196 City Road, Islington, EC1V 2QH (practice code F83064). City Road Medical Centre is based in leased accommodation for which the lease is due to expire in March 2024 and there is a fundamental need to reprovide suitable accommodation, in order to maintain continuity of service provision within the locality.

Figure 6 identifies the GP practices within Islington South PCN including City Road Medical Centre, located to the east side of the PCN catchment area.

Figure 6: Islington South PCN

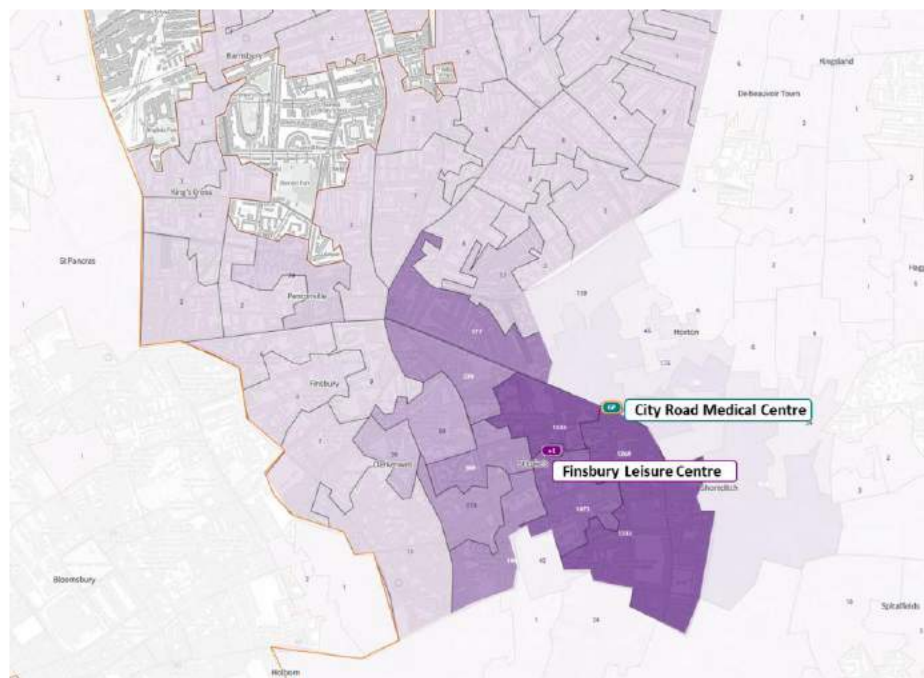


Summary of City Road Medical Centre

City Road Medical Centre is currently located on City Road in the Bunhill area of Islington. The area is bordered by Hackney to the north and east, Tower Hamlets to the southeast and the City of London to the south.

The catchment population for City Road Medical Centre along with its close proximity to the Finsbury Leisure Centre site is shown at Figure 7. The darker areas represent the higher concentration of patients being registered at City Road Medical Centre.

Figure 7: City Road Medical Centre Patient Catchment



City Road Medical Centre has seen a significant increase in list size recently with a 25.8% increase between October 2018 and January 2022. The practice is also likely to see an increase in its registered population irrespective of location due to projected growth in its core area of 900 residents. Whilst most new residents to the east are more likely to register at Hackney practices, and most residents to the west at Clerkenwell Medical Centre or Pine Street Medical Centre, a relocation to the Finsbury Leisure Centre site may result in some new residents from the area to the west registering at City Road Medical Centre.

Figure 8 shown a site map of the current City Road Medical Centre location.

Figure 8: City Road Medical Centre Current Location

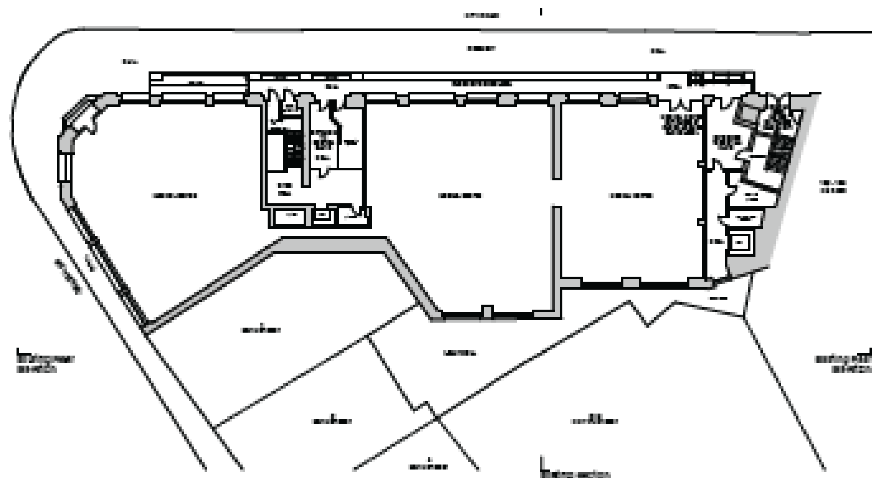
Summary of Current Estate Limitations

City Road Medical Centre has been identified for re-provision and is on the pipeline of schemes for South Islington.

The operating hours of the practice are Monday – Friday 08:30 – 18:30. When the surgery is closed, patients access services at the Extended Access iHUB at Ritchie Street Health Centre (Monday to Friday 18:30 – 20:00 and Saturday / Sunday 08:00 – 20:00. Outside of these hours, patients contact either NHS 111 or 999 as appropriate. A condition of the PCCC approval is that the practice opens at 08.00.

The current accommodation occupied by City Road Medical Centre is leased, with a lease expiry date of March 2024. The current capacity of the practice is relatively satisfactory at 532m^2 NIA (577m^2 GIA). However the layout of the premises is poor, not fit for purpose and with no scope for reconfiguration. Figure 9 provides a layout of the existing accommodation. As the building is operating at near capacity, the practice has had to restrict clinical activity and has difficulty accommodating and scheduling services as they would wish. Rooms are allocated according to the immediate priorities. In order to meet minimum service requirements, the practice is often not able to run services concurrently, limiting access and choice for patients. The practice has also not been able to host several services due to capacity limitations.

Figure 9: City Road Medical Centre Existing Accommodation Layout



The practice also teaches GP trainees and does not have sufficient space to take on as many trainees needed to meet demand. Enabling practices to train the next generation of GPs in appropriate facilities is critical to solving the workforce crisis that Islington is experiencing. A key part of NHS NCL CCG's Estates Strategy is to facilitate GP training along with other clinical members of the Primary Care team. The practice also regularly trains medical students from Bart's Hospital and the London School of Medicine and Dentistry Queen Mary, University of London. Current restriction on space limits the number of students that can be trained at the practice. There is currently no dedicated room for the students to self-study and access the computer system so impeding their educational experience.

Below is a summary of the limitations of the existing City Road Medical Centre estate:

- Current treatment and consulting rooms do not meet the number required to meet future demand. Presently, there are often up to 12 clinicians having to share 7 clinical rooms, which limits their ability to see patients face to face.
- There is no privacy for patients at the front reception desks and the proximity of the shared waiting area.
- There is no private room for patients who may be distressed or an interview room for patients needing confidentiality.
- There is limited space in the surgery to provide additional services to the community such as social prescribing, employment and housing services or to accommodate specialist groups such as mother and baby clinics as well as drug and alcohol services.
- There is insufficient space to provide patient information areas for health promotion and education events for patient such as group work for self-care and chronic diseases such as diabetes and asthma and people who are newly diagnosed with such diseases.
- Due to the nature and construction of the current premise's future flexibility is constrained. There is no capacity on the site to economically extend the current building.
- Currently, there are no car parking spaces at the practice and very limited blue badge parking options for patients with disabilities as the practice is on a Red Route on City Road.
- The premises do not have capacity to meet any growth in local population or facilitate future practice mergers to deliver primary care at scale.
- There is limited space for training and development for trainee GPs and medical students as well as other members of the primary care team.

Current Service Provision

Figure 10 summarises the current workforce profile.

Figure 10: City Road Medical Centre Existing Workforce

Clinical Staff	Number	WTE
GP	9	4.06
GP Registrar	3	1.92
Physician's Associate	1	1
Nurse	1	0.7
HCA	1	0.8
Practice-Based Pharmacist	3	1.4
TOTAL	**18**	**9.88**

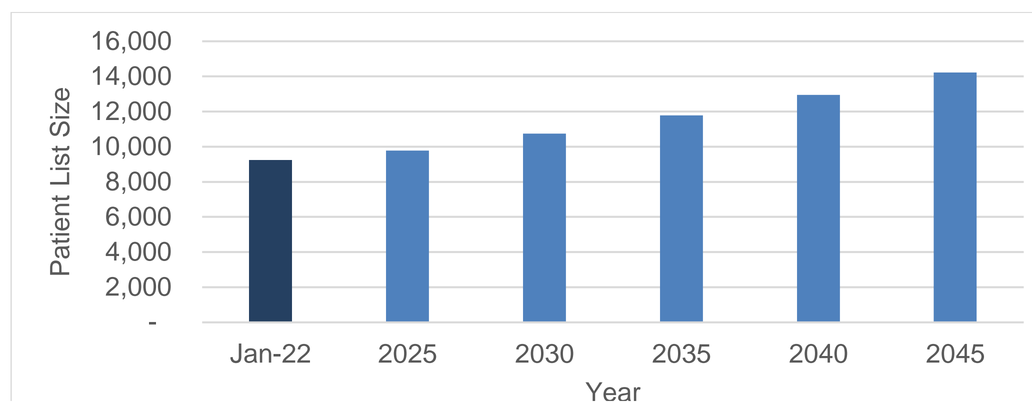
Admin Staff	Number	WTE
Practice Manager	1	1
Administration	3	1.4
Receptionist	5	3.12

TOTAL	9	5.52

Local Demographics and List Size Projections

City Road Medical Centre is a mid-sized practice with a current list size of 9240 patients (source SHAPE as at January 2022). Figure 11 summarises the current and projected list size for the practice. A growth factor as an average between the historic growth and the GLA projections has been applied [3], equating to a growth factor of 1.89% per annum. This shows a growth of 54% (from a January 2022 baseline of 9240 patients) to 14,220 patients over the planning period to 2045.

Figure 11: City Road Medical Centre List Size – Current and Projected



Future Accommodation Requirements

The CCG has recently commissioned a PCN estates strategy. Once the outputs of this are available they will be used to inform the CCG's investment planning for the future.

Based on the projected list size included at Figure 11 the future accommodation requirements for City Road Medical Centre are shown at Figure 12. The schedule of accommodation will be finalised with the practice.

Figure 12: Projected Accommodation Requirements

Accommodation	No. of Clinical Rooms	m2
Entrance		$75m^2$
Clinical Accommodation		
Consultation / Examination Rooms	7	$206m^2$
Treatment Rooms (GMS/PMS)	3	
Consulting Room	1	
Office/Virtual Consultation / Examination Rooms	4	
Clinical Support Accommodation		$30.5m^2$
Office Accommodation		$91.0m^2$
Staff Accommodation		$30m^2$
FM		$19m^2$
Net Total		$451.5m^2$
Planning Allowance (25%)		$113m^2$
Engineering Allowance (12.5%)		$56m^2$
Circulation (28%)		$126m^2$
TOTAL		**$747m^2$**

[3] The GLA projects an average annual growth across Islington of between 2010 and 2045 of 0.89%.
Historically the patient list size in South PCN shows an increase of 2.9% in the period 2018 to Jan 2022. This is primarily due to the consistent increases in City Road and Clerkenwell Practices. City Road showed a consistent increase however with a notable 15% increase in the period 2021 to 2022 (Jan).
Simply applying the GLA growth rate is therefore not likely to reflect the growth specific to the PCN. However applying the historic growth is not likely to reflect the actual growth as this cannot be maintained. Therefore a growth factor as an average between the historic growth and the GLA projections of 1.89% has been applied.

C. SITE OPTIONS AND PREFERRED WAY FORWARDS

1. Summary of Potential Options

Figure 13 shows the range of potential options for the re-provision of City Road Medical Practice and shows a rationale for either carrying the option forward, or for discounting it.

Figure 13: Long list of Options

No.	Option	Shortlisted / Discounted
1	Business As Usual – the practice continues to operate from its existing premises with no investment in the estate.	**Discounted** • The lease expires in March 2024. This is not a viable option as the landlord of the existing premises has indicated that they are seeking to have the practice vacate the site, to facilitate their planned redevelopment of the site. Therefore BAU is not viable.
2	Do Minimum – convert non-clinical space within existing premises to increase clinical capacity	**Discounted** • Whilst it may be possible to convert the medical records store to an additional clinical space (on the assumption that the records could be digitised), the lease expires in March 2024 and therefore Do Minimum is not viable for the same reasons as indicated at BAU.
3	Relocate to Finsbury Leisure Centre – Council led scheme for the development of regeneration project including housing, sports/leisure facilities and primary care premises.	**Preferred Option** • Council has indicated that this is a viable option and they would fund the construction. • Finsbury Leisure Centre premises are c. 0.3 miles (6 minute walk) from current site so limited impact on travel for patients. • No interruption to service delivery as there would only be a single move into the new building when it is completed
4	Practice list dispersal to existing PCN primary care capacity	**Discounted** • There is insufficient current accommodation within Islington to accommodate a dispersed list of this size.
5	Practice list dispersal - Develop additional capacity at another GP practice(s) within the PCN	**Discounted** • It may be feasible to provide some additional capacity through investment in another GP premises within the locality. There is no practice within the vicinity that would provide a development option to provide the full capacity requirements to meet future demand. It may also require capital input.

2. Preferred Way Forwards

From the initial options appraisal, the preferred option is for the relocation to Finsbury Leisure Centre.

CAPITAL COSTS

The following capital is available in support of this scheme:

- £1,185,585 Section 106 monies

It is likely that this capital will be used as a contribution to fit out costs which will result in a partially abated future rent. The extent of this will be determined as part of Council plans and in association with the District Valuer.

There will be no requirement for the NHS NCL CCG to fund any capital associated with the scheme.

REVENUE AFFORDABILITY / IMPACT

The current rent reimbursed for City Road Medical Centre is £192,700 per annum (extracted from the CCG's affordability model data).

The estimated rental value (ERV) for the new surgery within Finsbury Leisure Centre is £182,000 per annum. However, with the use of the Section 106 healthcare allocation identified above, it will reduce the annual rental. This reduction will be calculated by the District Valuer.

	Other reimbursement costs to be business rates and clinical waste are to be determined. The CCG will undertake further design development with the Council (as developer and landlord), including a District Valuer sign off for the final rent and clarification of other reimbursements. Based on the ERV rental figure above, the Stamp Duty Land Tax (SDLT) calculation is as follows, based on the Council's latest delivery programme: - Effective date of transaction (assumed agreement to lease and lease) – 01.12.2022 - Lease start date - 01.05.2025 (practical completion date for the leisure part of the Council's scheme which includes the new surgery) - Lease expiry date – 30.04.2045 (assumed to be 20 year lease) - Resultant SDLT calculation - £24,500 The GP IT costs have been estimated, based on a recent project within the ICS. The total GP IT capital costs are estimated to be £65,000 and the total revenue costs £7,500. These will be funded through separate budgets within the CCG. Other estimated costs will include: - GP legal costs – £20,000 plus VAT - GP Project Manager - £30,000 plus VAT (covering pre- and post-financial close work for the GPs and interfacing with Council's design team and contractor) - GP Surveyor/engineer - £50,000 plus VAT (checking quality and assuring compliance and fit-for-purpose) It is proposed that the SDLT and the other estimated costs above are funded from the Primary Care Delegated Budget. In total £125,000 plus VAT.

PROPOSED PROCUREMENT STRATEGY	The procurement will be led by LBI as part of the wider redevelopment of the site. City Road Medical Centre would take a lease on the premises (length of lease to be confirmed but likely to be 15-20 years) directly from the Council.

KEY RISKS	Risk of…	Mitigated by…
	LBI timescales for the delivery of Finsbury Leisure Centre do not fully align with the need to vacate the existing premises prior to lease end (March 2024)	Either a negotiated lease extension or temporary accommodation would be required, both of which are likely to incur additional costs
	LBI required date for commitment to the scheme is not aligned with the CCG's timescale	• Ongoing dialogue with LBI • Partially mitigated there is already written support from the GP practice and PPG
	LBI are not able to redevelop Finsbury Leisure Centre as planned and the practice has no alternative accommodation prior to lease end in March 2024	• Ongoing dialogue with LBI
	Planning consent is not granted	• Ongoing dialogue with LBI • LBI to be requested to engage with the town planning authority to gauge in principle support

NHS North Central London Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee Meeting
21 April 2022

<table>
<tr><td>Report Title</td><td>Changes to Enfield Primary Care Networks composition</td><td>Date of report</td><td>22 March 2022</td><td>Agenda Item</td><td>4.1</td></tr>
<tr><td>Lead Director / Manager</td><td>Deborah McBeal,
Director of Integration, Enfield Borough Directorate, NCL CCG</td><td colspan="2">Email / Tel</td><td colspan="2">d.mcbeal@nhs.net

07710 269705</td></tr>
<tr><td>GB Member Sponsor</td><td colspan="5"></td></tr>
<tr><td>Report Author</td><td>Riyad Karim,
Assistant Director of Primary Care,
Enfield Borough Directorate, NCL CCG</td><td colspan="2">Email / Tel</td><td colspan="2">riyad.karim@nhs.net

07950 882842</td></tr>
<tr><td>Name of Authorising Finance Lead</td><td>Tracey Lewis,
Head of Finance – NCL STP Primary Care

tracey.lewis9@nhs.net</td><td colspan="4">Summary of Financial Implications

(see below)</td></tr>
<tr><td>Report Summary</td><td colspan="5">The urgent decision panel met on Friday 4 March 2022 to consider the new structure of PCN changes in Enfield (see paper below). They were asked to confirm any proposed changes.

Following the review and approval of the proposed PCN changes, the Enfield Borough GP Transformation Sub Group Part 2 (GPTSG P2) group asked the PCCC to consider and confirm approval of the new PCN structure (Edmonton PCN) and the remaining current PCN structure (Enfield Care Network PCN), which will all take effect from 1st April 2022.

The following was highlighted:

• This was a single PCN working as two neighbourhoods and they will now be two separate PCNs. This was an amicable clean split but there will still be room for collaboration as they are both geographically close.
• There are many similarities with the two separate PCNs and it gives the smaller PCN a chance to focus on the population. It is in an area where there are a lot of deprived communities. It allows them to focus on what they can do to improve the health and wellbeing which is important when moving to ICS.
• There is already collaboration, so that regardless of where the patients are registered, they will have access to the services across the whole of Enfield.

The urgent decision panel confirmed approval of the new PCN structure.</td></tr>
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Recommendation	The Committee is asked to **NOTE** the decision taken by the urgent decision panel to confirm approval of the new PCN Structure (Edmonton PCN) and the remaining current PCN structure (Enfield Care Network PCN), which took effect from 1st April 2022.
Identified Risks and Risk Management Actions	*(see below)*
Conflicts of Interest	*(see below)*
Resource Implications	*(see below)*
Engagement	*(see below)*
Equality Impact Analysis	*(see below)*
Report History and Key Decisions	*(see below)*
Next Steps	*(see below)*
Appendices	*(see below)*

North Central London
Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee
Urgent Decision
4 March 2022

Report Title	Changes to Enfield Primary Care Networks composition	**Date of report**	3rd Mar 2022	**Agenda Item**	Urgent Decision
Lead Director / Manager	Deborah McBeal, Director of Integration, Enfield Borough Directorate, NCL CCG	**Email / Tel**		d.mcbeal@nhs.net 07710 269705	
GB Member Sponsor					
Report Author	Riyad Karim, Assistant Director of Primary Care, Enfield Borough Directorate, NCL CCG	**Email / Tel**		riyad.karim@nhs.net 07950 882842	
Name of Authorising Finance Lead	Tracey Lewis, Head of Finance – NCL STP Primary Care tracey.lewis9@nhs.net 020 3688 1728	**Summary of Financial Implications** No additional expenditure. The overall budgets allocated to PCNs will not be affected. As PCN funding is allocated on the basis of practice list sizes and any changes to PCN composition approved by the commissioner will result in changes to financial allocations to the respective PCNs. Enfield Borough Primary Care team will work with NCL CCG Finance and contracting colleagues to revise budget statements for the new year for the remaining Enfield Care Network PCN and align budget to the proposed new PCN, Edmonton PCN.			
Report Summary	This paper summarises proposed changes to the core membership of Enfield Care Network PCN, with some practices leaving to form a proposed, resultant new Edmonton PCN in Enfield. **Summary of proposed change** • Enfield has four Primary Care Networks since introduction (July 2019). The proposal would increase this to five on 1st April 2022. • The current Enfield Care Network PCN has a total of 13 Practices (108,219 list size) operating as two distinct neighbourhoods. The two neighbourhood groups wish to formally separate to become distinct, separate Networks as of 1st April 2022.				

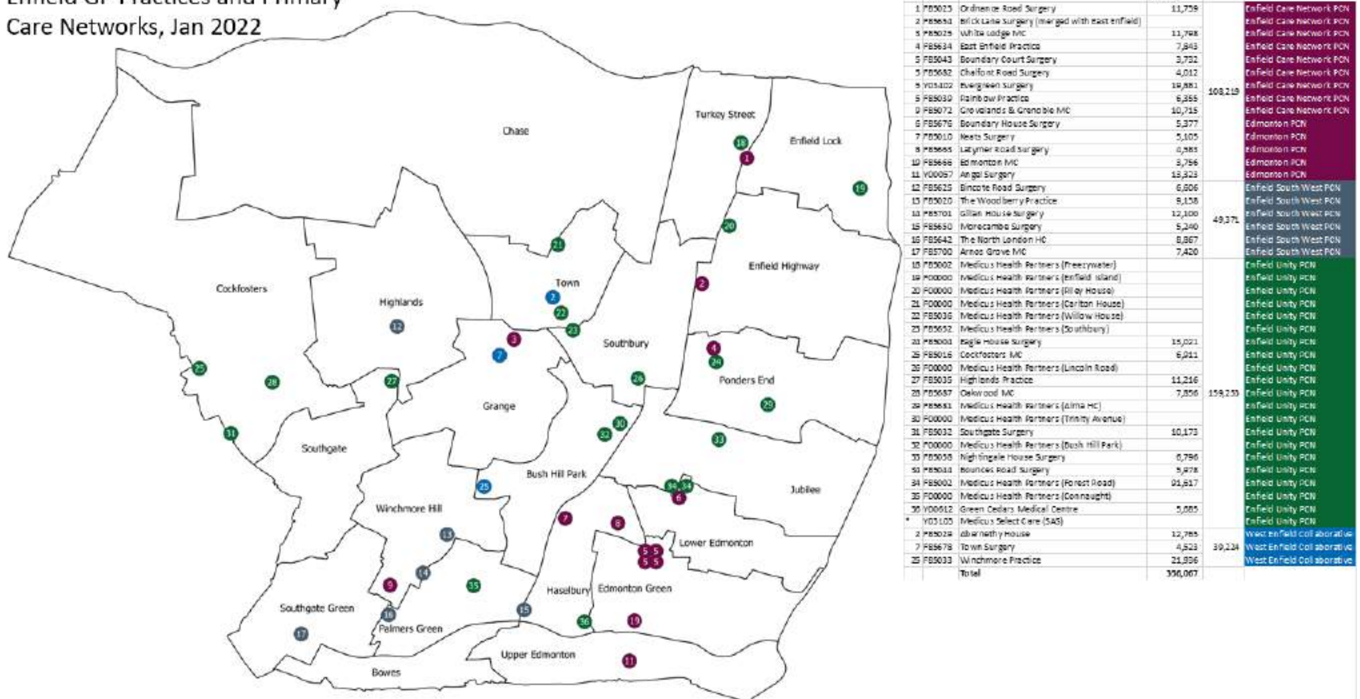
	• The two neighbourhoods have developed different operating models and ambitions and believe a formal separation would be in the best interests of member Practices and patients. • The proposed Edmonton Primary Care Network practices are geographically aligned and have been working in close collaboration with each other in the south neighbourhood since the inception of Enfield Care Network PCN. • The current Network will continue to use the name Enfield Care Network PCN (76,075 revised list size as of 1st April 2022) and will retain Evergreen Surgery as the nominated lead practice. • Five practices intending to leave Enfield Care Network PCN to form Edmonton PCN are as follows: o Angel Surgery (13,323 list size) o Boundary House Surgery (5,377 list size) o Edmonton Medical Centre (3,756 list size) o Keats Surgery (5,105 list size) o Latymer Surgery (4,583 list size) • Edmonton PCN with 32,144[1] patients is above 30,000 patient threshold. • Network Area - No change for Enfield Care Network PCN. Edmonton PCN shares part of the same network area for Enfield Care Network. (refer to Network Area section, pages 7-9 of this report). • 100% population coverage in Enfield is not impacted. • Of the three current Clinical Directors (CDs) of Enfield Care Network PCN, Drs Sanjay Patel (Evergreen Surgery) and Dr Harry Grewal (Boundary Court Surgery) will continue as CDs for the remaining PCN. Dr Mohammad Choudhry, Latymer Road Surgery, (*currently a CD for Enfield Care Network PCN) is proposed to be the CD for the new Edmonton PCN. **Proposed changes to clinical directors** **PCN** — **CD** Edmonton — Dr Mohammad Choudhry * Enfield Care Network — Dr Sanjay Patel; Dr Harry Grewal
Recommendation	Commissioners are not required to approve proposed changes to PCNs, but are asked to confirm any proposed changes. Following the review and approval of the proposed PCN changes, the Enfield Borough GP Transformation Sub Group Part 2 (GPTSG P2) group has asked the PCCC to consider and confirm **APPROVAL** of the new PCN structure (Edmonton PCN) and the remaining current PCN structure (Enfield Care Network PCN), which will all take effect from 1st April 2022.
Identified Risks and Risk Management Actions	The key potential risks associated with these changes to the PCNs in Enfield are: - Financial risk e.g. use of PCN funding for additional workforce (Additional Roles Reimbursement Scheme – ARRS). - Care Homes Alignment. - Risk of reduced collaboration between Enfield Care Network PCN and the proposed Edmonton PCN and with other PCNs in Enfield.

[1] All list sizes taken as raw list sizes at January 2022

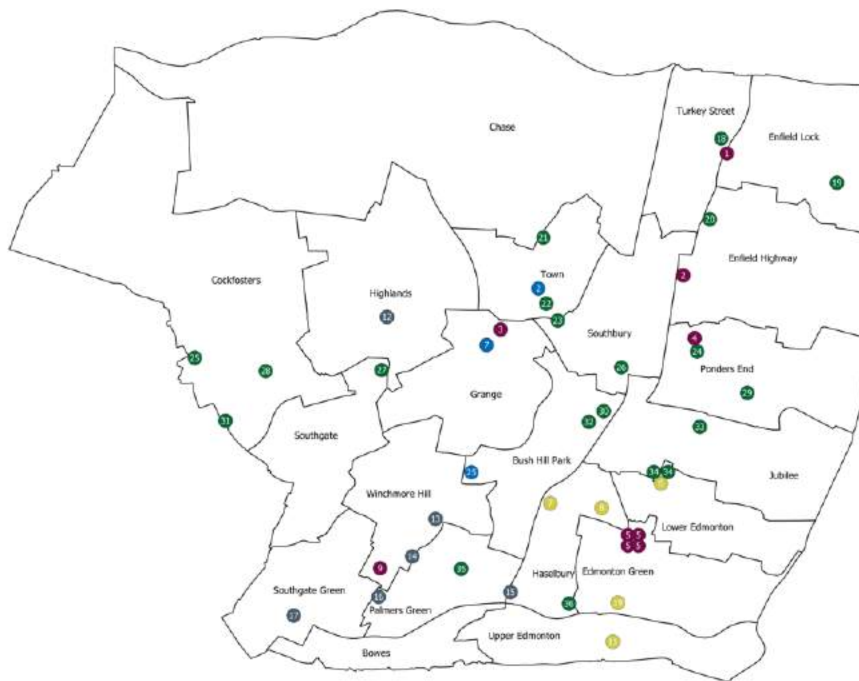
	The pre-existing embedded autonomy within the two neighbourhoods in the current Enfield Care Network PCN and their mutual intention for amicable separation bodes well and mitigates against any potential risks. **ARRS** • The independent arrangement on PCN ARRS roles that both neighbourhoods of the current Enfield Care Network have will be formalised into the remaining and resultant PCN structures. • Both Enfield Care Network PCN and the proposed Edmonton PCN, have confirmed that ARRS (Additional Roles Reimbursement Scheme) recruitment has been independent for the two neighbourhoods, with roles being employed by Evergreen Surgery (which will continue to be the lead practice for Enfield Care Network PCN) and through Latymer Road Surgery (lead practice for the proposed Edmonton PCN) and within the proportions of the neighbourhood budgets. • Going forwards therefore there is no split of additional roles team members. **Care Homes Alignment** Dr Mohammad Choudhry, CD for the proposed Edmonton PCN, has confirmed that Angel surgery, Latymer Road Surgery and Edmonton Medical centre will remain aligned to the MCA Care Home, Henran Lodge and Oak House care homes respectively. The change of membership does not impact the alignment of Care Homes in Enfield. **Collaboration between Enfield Care Network and Edmonton PCN and other PCNs in Enfield** Existing PCNs within Enfield, the GP Federation and the CCG Borough Directorate work in a collaborative manner. Edmonton PCN has noted that it will look forward to working with their borough partners and remain open to collaboration with Enfield Care Network PCN and other Enfield PCNs.
Conflicts of Interest	The PCCC Urgent Decision Making Process provides for independent review of the proposals.
Resource Implications	*Not Applicable*
Engagement	Not carried out.
Equality Impact Analysis	• Proposal has potential to improve access to primary care for the underserved and diverse communities both through the remaining Enfield Care Network PCN and through the formation of a new PCN. • Practices within the newly proposed PCN structure (Edmonton Primary Care Network) are more *'geographically contiguous'*. These practices have already been working as a separate neighbourhood since July 2019 and formalised collaborative working and financial autonomy in the new PCN provides the potential to improve strategies and planning to meet the needs of the growing, diverse populations and address health inequalities. • The new Edmonton PCN seeks to review and optimise its estates capacity and develop strategies to better support local partners in primary, secondary and social and voluntary sectors and support work on population health in the southeast of Enfield. • The new PCN intends to build on the engagement of practices with their individual PPGs and form an inclusive "super- PPG" • This is intended to further promote stability for patients in the southeast of Enfield and enhance engagement of the voluntary community social enterprises.

Report History and Key Decisions	17th November 2021- 5 practices communicated its intention to leave the Enfield Care Network PCN from 1st April 2022. Enfield Care Network PCN confirmed intention for an amicably agreed separation on same day. - PCN changes flagged and discussed with Dr Vicky Weeks, Medical Director, Londonwide LMC on 3rd February. - Key documents have been signed and sent from PCNs in February 2022 (including: Network Contract DES Registration Form; Network Contract DES Participation and Notification Form; Network Mandatory Network Agreement and Network Agreement Schedules – reviewed by Enfield Primary Care and NCL Commissioning and Contracting team). - New PCN has signed agreement with the 5 practices. - Enfield Care Network has revised agreement with remaining practices. - Proposed PCN changes reviewed and discussed at Enfield Borough GPTSG Part 2 meeting on 11th February 2022. Members confirmed Enfield continues to give 100% patient coverage and members formally recommend that NCL PCCC approve the PCN changes for confirmation.
• **Next Steps**	Confirm proposals and communicate to respective PCNs Report for information to PCCC
Appendices	None

Map of Enfield showing practices, PCN composition (Jan 2022 to proposed April 2022)



Key	Practice code	Practice	Raw list size (Jan 22)	PCN list	Primary Care Network
1	F85023	Ordnance Road Surgery	11,739		Enfield Care Network PCN
2	F85630	Brick Lane Surgery (merged with East Enfield)			Enfield Care Network PCN
3	F85025	White Lodge MC	11,798		Enfield Care Network PCN
4	F85634	East Enfield Practice	7,843		Enfield Care Network PCN
5	F85043	Boundary Court Surgery	3,732		Enfield Care Network PCN
5	F85682	Chalfont Road Surgery	4,012		Enfield Care Network PCN
9	Y03402	Evergreen Surgery	19,881	108,219	Enfield Care Network PCN
5	F85039	Rainbow Practice	6,355		Enfield Care Network PCN
9	F85072	Grovelands & Grenoble MC	10,715		Enfield Care Network PCN
6	F85676	Boundary House Surgery	5,377		Edmonton PCN
7	F85010	Keats Surgery	5,105		Edmonton PCN
8	F85665	Latymer Road Surgery	0,985		Edmonton PCN
10	F85666	Edmonton MC	3,756		Edmonton PCN
11	Y00057	Angel Surgery	13,323		Edmonton PCN
12	F85625	Bincote Road Surgery	6,606		Enfield South West PCN
13	F85020	The Woodberry Practice	9,158		Enfield South West PCN
14	F85701	Gillan House Surgery	12,100	49,371	Enfield South West PCN
15	F85650	Morecambe Surgery	5,240		Enfield South West PCN
16	F85642	The North London HC	8,867		Enfield South West PCN
17	F85700	Arnos Grove MC	7,420		Enfield South West PCN
18	F85002	Medicus Health Partners (Freezywater)			Enfield Unity PCN
19	F00000	Medicus Health Partners (Enfield Island)			Enfield Unity PCN
20	F00000	Medicus Health Partners (Riley House)			Enfield Unity PCN
21	F00000	Medicus Health Partners (Carlton House)			Enfield Unity PCN
22	F85036	Medicus Health Partners (Willow House)			Enfield Unity PCN
23	F85652	Medicus Health Partners (Southbury)			Enfield Unity PCN
24	F85001	Eagle House Surgery	15,021		Enfield Unity PCN
25	F85016	Cockfosters MC	6,011		Enfield Unity PCN
26	F00000	Medicus Health Partners (Lincoln Road)			Enfield Unity PCN
27	F85035	Highlands Practice	11,216		Enfield Unity PCN
28	F85687	Oakwood MC	7,856	159,239	Enfield Unity PCN
29	F85681	Medicus Health Partners (Alma HC)			Enfield Unity PCN
30	F00000	Medicus Health Partners (Trinity Avenue)			Enfield Unity PCN
31	F85032	Southgate Surgery	10,173		Enfield Unity PCN
32	F00000	Medicus Health Partners (Bush Hill Park)			Enfield Unity PCN
33	F85058	Nightingale House Surgery	6,796		Enfield Unity PCN
33	F85044	Bounces Road Surgery	5,978		Enfield Unity PCN
34	F85002	Medicus Health Partners (Forest Road)	91,617		Enfield Unity PCN
35	F00000	Medicus Health Partners (Connaught)			Enfield Unity PCN
36	Y00612	Green Cedars Medical Centre	5,085		Enfield Unity PCN
*	Y03105	Medicus Select Care (SAS)			Enfield Unity PCN
2	F85028	Abernethy House	12,765		West Enfield Collaborative
7	F85678	Town Surgery	4,523	39,224	West Enfield Collaborative
25	F85033	Winchmore Practice	21,936		West Enfield Collaborative
		Total	356,067		



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4	F85634	East Enfield Practice	7,843		Enfield Care Network PCN
5	F85045	Boundary Court Surgery	3,732	76,075	Enfield Care Network PCN
5	F85682	Chalfont Road Surgery	4,012		Enfield Care Network PCN
5	Y03402	Evergreen Surgery	19,881		Enfield Care Network PCN
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6	F85676	Boundary House Surgery	5,377		Edmonton PCN
7	F85010	Keats Surgery	5,105		Edmonton PCN
8	F85663	Latymer Road Surgery	4,583	52,104	Edmonton PCN
10	F85666	Edmonton MC	3,756		Edmonton PCN
11	Y00057	Angel Surgery	13,323		Edmonton PCN
12	F85625	Bincote Road Surgery	6,606		Enfield South West PCN
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26	F00000	Medicus Health Partners (Lincoln Road)			Enfield Unity PCN
27	F85059	Highlands Practice	11,216		Enfield Unity PCN
28	F85687	Oakwood MC	7,856	159,253	Enfield Unity PCN
29	F85681	Medicus Health Partners (Alma HC)			Enfield Unity PCN
30	F00000	Medicus Health Partners (Trinity Avenue)			Enfield Unity PCN
31	F85032	Southgate Surgery	10,173		Enfield Unity PCN
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25	F85033	Winchmore Practice	21,936		West Enfield Collaborative
			356,067		

The following table shows the changes in Enfield Care Network PCN composition

PCN	Current member practices	Raw list size Jan 22	Change from 1st April 2022	Revised Raw list size post 1 Apr 22
Enfield Care Network PCN	Evergreen Surgery Boundary Court Surgery Chalfont Surgery Ordnance Unity Centre for Health Rainbow Surgery East Enfield Medical Practice* Grovelands and Grenoble Gardens Surgery White Lodge Medical Practice (*East Enfield Medical Practice merged with Brick Lane Surgery in 2021) Angel Surgery Boundary House Surgery Edmonton Medical Centre Keats Surgery Latymer Surgery	108,219	- Angel Surgery - Boundary House Surgery - Edmonton Medical Centre - Keats Surgery - Latymer Surgery	76,075

Other Enfield PCNs: Enfield South West PCN; (list size 49,371), Enfield Unity PCN (list size 159,253); and West Enfield Collaborative PCN (list size 39,224) are not affected by this proposal.

April 2022 Enfield Care Network and Edmonton PCNs

PCN	Member practices	Based on Raw list size Jan 2022
Enfield Care Network PCN	Evergreen Surgery Boundary Court Surgery Chalfont Surgery Ordnance Unity Centre for Health	19,881 3,732 4,012 11,739

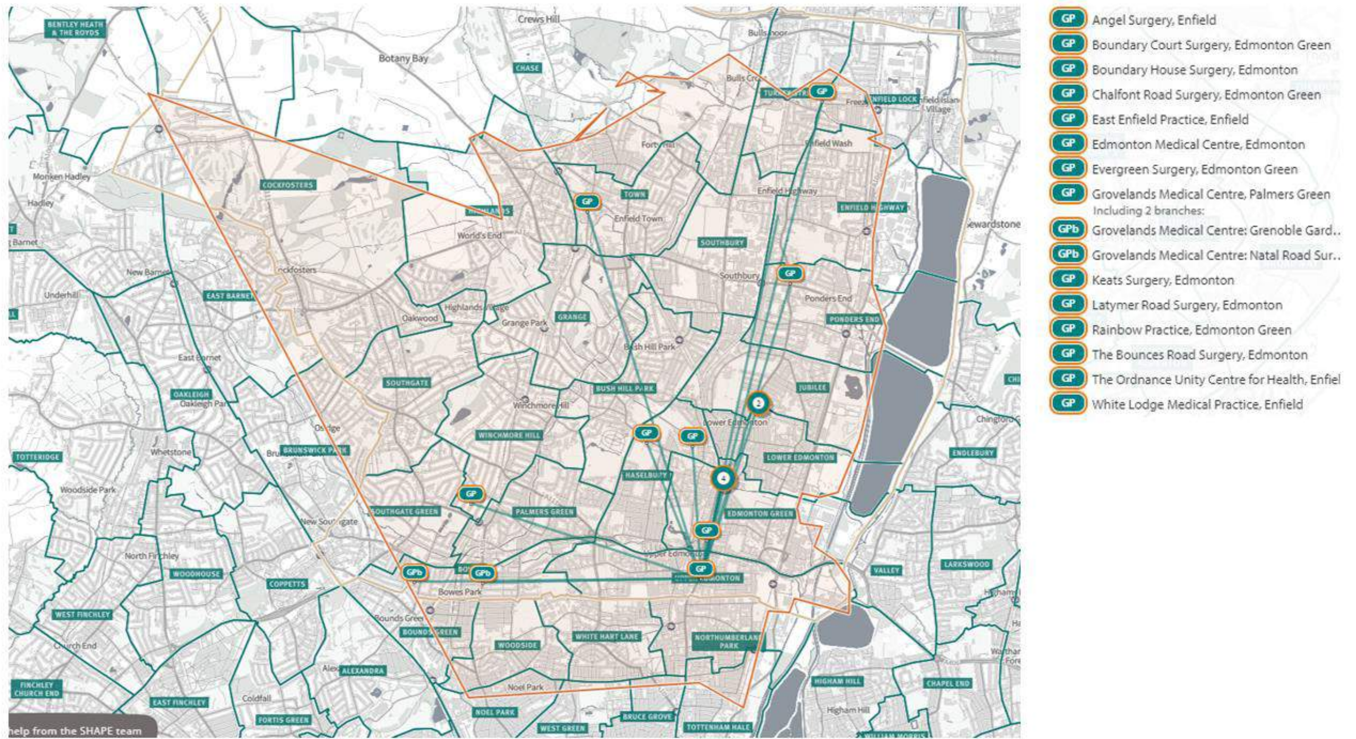
	Rainbow Surgery East Enfield Medical Practice* Grovelands and Grenoble Gardens Surgery White Lodge Medical Practice (*East Enfield Medical Practice merged with Brick Lane Surgery in 2021)	6,355 7,843 10,715 11,798
		(76,075)
Edmonton PCN	Angel Surgery Boundary House Surgery Edmonton Medical Centre Keats Surgery Latymer Surgery	13,323 5,377 3,756 5,105 4,583
		(32,144)

Network Area

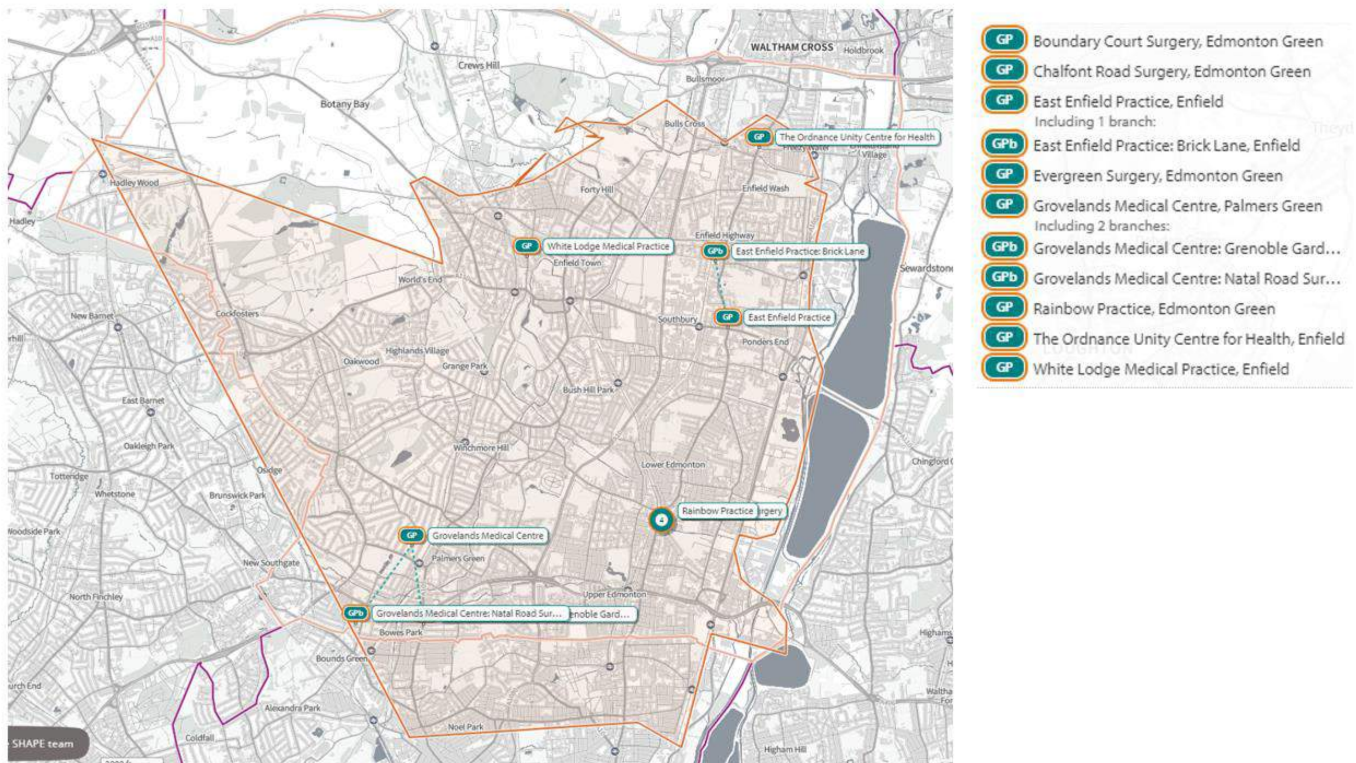
Enfield Care Network PCN, the combined registered and contract catchment area is unaffected.

Enfield Care Network from July 2019 to April 2022 (no change)

Enfield Care Network PCN July 2019: Combined registered patients and contract catchments combined

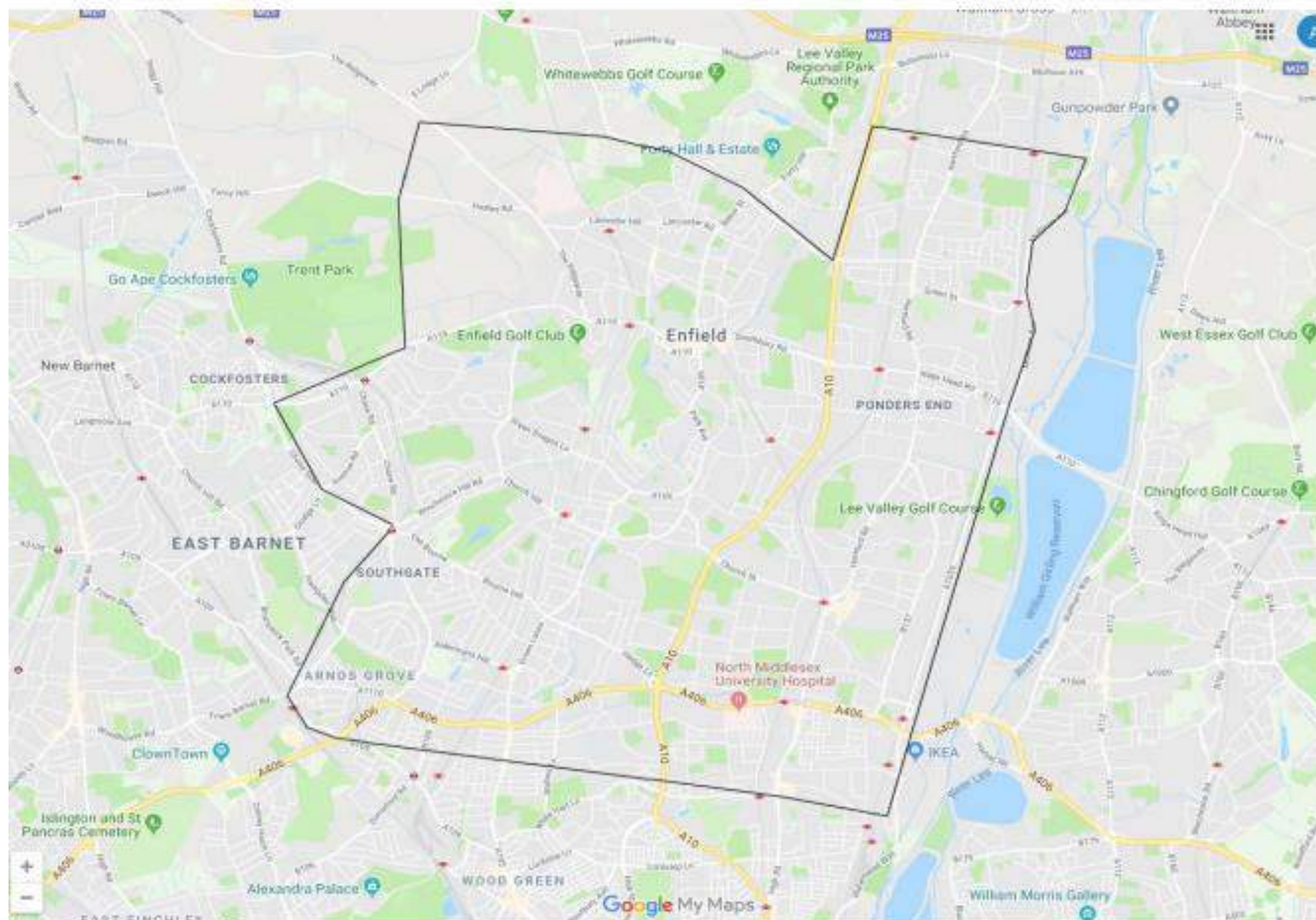


Enfield Care Network PCN proposed 1 April 2022: Combined registered patients and contract catchments <u>combined</u>



Network Area – Submitted by Enfield Care Network for 1 April 2022

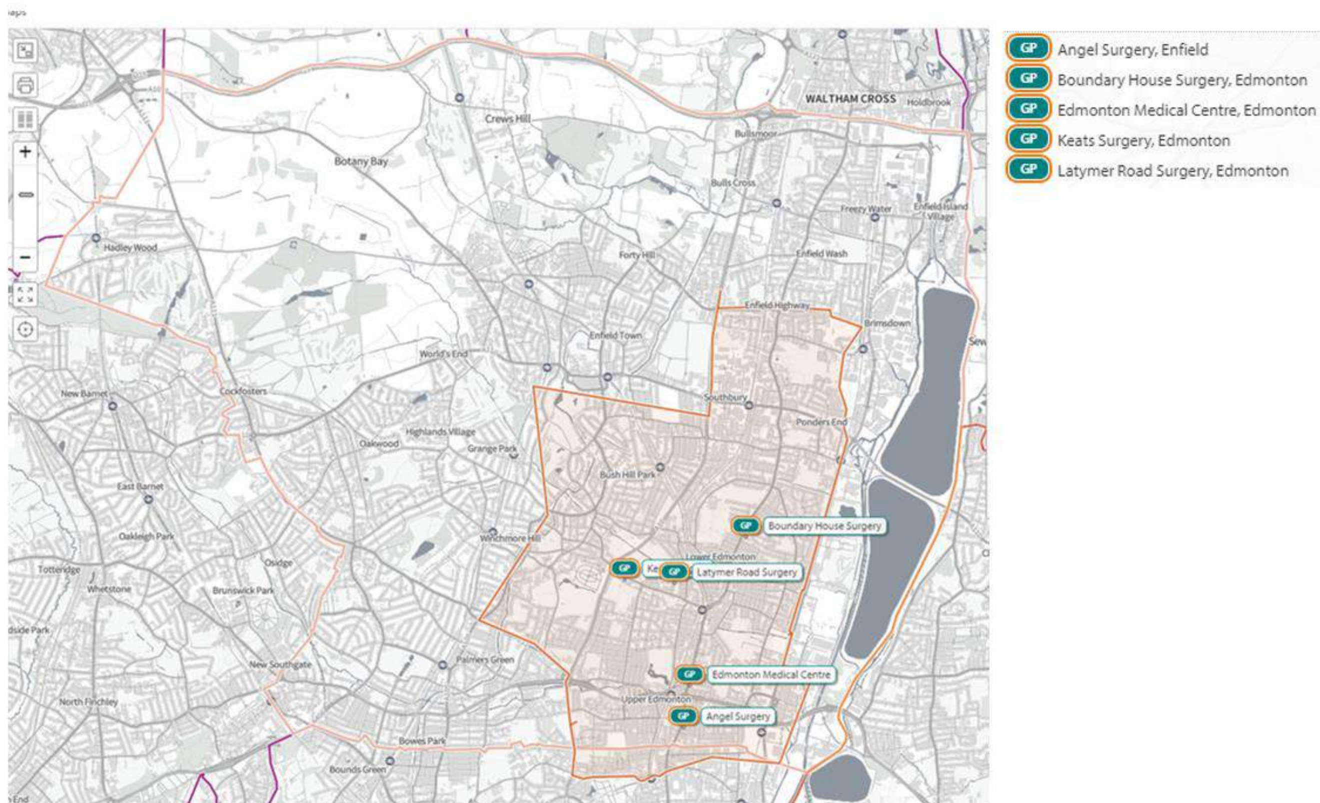
Map of Network Area



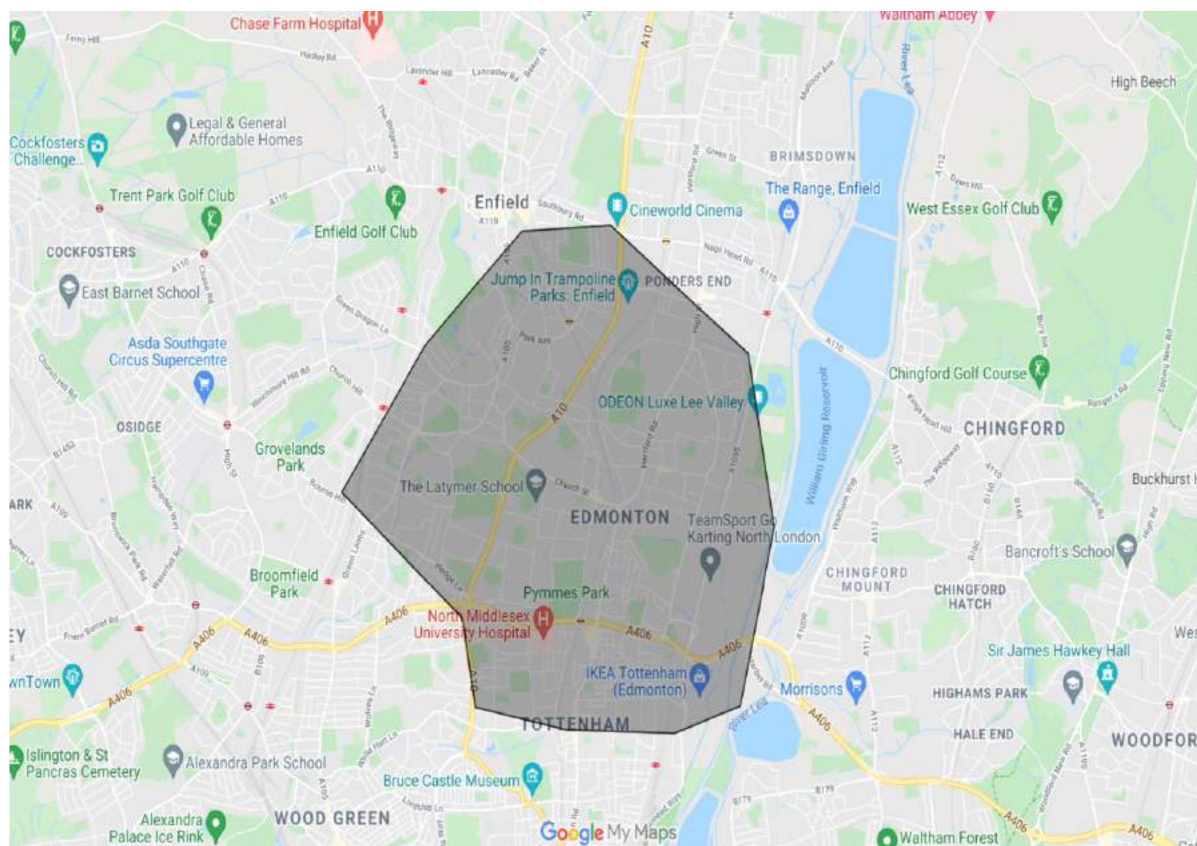
Proposed Edmonton PCN April 2022

Edmonton PCN falls in the same combined registered and contract catchment area as Enfield Care Network PCN

Proposed Edmonton PCN : Combined registered patients and contract catchments combined



Network Area – Submitted by proposed Edmonton PCN for 1 April 2022



North Central London
Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee Meeting
21 April 2022

Report Title	James Wigg Practice / Queens Crescent Surgery sites appraisal	**Date of report**	12 April 2022	**Agenda Item**	4.2
Considered at	**Part 1**☒ Part 2 ☐ Urgent decision ☐				
Lead Director / Manager	Simon Wheatley, Director of Integration - Camden Directorate	**Email / Tel**	simon.wheatley2@nhs.net		
GB Member Sponsor					
Report Author	Anthony Marks Assistant Head of Primary Care	**Email / Tel**	anthony.marks@nhs.net		
Name of Authorising Finance Lead	Tracey Lewis Head of Finance-Primary Care Commissioning	**Summary of Financial Implications** Saving of £47,600 rent if the one site option is chosen			
Report Summary	The Committee is asked to note the decision taken via urgent decision when considering the two options for the merger of James Wigg Practice and Queens Crescent Surgery: Option 1 - Merger onto one site: Kentish Town Health Centre, the current James Wigg Practice site, with the Queens Crescent Surgery site closing Option 2 - Merger retaining both sites. Committee members considered - The Department of Health (DH) Health Building Notes Estimator (HBN) space estimator calculated required clinical and treatment rooms - Workforce data - List size growth - Population growth and projections in the area - Any significant growth from residential developments - Any other premises developments in the areas - Potential savings from both models - Benefits and disadvantages of both models Committee also considered from the practices' representation - additional space needed to deliver current services - patient need in the Queens Crescent Surgery area - the unaffordability of breaking the current lease at Queens Crescent Surgery site				

	Committee members decided to approve Option 1 – Merger onto one site: Kentish Town Health Centre, the current James Wigg Practice site, with the Queens Crescent Surgery site closing. Commissioners have notified the practices about the decision made by committee members and await a response. The full urgent decision paper is included below.
Recommendation	The Committee is asked to **NOTE** the decision taken by the urgent decision panel on 14 March 2022 to approve: Option 1 - Merger onto one site: Kentish Town Health Centre, the current James Wigg Practice site, with the Queens Crescent Surgery site closing.
Identified Risks and Risk Management Actions	Possible opposition to a one site model. Mitigation – early engagement with patients and stakeholders and evidence of the practice actively seeking legal advice on their options to exit the lease and the Queens Crescent Site
Conflicts of Interest	*Not Applicable*
Resource Implications	Cost saving of £47,600 if the practices proceed with the one site model
Engagement	Full engagement will take place with all patients once the preferred model has been approved
Equality Impact Analysis	A full analysis will be completed as a part of the merger
Report History and Key Decisions	*Not Applicable*
Next Steps	1. To provide feedback to the practice about the Committee's decision on the approved model. 2. Practices submit appropriate merger application to bring to a future committee meeting.
Appendices	*Not Applicable*

NHS North Central London Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee Meeting
Urgent Decision
14 March 2022

Report Title	James Wigg Practice / Queens Crescent Surgery sites appraisal	**Date of report**	11 March 2022	**Agenda Item**	Urgent Decision
Considered at	**Part 1**☐ Part 2 ☐ Urgent decision ☒				
Lead Director / Manager	Simon Wheatley, Director of Integration - Camden Directorate	**Email / Tel**		simon.wheatley2@nhs.net	
GB Member Sponsor	Simon Wheatley, Director of Integration - Camden Directorate				
Report Author	Anthony Marks Assistant Head of Primary Care	**Email / Tel**		anthony.marks@nhs.net	
Name of Authorising Finance Lead	Tracey Lewis Head of Finance-Primary Care Commissioning	**Summary of Financial Implications** Saving of £47,600 rent if the one site option is chosen			
Report Summary	The members of the committee are asked to consider the two options for the merger of James Wigg Practice and Queens Crescent Surgery: Option 1 - Merger onto one site: Kentish Town Health Centre, the current James Wigg Practice site, with the Queens Crescent Surgery site closing Option 2 - Merger retaining both sites. James Wigg Practice is a PMS practice with a list size of 22,063 at 1 January 2022. It is the largest practice in Camden borough and in a PCN with Queens Crescent Surgery, a GMS practice with a list size of 6,601 as at 1 January 2022. The same contractors hold both contracts and are seeking to merge. The Practices submitted plans to merge and retain both sites in 2019, this was paused due to the COVID-19 response. The Practices now wish to proceed. To enable consistency amongst practices commissioners assess practice space requirements using the; - The Department of Health (DH) Health Building Notes Estimator (HBN) space estimator - Workforce data - List size growth - Population growth and projections in the area - Any significant growth from residential developments - Any other premises developments in the areas				

	The DH HBN space estimator tool also calculates at (1) 80% utilisation of the patient list, (2) 6 contacts per annum, (3) 15 minute consultations and (4) number of appointments per week, which exceeds the BMA guidance of 72 GP and 32 nursing appointments per week, which allows for a wider workforce operating in the practice. The DH HBN tool indicates that the combined list size requires 24 clinical and treatment rooms. The Practice already occupies 27 rooms over the two sites. If the Practice occupied one site (Kentish Town Health Centre) using the 23 rooms already utilised the patient to room ratio would be 1:1303 The Practice has submitted representation stating the existing lease at Queens Crescent Surgery will be unaffordable for them. The practice has further stated that a one site model does not follow the strategic direction of Primary Care bringing more services into PCNs and may lead to a reduction in services and provision of core Primary Care services. Greater London Authority population predictions for Cantelowes and Haverstock wards show a 3% decline respectively between 2020 and 2030. The list sizes of the practices have been relatively stable with James Wigg Practice growing 5% in 5 years and the Queens Crescent Surgery list has remained largely stable aside from two larger increases as the result of two practice mergers. The current James Wigg Practice site at the Kentish Town Health Centre has 112 sq m void space (offices) and 135 sq m of bookable space. This will allow for potential future growth although the void space will require capital investment to convert it from office to clinical space. Should the Practice merge onto the Kentish Town Health Centre site there would be a saving of £47,600 rent from the closure of Queens Crescent Surgery site. The combined rent would decrease from £906,847.83 (including VAT) to £859,247.83 The partners whom are tenants have signed a 10 year lease at Queens Crescent Surgery which has no break clause. The partners (tenants) would therefore incur costs of approximately £476,000 plus dilapidations to exit the lease early. The partners who are tenants have stated that these costs would be unaffordable. Part of the partnership is also the landlord of the building, therefore commissioners have advised the partners (tenant) and landlord that the CCG would not advice a practice to enter into a lease with no break clause and to seek advice (Local Medical Committee or legal) regarding the opportunities to exit the lease.
Recommendation	The members of the committee are asked to consider the two options for the merger of James Wigg Practice and Queens Crescent Surgery and identify the preferred model: Option 1 - Merger onto one site: Kentish Town Health Centre, the current James Wigg Practice site, with the Queens Crescent Surgery site closing

	Option 2 - Merger retaining both sites If committee members preferred option, is option 1, then commissioners will advise the practice that we wish to see evidence of legal advice sought on the options to exit the lease that reduces their liability.
Identified Risks and Risk Management Actions	Possible opposition should a one site model be chosen. Mitigation – early engagement with patients and stakeholders and evidence of the practice actively seeking legal advice on their options to exit the lease and the Queens Crescent Site Full efficiencies are not realised if the two site model is chosen
Conflicts of Interest	Not Applicable
Resource Implications	Cost saving of £47,600 if the one site model is chosen
Engagement	Full engagement will take place with all patients once the preferred model has been approved
Equality Impact Analysis	A full analysis will be completed as a part of the merger
Report History and Key Decisions	n/a
Next Steps	3. To provide feedback to the practice about the Committee's decision on which model is approved. 4. Practices submit appropriate merger application to bring to a future committee meeting.
Appendices	N/A

Options considered

The members of the committee are asked to consider the two options for the merger of James Wigg Practice and Queens Crescent Surgery:

- Merger onto one site: Kentish Town Health Centre, the current James Wigg Practice site, with the Queens Crescent Surgery site closing
- Merger retaining both sites.

The committee's decision on the preferred model will be presented to the practices who will then consider if they wish to proceed and begin patient engagement on the preferred option.

Background

James Wigg Practice is a PMS practice with a list size of 22,063 at 1 January 2022. It is the largest practice in Camden borough and in a PCN with Queens Crescent Surgery, a GMS practice with a list size of 6,601 as at 1 January 2022. The same contractors hold both contracts.

In 2019 the practices submitted proposals to merge the two contracts on to the PMS agreement. The proposed model was to operate from two sites; Kentish Town Health Centre and Queens Crescent

Surgery. At the time commissioners began exploring with the practices the possibility of the merged contract operating from one site. Discussions were paused due to the COVID-19 pandemic.

The practices have stated that they would like to resume plans to merge with their preferred option of operating from two sites.

Current locations

Kentish Town Health Centre

James Wigg Practice is situated in an award winning multi use health and community use building spread over 3 floors. The practice occupies 810 sq m of space, with 23 clinical and treatment rooms. Other occupiers in the building include CNWL Children's services, Royal Free Breast Screening, UCLH phlebotomy services and Whittington Health dental services. The building has 112 sq m void space (offices) and 135 sq m of bookable space. The buildings are approximately 0.7 miles / 15 minutes walking distance apart.

Queens Crescent Surgery

The Surgery is sited in converted retail and residential space above over 3 floors. One of the current partners is co-landlord of the building. The practice has a patient lift and 4 clinical and treatment rooms.

In March 2020 due to symptomatic and isolating clinical and non-clinical staff, Queens Crescent Surgery temporarily relocated and operated from Kentish Town Health Centre for 6 months. The practice said this was for viability of the surgery due to a reduction in staff and the improved facilities at Kentish Town Health Centre. They also pointed to the fact that Queens Crescent relocated to the building for a year previously when building work was underway. It should be noted that during the 2020 co location reduced numbers of face to face contacts with patients were being provided by all practices with a greater reliance on telephone and electronic consultations at this stage of the pandemic response.

Analysis of space requirements

Commissioners have used the Department of Health Building (HBN) Note calculator, which provides an indication of the number of clinical rooms required by general practice. The HBN estimator calculates the practice requirement to be

Site	Clinical rooms required	Treatment rooms required	Total rooms required	Current clinical and treatment rooms being used	Current room to patient ratio
James Wigg Practice	14	3	17	23	1:960
Queens Crescent Surgery	4	1	5	4	1:1321
Both sites	18	6	24	27	1:1062

Table 1: site room comparison

The above table shows that there is a requirement for an additional room at Queens Crescent Surgery site based on current patient numbers however if the merged practice was delivered from the Kentish Town Health Centre the practice would require a total of 24 clinical and treatment rooms. The practice

already occupies 23 rooms at this site. In addition there is bookable space available at the health centre as well as void space which the CCG is currently funding.

The DH HBN tool at 6 contacts per annum and 80% utilisation also estimated that the practice should provide 171,984 contacts per annum. This equates to 3,307 per months and 115 contacts / 1000 / week, delivered out of 24 rooms. This is significantly higher than the BMA guide of 72 appointments / 1000 / week. Therefore this demonstrates that the DH HBN tool has built additional clinical capacity for the workforce and practice.

It should be noted that if the void space were to be converted to clinical space it would require capital investment to convert this space from current office use.

Should the practice be sighted only at Kentish Town Health Centre and occupy the current 23 rooms this would give a room to patient ratio of 1:1303. This is a slightly higher ratio than previous cases PCCC have approved, but the void space provides an opportunity in the future.

List Size and Population Growth

The list size for James Wigg Practice has grown slowly by 5% over the past 5 years as detailed in table 2 below

Year	Apr	Jul	Oct	Jan
2017	20904	20984	21098	21200
2018	21292	21351	21493	21637
2019	21621	21644	21750	21914
2020	21905	21916	21817	21859
2021	22002	21957	22008	22063

Table 2 James Wigg Practice raw list size

The list size for Queens Crescent Surgery has fluctuated when the practice merged with two nearby practices in 2017 and in May 2020, but has otherwise been stable as shown in table 3

Year	Apr	Jul	Oct	Jan
2017	3837	5583	5609	5618
2018	5551	5499	5514	5618
2019	5606	5567	5561	5621
2020	5606	7227	7098	6912
2021	6787	6737	6677	6601

Table 3 Queens Crescent Surgery raw list size

The practices have stated they expect list size growth of 10% due to local housing developments, however the Greater London Authority population projections show a 3% decline locally between 2020 and 2030[1]

Financial Implications

The current rent reimbursement for two sites is £906,847.83 (including VAT) combined.

If the practice merged onto the existing space used by James Wigg Practice this would represent a saving of £47,600

[1] https://data.london.gov.uk/dataset/housing-led-population-projections

Lease implications

The partners at Queens Crescent have a lease in place for 10 more years. This lease has no break clause for the practice and should they vacate the building the practice would be liable for any associated costs. This would be estimated at approximately £476,000. This figure does not include any dilapidations which the tenants will be liable for regardless.

Practices' representation

The Practices believe that only a two site model is viable. In their representation they state that the Queens Crescent Surgery is in an area of high deprivation with lower life expectancy than other wards in Camden. They believe it is not in the interests of patient outcomes to close the building and may lead to increased use of acute services. Commissioners note that the list would transfer to the Kentish Town Health Centre for a one site model and not be a dispersal of the Queens Crescent Surgery list. There is no planned reduction in access.

The Practices state that there is no usable additional clinical space at Kentish Town Health Centre. Commissioners note that there is bookable and void space in the building but reconfiguration would be required. They say that James Wigg Practice is already at full capacity and point to an additional 10% list growth expected from housing developments. They have not said how they would meet the additional demand on two sites but this would likely be through the use of the bookable and void space in Kentish Town Health Centre.

The Practices argue that the HBN1 assessment is outdated and does not take account of:

- Training – the practice has 15 clinicians in training in the practice
- The practice provides full range of Enhanced services including IUCD fitting for Camden
- Integrated services with mental health serviced, paediatric multidisciplinary working and Camden carers sessions
- GP administration time is not included
- 15 ARRS staff working in the practice are not taken into account in space requirements

Commissioners acknowledge the practices concern but the DH HBN tool using the existing list size over estimated the number of contacts at 115 appointments / 1000 / week, delivered out of 24 rooms. This is compared to the BMA recommendation of 72 appointments / 1000 / week. Therefore additional capacity has been built in for a wider clinical workforce.

Transferring to a one site model the Practices state does not follow the strategic direction of Primary Care bringing more services into PCNs and will lead to a reduction in services:

- Opting out of medical student, nurse and GP registrar teaching
- A halt to recruitment of ARRS staff and therefore the ability to provide the Network Contract DES
- Ceasing enhanced services such as IUD fitting, wound dressings and opiate prescribing, putting pressure on community services
- Ceasing integrated working with community midwives, paediatricians, mental health team, health visitors, smoking cessation team
- Ceasing all enhanced and locally commissioned services
- Difficulty to recruit staff to the practice.

From Commissioners assessment of the HBN1 tool the Practices current have 27 clinical and treatment rooms and require 22 rooms. It is therefore implied that the above services which the Practice say would be impacted are being delivered from the 5 additional rooms. These services could be incorporated into the Kentish Town Health Centre if void space and bookable space was utilised following reconfiguration. It should also be noted that these two practices form the entirety of the PCN so there is no additional space across the PCN that can be used.

The Practices have highlighted that the cost of exiting their lease early would be unaffordable. It is therefore likely that if Committee approve a one site model the Practices will decide not to merge and achieve efficiencies and economies of scale.

Options considered

A comparison of the two options for the proposed merger is provided below

Option	Benefits	Disadvantages	Savings
One site model (Kentish Town Health Centre)	• Services operate from large modern health centre building • Economies of scale maximised when delivering from one site • Capacity to expand into void / bookable space in the future • Patients are already accustomed to receiving care at the site through PCN services	• Closure of one site • Provider will need to pay any associated lease and dilapidation costs • Patients may have to travel further to access health services • The practices are currently using more clinical and treatment rooms (27) than the HBN1 tool requires (22) • The practices may have to limit their offer to core Primary Care	Initial saving of £47,600 rent from Primary Care budget
Two site model	• Patients are accustomed to delivery across the two sites and have greater choice • No additional cost is incurred for the practice • Services as currently provided will continue	• No saving is made for the commissioners • Full efficiencies of operating from one site are not realised	None

Next Steps

1. To provide feedback to the practice about the Committee's decision on which option is approved
2. Confirm with the practices if they wish to proceed with the approved option.
3. If the practices wish to retain a two site option, then commissioners will request a copy of the legal advice regarding the lease without a break clause
4. Begin full patient and stakeholder engagement.
5. Refer the proposal to merge to Committee.

North Central London Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee Meeting
21 April 2022

Report Title	Deploying CCG funds in General Practice	**Date of report**	7 April 2022	**Agenda Item**	4.3
Lead Director / Manager	Sarah McDonnell-Davies	**Email / Tel**		sarah.mcdonnell1@nhs.net 0777 138 1377	
GB Member Sponsor					
Report Author	Diane Macdonald / Karla Damba	**Email / Tel**		diane.macdonald3@nhs.net 07840 884699	
Name of Authorising Finance Lead	Anthony Browne Anthony.Browne@nhs.net 020 3688 1394	**Summary of Financial Implications** *(see below)*			
Report Summary	The urgent decision panel met on Monday 7 March 2022 to consider deploying CCG funds in General Practice (see full paper below). They were asked to approve the transfer of funding with funding required of £469,411 for 28 schemes. The CCG estates, primary care, IT and finance teams have worked to identify and shortlist of priority estates and IT investments schemes in general practice across NCL in 2021/22. These funds represented a unique opportunity to accelerate improvements in general practice in this financial year. The teams worked together to identify a list of potential schemes and confirm their priority in each borough. Each practice was given an equal chance to nominate schemes for the longlist. Given the urgency to consider the business in this financial year, it was agreed that the committee should meet by email and to be considered by members to meet quoracy requirements. The urgent decision panel considered the above report. Members noted the 28 shortlisted schemes based on local priorities and eligibility of spend, amounting to a total of value of £469,441. In overview, schemes covered the following themes: • Security • Digitisation / IT • Off-site storage • Improvement schemes – small premises improvements • Professional fees to support scheme development and feasibility. After due consideration, the urgent decision panel supported unanimously and unequivocally the transfer of funding to support all 28 schemes listed in Appendix 1 of the above report; with agreement reached on the 8 March 2022. **The urgent decision panel approved the transfer of funding with the funding required of £469,411 for 28 schemes.**				

Recommendation	The Committee is asked to **NOTE** the decision taken by the urgent decision panel on 7 March 2022 to approve the transfer of funding of £469,441 for 28 schemes.
Identified Risks and Risk Management Actions	See below
Conflicts of Interest	See below
Resource Implications	See below
Engagement	See below
Equality Impact Analysis	See below
Report History and Key Decisions	See below
Next Steps	See below
Appendices	See below.

NHS
North Central London
Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee
Urgent Decision
7 March 2022

Report Title	Deploying CCG funds in General Practice	**Date of report**	03 Mar 2022	**Agenda Item**	Urgent Decision
Lead Director / Manager	Sarah McDonnell-Davies	**Email / Tel**		sarah.mcdonnell1@nhs.net 0777 138 1377	
GB Member Sponsor					
Report Author	Diane Macdonald / Karla Damba	**Email / Tel**		diane.macdonald3@nhs.net 07840 884699	
Name of Authorising Finance Lead	Anthony Browne Anthony.Browne@nhs.net 020 3688 1394	**Summary of Financial Implications** The CCG has identified 28 schemes across NCL GP practices for estates investment this financial year. The total value of this investment in 2021/22 is £469,441.			
Report Summary	The CCG estates, primary care, IT and finance teams have worked to identify and shortlist of priority estates and IT investments schemes in general practice across NCL in 2021/22. These funds represent a unique opportunity to accelerate improvements in general practice this financial year. The teams worked together to identify a longlist of potential schemes and confirm their priority in each borough. Each practice was given an equal chance to nominate schemes for the longlist. Each proposal was reviewed to ensure compliance with the Premises Cost Directions and GPIT guidance – using the London Improvement Grant guidance / GPIT on eligibility. CCG funding will be provided on Improvement Grant lines, funding 66%, with practices contributing 34%. The team shortlisted schemes based on local priorities and eligibility of spend. The outcome of the shortlisting is 33 schemes, with a value of £469,441. In overview, schemes cover the following broad headings: • Security – proposals that missed out on funding via the Winter Access Fund (removing ineligible items and notifying practices that only 66% will be funded) • Digitisation / IT – shortfalls in GPIT funding, to cover purchase of new equipment for relocation projects • Off-site storage – one year of funding to store records in anticipation of the second phase of the national Lloyd George records digitisation programme • Improvement schemes – small premises improvements • Professional fees to support scheme development and feasibility.				

	The schemes proposed do not have additional revenue impact. Where applicable, practices will be expected to approach their projects using the Improvement Grant approach. Funding will be granted to practices on the basis that it can be clawed back if not spent, or not spent on the agreed scope. The list of schemes has been validated and finalised by CCG Finance and Primary Care contracting teams, who support the recommendation to approve fund.
Recommendation	The Committee is asked to **APPROVE** the transfer of funding. The funding required is £469,441 for 28 schemes.
Identified Risks and Risk Management Actions	**Not approving the transfer of funding –** these priority projects will be carried over to the next financial year and would therefore be a call on future year funding. There is a risk that some projects will not be allocated funding next financial year, despite identified need, due to budgetary constraints. **Works not carried out as agreed –** Practices are required to accept the offer of funding on the proviso that they will provide evidence of what works have been carried out. This enables the CCG to clawback the funding if works are not in line with approvals or have not been carried out.
Conflicts of Interest	None
Resource Implications	• CCG funds of £469,441 • The schemes proposed do not have additional revenue impact. • Administration and monitoring of the GP schemes will be carried out by Borough Estates Leads, as part of their existing remit
Engagement	Significant engagement has taken place with the following interested parties: • GP practices – to establish need and to set out the eligibility of proposals and the terms, including required 34% co-funding • Borough Estates and Borough Primary Care Commissioning teams – colleagues were asked to identify priority projects and to work through the issues for each, assess against the Premises Cost Directions and the divergence of 100% funding with Winter Access Fund payment
Equality Impact Analysis	Schemes have been confirmed as priority projects in each Borough and will contribute to the overall impact on addressing health inequalities. No wider equalities impacts have been identified.
Report History and Key Decisions	
Next Steps	Signed agreements from practices and transfer of funding.
Appendices	

North Central London
Clinical Commissioning Group

North Central London CCG
Primary Care Commissioning Committee Meeting
21 April 2021

<table>
<tr><td>Report Title</td><td>Primary Care Commissioning Committee Risk Register</td><td>Date of report</td><td>12 April 2022</td><td>Agenda Item</td><td>5.1</td></tr>
<tr><td>Lead Director / Manager</td><td>Sarah McDonnell-Davies Executive Director of Borough Partnerships</td><td>Email / Tel</td><td colspan="3">sarah.mcdonnell1@nhs.net</td></tr>
<tr><td>GB Member Sponsor</td><td colspan="5"></td></tr>
<tr><td>Report Author</td><td>Chris Hanson, Governance and Risk Lead</td><td>Email / Tel</td><td colspan="3">christopher.hanson1@nhs.net</td></tr>
<tr><td>Name of Authorising Finance Lead</td><td>Not Applicable</td><td colspan="4">Summary of Financial Implications

This report assists the CCG in managing its most significant financial risks.</td></tr>
<tr><td>Report Summary</td><td colspan="5">This report provides an overview of material risks falling within the remit of the Primary Care Commissioning Committee (‘Committee’) of North Central London CCG.

There are 6 risks on the Committee Risk Register. The threshold for escalation to the Committee is a risk score of 12 or higher. Since the last Committee meeting, the number of risks on the register and their ratings have remained the same.

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 mitigation is to promote earlier recognition of struggling practices, and ensure that support is provided before regulatory action is required. The workforce and resilience workstream for primary care recovery has a focus on supporting, and early identification of, struggling practices.

The NCL financial resilience package for practices to cover the impact of the COVID-19 pandemic, in place since April 2020, is in line with national guidance published in August 2020. The resilience package aims to mitigate the impact of the COVID-19 pandemic, and had been extended to cover all of 2020/21. Support is based on income protection where practices are unable to complete income</td></tr>
</table>

	generating work due to the pandemic (Quality Outcomes Framework, Locally Commissioned Services) and to offset additional costs incurred including cover for staff absence and personal protective equipment. The financial resilience package forms part of the local support offer to practices with other aspects including a central clinical triage and home visiting service to treat COVID-19 positive patients separately, training for infection prevention control, and weekly practice webinars. The package for 2021/22 had been developed in line with planning guidance, and initially will be in place for quarters one, two and three, with a similar approach proposed for quarter four. The Primary Care SITREP reporting and income protection resulting from the Covid 19 Pandemic has ceased from 1 April 2022, following the National Primary Care Contract changes. The 2022/23 contract changes have provided additional funding to increase practice workforce numbers further through the Additional Roles Reimbursement Scheme. This risk is rated 12 **PERF15:** *Failure to address variation in Primary Care Quality and Performance across NCL (Threat)*: This risk highlights the ongoing need to reduce unwarranted variation in quality and performance across general practices. The risk is complex and requires multi-faceted actions to mitigate it. Work under way to support the reduction in unwarranted variation includes delivery of the PCN Direct Enhanced Service (DES) specifications for 2022/23, the development of the Primary Care Dashboard, the implementation of national guidance on re-procurement of Extended Access services, and the development of an NCL-wide Long Term Conditions Locally Commissioned Service. There is also ongoing work to develop the GP Provider Alliance and a unified primary care provider voice within the NCL integrated care system. This risk is rated 12 **PERF18:** *Primary care workforce development (Threat):* This risk highlights the importance of Primary Care workforce development, and the ongoing challenges with recruitment and retention. A range of national and local schemes are in place to mitigate the risk. These include the national PCN additional roles reimbursement scheme (ARRS). We are currently in year 4 of the 5 year scheme which enables PCNs to access national funding to recruit into a range of 15 different roles. There is an expectation that CCGs and systems will explore different ways of supporting PCNs to recruit. PCNs continue to recruit to these roles and are supported by Training Hubs with induction and professional development. Other recent key measures include: • Measures to support GP training, recruitment and retention to help deliver 6,000 more doctors in primary care. This includes £94m to address recruitment and retention issues, including a Partnership Premium of £20,000 and greater proportion of GP training time spent in general practice; • NCL Training Hub developed Primary Care Nursing Strategy and NCL Primary Care Nursing Programme Priorities 22-23. Discussed at February PCCC to identify further opportunities to strengthen this work within the ICS;

	• Expansion and promotion of Clinical Placements in NCL to attract, support and embed more new to practice workforce; • Winter Access Funding and additional GP Nursing funding received to enable workforce development schemes focusing on Reception & Admin staff, Healthcare Assistances (HCA), GP Nurses (GPN), Nursing Associates (NAs), Trainee Nursing Associates (TNAs), retention of volunteers; • Primary Care Flexible Staff Pool procurement is completed and a new offer to strengthen links between practices and GPs and GPNs wishing to work flexibly live from late March 2022; • Mentoring scheme first developed under the GP and GPN Fellowship and Mentoring scheme is to be expanded out to wider workforce in 2022/23; • 12 GP Retention Schemes live in NCL at a borough level supporting development and retention of GPs. Given the high demand on the Primary Care workforce during the pandemic, the CCG will have to monitor the impact on wellbeing and fatigue. The CCG and NCL training hub have been implementing a wellbeing programme targeting Primary Care staff. This will include Primary Care awards event in 2022/23. This risk is rated 16 **PERF21:** *Failure of Primary Care patient access (Threat)*: This risk was identified as part of the system recovery, further to the COVID-19 pandemic. At the outset of the COVID-19 pandemic, practices were asked to adopt Total Triage, advising patients not to come to practices, with appointments managed initially via telephone, online or video. Whilst telephone/ digital routes are still used for triaging in many practices, 52% of all GP appointments in NCL are now offered face to face. This is higher than NHS England requirements of 50%. The CCG has also measured that NCL GP practices have greater capacity now than pre-COVID-19. The move to Total Triage, a small number of practices who were not able to provide an open front door, and misinformation have resulted in service user perception that GPs are not providing face to face care. Nonetheless a significant amount of abuse, particularly of non-clinical and administrative staff, has been recorded and the CCG is collaborating with stakeholders to offer support and collate incidents reports. The CCG is conducting a communications campaign both in relation to GP practices, as set out above, and the patients to remind service users that General Practices are open. The winter access plan has been implemented using NHSE winter access funding. The plan aimed to sustain / increase capacity in general practice including practice level funding to support additional local locum costs, a PCN innovation fund to support delivery of access pilots, support of community pharmacy consultation service and a range of front door ED schemes. Work is now underway to evaluate the Plan's successes. This risk is rated 16 **PERF22:** *Failure to manage impact of increased building costs on General Practice estate (Threat)*: Due to disrupted supply chains, impacted by reduced HGV capacity, Brexit, and COVID-19, construction costs in terms of both building material and labour have been inflated. Building schemes will therefore take longer, and be more expensive (by c. 20%).

	This has resulted in pressure on the CCG to increase capital investment in building programmes, or to fund them indirectly through increased rents. This will put pressure on both contingency and rent budgets. Whilst the CCG has mitigated some of the effects in specific projects, it is unlikely that these pressures will reduce significantly until the broader economic factors have been resolved. This risk is rated 12 **COVID12:** *Capacity in General Practice (Threat):* This risk highlights the transfer from reactive Covid-19 response to the new 'Living with COVID' approach. Actions to ensure that there is sufficient capacity in general practice to manage demand include: • GP practices using the "telephone first" model where majority of patient triage is carried out on the phone – with face to face being offered where it is clinically appropriate; • Oximetery@Home pathway is being used; • Practice 'buddying' arrangements via their Primary Care Networks; • 2021/22 winter access plan has now been implemented. Evaluation and learning is now underway; • GP capacity is being impacted by workforce burnout / tiredness, pent up demand for general practice services, and due to demands of system recovery. Developed Health & Wellbeing Offer to practices launched in 2021/22 and continuing into 22/23 providing tailor resources and in reach. This risk is rated 12
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.

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	Sarah McDonnell-Davies - Executive Director of Borough Partnerships	Vanessa Piper - Head of Primary Care	Support system recovery and strengthen both Urgent Care & Integrated Urgent Care	**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 undertaken, 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 C9. General practice capacity fund distributed for 2021/21 (£4.1m) with further £1.2m to be distributed in 2021/22 (Quarters 1 &2) C10. NCL framework for early warning system C11. Performance and quality report to provide triangulated view of practice performance C12. Practice resilience programme through the primary care recovery programme C13. Financial support package for COVID-19 for 2021/22 in line with planning guidance	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 C9. Planning guidance for 2021/22 and PCCC papers for 2020/21 C10. Practice SITREP which is reported through the primary care silver call CN11. Performance and Quality report produced and reported through the NCL PCCC. Further work is being done to develop the dashboard further C12. Resilience finance package has been in place since April 2020 and has continued C13. Resilience finance package has been in place since April 2020 and has continued	AVERAGE: The controls have a 61 – 79% chance of successfully controlling the risk	3	4	12	CN1. Redevelop recovery plan for primary care in light of wave 2 of the pandemic and planning guidance	A1. Update recovery plan for primary care	A1. 30.06.2022	A1. Recovery priorities have been identified. Implementation is now being mobilised.	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 mitigation is to promote earlier recognition of struggling practices, and ensure that support is provided before regulatory action is required. The workforce and resilience workstream for primary care recovery has a focus on supporting, and early identification of, struggling practices. The NCL financial resilience package for practices to cover the impact of the COVID-19 pandemic, in place since April 2020, is in line with national guidance published in August 2020. The resilience package aims to mitigate the impact of the COVID-19 pandemic, and had been extended to cover all of 2020/21. Support is based on income protection where practices are unable to complete income generating work due to the pandemic (Quality Outcomes Framework, Locally Commissioned Services) and to offset additional costs incurred including cover for staff absence and personal protective equipment. The financial resilience package forms part of the local support offer to practices with other aspects including a central clinical triage and home visiting service to treat COVID-19 positive patients separately, training for infection prevention control, and weekly practice webinars. The package for 2021/22 had been developed in line with planning guidance, and initially will be in place for quarters one, two and three, with a similar approach proposed for quarter four. The Primary Care SITREP reporting and income protection resulting from the Covid 19 Pandemic has ceased from 1 April 2022, following the National Primary Care Contract changes. The 2022/23 contract changes has provided additional funding to increase practice workforce numbers further through the Additional Roles Reimbursement Scheme.	12.04.2022	Open
PERF15	Sarah McDonnell-Davies - Executive Director of Borough Partnerships	Sarah Mcilwaine, Director of Transformation - Primary Care	Tackle health inequalities and strengthen the system approach to population / place-based health and care management	**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 Primary Care Network (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 C7. Development of inequalities workplan to address differential access to primary care and NHS services C8. Implemented Directed Enhanced Service (DES) for PCNs C9. Enhanced performance and quality report	C1. Report C2. Committee papers C3. CCG papers C4. CCG Strategy C5. CCG papers and STP workstream papers C6. Primary Care Covid papers and minutes C7. CCG papers C8. DES documentation C9. Report	AVERAGE: The controls have a 61 – 79% chance of successfully controlling the risk	3	4	12	CN1. Development of Primary Care Dashboard CN2. Support national guidance to PCNs on delivering health inequalities specification CN3. Mobilise workstream to oversee national requirement for new extended access and extended hours procurement and include learning on differential access from covid vaccination programme CN4. Development of winter access plan against newly launched national winter access fund.	A1. Develop dashboard A2. Respond to requirements from national guidance A3. Implement national guidance on extended access procurement A4. Finalise winter access plan A5. Consistency of enhanced offer - long term conditions	A1. 30.06.2022 A2. 31.03.2023 A3. 31.10.2022 A4. 28.02.2022 A5. 30.06.2022	A1. Draft dashboard developed and being shared with clinical leads for comment. Further scoping needed on how dashboard can be used effectively and how it would can be resourced in a sustainable way. Due to resourcing issues the deadline has been pushed back. A2. Borough Primary Care teams working with PCNs to deliver health inequalities specification. A3. End of October deadline for initial PCN extended access plans. A4. Completed A5. Development of consistent approach to long term conditions enhanced offer pan-NCL	3	2	6	Primary Care Commissioning Committee	This risk highlights the ongoing need to reduce unwarranted variation in quality and performance across general practices. The risk is complex and requires multi-faceted actions to mitigate it. Work under way to support the reduction in unwarranted variation includes delivery of the PCN Direct Enhanced Service (DES) specifications for 2022/23, the development of the Primary Care Dashboard, the implementation of national guidance on re-procurement of Extended Access services, and the development of an NCL-wide Long Term Conditions Locally Commissioned Service. There is also ongoing work to develop the GP Provider Alliance and a unified primary care provider voice within the NCL integrated care system.	11.04.2022	Open
PERF18	Sarah McDonnell-Davies - Executive Director of Borough Partnerships	Tessa Newton Primary Care Programme Manager	Provide robust support to, and development of, our workforce - including through change	**Failure to effectively develop the primary care workforce (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. Primary Care Networks recruiting new roles through national Additional Roles Reimbursement Scheme (ARRS) programme. 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. Workforce development team in place in the CCG C5. The Workforce Action Plan is in draft and will be shared with stakeholders for comment imminently C6. Ongoing CCG support of PCNs in relation to ARRS role development and recruitment	C1. Committee papers C2. Programme papers C3. CCG papers and General Practice Forward View (GPFV) funding C4. Strategy Directorate structures include workforce development C5. Plan C6. Staff in place, annual PCN workforce planning submission to NHSE	STRONG: The controls have a 80%+ chance or higher of successfully controlling the risk	4	4	16	CN1. Implementation of 2022/23 GP retention funding CN4. Development of Borough-based workforce analysis - to be reviewed by PCCC	A1. Ongoing implementation and delivery of borough GP retention plans. A2. Borough Primary Care teams and NCL training hub to work with PCNs to support annual workforce planning	A1. 31.03.2023 A2. 31.10.2023	A1. Work ongoing - CCG primary care teams working with local training hubs to develop plans against 2022/23 GP retention funding. A2. End of deadline October for PCN workforce plans to be submitted to NHSE.	3	3	9	Primary Care Commissioning Committee	This risk highlights the importance of Primary Care workforce development, and the ongoing challenges with recruitment and retention. A range of national and local schemes are in place to mitigate the risk. These include the national PCN additional roles reimbursement scheme (ARRS). We are currently in year 4 of the 5 year scheme which enables PCNs to access national funding to recruit into a range of 15 different roles. There is an expectation that CCGs and systems will explore different ways of supporting PCNs to recruit. PCNs continue to recruit to these roles and are supported by Training Hubs with induction and professional development. Other recent key measures include: • Measures to support GP training, recruitment and retention to help deliver 6,000 more doctors in primary care. This includes £94m to address recruitment and retention issues, including a Partnership Premium of £20,000 and greater proportion of GP training time spent in general practice; • NCL Training Hub developed Primary Care Nursing Strategy and NCL Primary Care Nursing Programme Priorities 22-23. Discussed at February PCCC to identify further opportunities to strengthen this work within the ICS. • Expansion and promotion of Clinical Placements in NCL to attract, support and embed more new to practice workforce. • WAF funding and additional GP Nursing funding received to enable workforce development schemes focusing on Reception & Admin staff, HCA, GPNs, NAs, TNAs, retention of volunteers • Primary Care Flexible Staff Pool procurement completed and new offer to strengthen links between practices and GPs and GPNs wishing to work flexibly live from late March 2022 • Mentoring scheme first developed under the GP and GPN Fellowship and Mentoring scheme to be expanded out to wider workforce in 2022/23 • 12 GP Retention Schemes live in NCL at a borough level supporting development and retention of GPs Given the high demand on the Primary Care workforce during the pandemic, the CCG will have to monitor the impact on wellbeing and fatigue. The CCG and NCL training hub have been implementing a wellbeing programme targeting Primary Care staff. This will include Primary Care awards event in 2022/23.	11.04.2022	Open
PERF21	Sarah McDonnell-Davies - Executive Director of Borough Partnerships	Sarah Mcilwaine, Director of Transformation - Primary Care	Support system recovery and strengthen both Urgent Care & Integrated Urgent Care	**Failure of Primary Care patient access (Threat)** **CAUSE:** If the CCG fails to address patient perceptions that GPs will not offer face to face appointments (either due to historical experience, public misunderstanding, or the prioritisation of telephone triaging) and any issues in accessing general practice). **EFFECT:** There is a risk that either patients do not present to GPs or present to other parts of the Integrated Care Systems ('ICS') creating additional pressure elsewhere. There is also a risk to NHS staff of abuse due to public and patient frustration **IMPACT:** This may result in patient harm, negative impact on workforce wellbeing and turnover especially in non-clinical staff, system instability due to increased demand in Emergency Departments ('ED') and Urgent Treatment Centres('UTC'), and reputational damage for the CCG and the ICS.	4	4	16	C1. CCG Primary Care, and Comms teams in situ C2. Primary Care Silver meetings with stakeholders including Local Medical Committees (LMC) C3. Communication campaign C4. System Recovery Executive in place C5. Primary Care capacity in excess of pre-COVID-19 baseline (2019) (excluding COVID-19 vaccination appointments) C6. Winter Access Plan implemented	C1. Employment contracts, structure charts C2. Reports, meeting notes, minutes C3. Communications with GPs, GP website resources for patient communication providing GP practice material to deal with abuse of staff, and Partnership Council in place C4. Reports, meeting notes and minutes, ICS communications C5. Local support process in place C6. Winter Access Plan submitted to NHS England for approval	AVERAGE: The controls have a 61 – 79% chance of successfully controlling the risk	4	4	16	CN1. 100% practices providing open front door service CN2. Development of agreed action plan CN3. Mobilisation of winter access plan.	A1. Engagement with practices to support provision of open front door service (IPC, clinical, estates/ other) A2. Primary Silver Calls to develop action plan A3. Begin mobilisation of Winter Access Plan once plan has been approved by NHSE. A4. Evaluate the success of Winter Access Plan for future learning	A1. 31.03.2022 A2. 28.02.2022 A3. 28.02.2022 A4. 30.05.2022	A1. Complete A2. Complete A3. Complete A4. Has commenced	3	3	9	Primary Care Commissioning Committee	This risk was identified as part of the system recovery, further to the COVID-19 pandemic. At the outset of the COVID-19 pandemic, practices were asked to adopt Total Triage, advising patients not to come to practices, with appointments managed initially via telephone, online or video. Whilst telephone/ digital routes are still used for triaging in many practices, 52% of all GP appointments in NCL are now offered face to face. This is higher than NHS England requirements of 50%. The CCG has also measured that NCL GP practices have greater capacity now than pre-COVID-19. The move to Total Triage, a small number of practices who were not able to provide an open front door and misinformation have resulted in service user perception that GPs are not providing face to face care. Nonetheless a significant amount of abuse, particularly of non-clinical and administrative staff, has been recorded and the CCG is collaborating with stakeholders to offer support and collate incidents reports. The CCG is conducting a communications campaign both in relation to GP practices, as set out above, and the patients to remind service users that General Practices are open. The winter access plan has been implemented using NHSE winter access funding. The plan aimed to sustain / increase capacity in general practice including practice level funding to support additional local locum costs, a PCN innovation fund to support delivery of access pilots, support of community pharmacy consultation service and a range of front door ED schemes. Work is now underway to evaluate the Plan's successes.	11.04.2022	Open
PERF22	Sarah McDonnell-Davies - Executive Director of Borough Partnerships	Nicola Theron - Director of Estates	Maintain strong financial vigilance	**Failure to manage impact of increased building costs on General Practice estate (Threat)** **CAUSE:** If the CCG does not manage the need for increased capital investment or increased rent to develop the General Practice estate, due to increased construction costs because of disrupted supply chains **EFFECT:** There is a risk that Primary Care development schemes will either be cancelled, or will have be to be scaled down, Additional capital will need to be found for existing schemes already under contract. **IMPACT:** This may result in the CCG being unable to deliver improvement to Primary Care services and negative patient experience. This may also result in an inability to invest as desired to improve patient care and support existing services.	3	4	12	C1. Primary Care Commissioners and Estate teams in situ, with negotiation experience, and ensure buy in of all partners of process and timetable C2. Robust governance of Rent Budgets and contingency budgets, to identify potential budgets (potential external) to increase contingency C3. Primary Care Commissioning Committee ('PCCC') established to manage Primary Care strategy and commissioning	C1.Employment contracts, Structure charts, previous negotiated investment agreements, agreed delivery toolkit between all partners C2. Budgets, Financial reports, SFIs. C3. PCCC Terms of Reference.	WEAK: The controls have a 1 – 60% chance of successfully controlling the risk	3	4	12	CN1. Monitoring of increased costs, currently c. 20%, and impact on Rent and Contingency Budgets CN2. Prioritisation of Primary Care development schemes CN3. Support critical negotiations with Landlords and Developers C4. Review estate to identify properties at risk of requiring development	A1. Pipeline of potential work via primary and community care estates group and buy in by finance, primary care, contracting and estate to these projects A2. Exploration of ability to increase flexibility of use in NHS-owned estate within NCL	A1. 30.06.2022 A2. 31.07.2022	A1. review underway. Stage 1 findings due 31.03.2022 and being brought to PCCC in April A2. Ongoing action and needs to incorporate the findings of prioritisation process in A1	3	3	9	Primary Care Commissioning Committee	Due to disrupted supply chains, impacted by reduced HGV capacity, Brexit, and COVID-19, construction costs in terms of both building material and labour have been inflated. Building schemes will therefore take longer, and be more expensive (by c. 20%). This has resulted in pressure on the CCG to increase capital investment in building programmes, or to fund them indirectly through increased rents. This will put pressure on both contingency and rent budgets. Whilst the CCG has mitigated some of the effects in specific projects, it is unlikely that these pressures will reduce significantly until the broader economic factors have been resolved.	11.04.2022	Open
COVID 12	Sarah McDonnell-Davies - Executive Director of Borough Partnerships	Sarah Mcilwaine, Director of Transformation - Primary Care	Support the ongoing response to Covid-19 pandemic and vaccination programme	**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. GP practices have established a "telephone first" model where majority of consultations are triaged on the phone. C2.Ongoing support with Vaccination sites C3. Practice 'buddying' arrangements via business continuity plans C4. Review of GP workload in line with RCGP BMA guidance, NCL-tailored approach C5. Ongoing use of Oximetery@Home pathway	C1. Triage first model in place as per national mandate C2. Vaccination steering group and regular vaccination bulletin for PCN sites. C3. Primary care COVID action plan C4. Implemented regular review of practice prioritisation advice - reviewing on fortnightly basis C5. Pathway and resources developed and shared on GP website.	AVERAGE: The controls have a 61 – 79% chance of successfully controlling the risk	4	3	12	CN1. Need to prevent fatigue and burn-out in primary care staff	A1. Secure funding for programmes to ensure staff wellbeing A2. Implement the Winter Access Fund plan	A1. 31.08.2022 A2. 28.02.2022	A1. Pan-NCL bid for Primary Care and wellbeing and resilience funding submitted June 2021 and was successful. Funding now in place. Wellbeing programme is being implemented. A2. Complete	4	3	12	Primary Care Commissioning Committee	This risk highlights the transfer from reactive Covid-19 response to the new 'Living with COVID' approach. Actions to ensure that there is sufficient capacity in general practice to manage demand include: • GP practices using the "telephone first" model where majority of patient triage is carried out on the phone – with face to face being offered where it is clinically appropriate; • Oximetery@Home pathway is being used; • Practice 'buddying' arrangements via their Primary Care Networks; • 2021/22 winter access plan has now been implemented. Evaluation and learning is now underway; • GP capacity is being impacted by workforce burnout / tiredness, pent up demand for general practice services, and due to demands of system recovery. Developed Health & Wellbeing Offer to practices launched in 2021/22 and continuing into 22/23 providing tailor resources and in reach.	11.04.2022	Open

North Central London CCG PCCC Risk Register - Highlight Report				2021/22 Current Risk Score					Movement From Last Report	Target Risk Score
Risk ID	Risk Title	Risk Owner	Key Updates	OCT	DEC	FEB	APRIL			
PERF4	**Opportunities to support struggling practices are sometimes delayed by the absence of a systematic early warning system (Threat)**	Sarah McDonnell-Davies Executive Director of Borough Partnerships	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 mitigation is to promote earlier recognition of struggling practices, and ensure that support is provided before regulatory action is required. The workforce and resilience workstream for primary care recovery has a focus on supporting, and early identification of, struggling practices. The NCL financial resilience package for practices to cover the impact of the COVID-19 pandemic, in place since April 2020, is in line with national guidance published in August 2020. The resilience package aims to mitigate the impact of the COVID-19 pandemic, and had been extended to cover all of 2020/21. Support is based on income protection where practices are unable to complete income generating work due to the pandemic (Quality Outcomes Framework, Locally Commissioned Services) and to offset additional costs incurred including cover for staff absence and personal protective equipment. The financial resilience package forms part of the local support offer to practices with other aspects including a central clinical triage and home visiting service to treat COVID-19 positive patients separately, training for infection prevention control, and weekly practice webinars. The package for 2021/22 had been developed in line with planning guidance, and initially will be in place for quarters one, two and three, with a similar approach proposed for quarter four. The Primary Care SITREP reporting and income protection resulting from the Covid 19 Pandemic has ceased from 1 April 2022, following the National Primary Care Contract changes. The 2022/23 contract changes has provided additional funding to increase practice workforce numbers further through the Additional Roles Reimbursement Scheme.	12	12	12	12		➔	6
PERF15	**Failure to address variation in Primary Care Quality and Performance across NCL (Threat)**	Sarah McDonnell-Davies Executive Director of Borough Partnerships	This risk highlights the ongoing need to reduce unwarranted variation in quality and performance across general practices. The risk is complex and requires multi-faceted actions to mitigate it. Work under way to support the reduction in unwarranted variation includes delivery of the PCN Direct Enhanced Service (DES) specifications for 2022/23, the development of the Primary Care Dashboard, the implementation of national guidance on re-procurement of Extended Access services, and the development of an NCL-wide Long Term Conditions Locally Commissioned Service. There is also ongoing work to develop the GP Provider Alliance and a unified primary care provider voice within the NCL integrated care system.	12	12	12	12		➔	6
PERF18	**Primary care workforce development (Threat)**	Sarah McDonnell-Davies Executive Director of Borough Partnerships	This risk highlights the importance of Primary Care workforce development, and the ongoing challenges with recruitment and retention. A range of national and local schemes are in place to mitigate the risk. These include the national PCN additional roles reimbursement scheme (ARRS). We are currently in year 4 of the 5 year scheme which enables PCNs to access national funding to recruit into a range of 15 different roles. There is an expectation that CCGs and systems will explore different ways of supporting PCNs to recruit. PCNs continue to recruit to these roles and aresupported by Training Hubs with induction and professional development. Other recent key measures include: • Measures to support GP training, recruitment and retention to help deliver 6,000 more doctors in primary care. This includes £94m to address recruitment and retention issues, including a Partnership Premium of £20,000 and greater proportion of GP training time spent in general practice; • NCL Training Hub developed Primary Care Nursing Strategy and NCL Primary Care Nursing Programme Priorities 22-23. Discussed at February PCCC to identify further opportunities to strengthen this work within the ICS; • Expansion and promotion of Clinical Placements in NCL to attract, support and embed more new to practice workforce; • WAF funding and additional GP Nursing funding received to enable workforce development schemes focusing on Reception & Admin staff, Healthcare Assistances (HCA), GP Nurses (GPN), Nursing Associates (NAs), Trainee Nursing Associates (TNAs), retention of volunteers; • Primary Care Flexible Staff Pool procurement is completed and a new offer to strengthen links between practices and GPs and GPNs wishing to work flexibly live from late March 2022; • Mentoring scheme first developed under the GP and GPN Fellowship and Mentoring scheme is to be expanded out to wider workforce in 2022/23; • 12 GP Retention Schemes live in NCL at a borough level supporting development and retention of GPs. Given the high demand on the Primary Care workforce during the pandemic, the CCG will have to monitor the impact on wellbeing and fatigue. The CCG and NCL training hub have been implementing a wellbeing programme targeting Primary Care staff. This will include Primary Care awards event in 2022/23.	16	16	16	16		➔	9

PERF21	**Failure of Primary Care patient access (Threat)**	Sarah McDonnell-Davies Executive Director of Borough Partnerships	This risk was identified as part of the system recovery, further to the COVID-19 pandemic. At the outset of the COVID-19 pandemic, practices were asked to adopt Total Triage, advising patients not to come to practices, with appointments managed initially via telephone, online or video. Whilst telephone/ digital routes are still used for triaging in many practices, 52% of all GP appointments in NCL are now offered face to face. This is higher than NHS England requirements of 50%. The CCG has also measured that NCL GP practices have greater capacity now than pre-COVID-19. The move to Total Triage, a small number of practices who were not able to provide an open front door and misinformation have resulted in service user perception that GPs are not providing face to face care. Nonetheless a significant amount of abuse, particularly of non-clinical and administrative staff, has been recorded and the CCG is collaborating with stakeholders to offer support and collate incidents reports. The CCG is conducting a communications campaign both in relation to GP practices, as set out above, and the patients to remind service users that General Practices are open. The winter access plan has been implemented using NHSE winter access funding. The plan aimed to sustain / increase capacity in general practice including practice level funding to support additional local locum costs, a PCN innovation fund to support delivery of access pilots, support of community pharmacy consultation service and a range of front door ED schemes. Work is now underway to evaluate the Plan's successes.	16	16	16	16		→	9
PERF22	**Failure to manage impact of increased building costs on General Practice estate (Threat)**	Sarah McDonnell-Davies Executive Director of Borough Partnerships	Due to disrupted supply chains, impacted by reduced HGV capacity, Brexit, and COVID-19, construction costs in terms of both building material and labour have been inflated. Building schemes will therefore take longer, and be more expensive (by c. 20%). This has resulted in pressure on the CCG to increase capital investment in building programmes, or to fund them indirectly through increased rents. This will put pressure on both contingency and rent budgets. Whilst the CCG has mitigated some of the effects in specific projects, it is unlikely that these pressures will reduce significantly until the broader economic factors have been resolved. .	12	12	12	12		→	9
COVID12	**Capacity in General Practice (Threat)**	Sarah McDonnell-Davies Executive Director of Borough Partnerships	This risk highlights the transfer from reactive Covid-19 response to the new 'Living with COVID' approach. Actions to ensure that there is sufficient capacity in general practice to manage demand include: • GP practices using the "telephone first" model where majority of patient triage is carried out on the phone – with face to face being offered where it is clinically appropriate; • Oximetery@Home pathway is being used; • Practice 'buddying' arrangements via their Primary Care Networks; • 2021/22 winter access plan has now been implemented. Evaluation and learning is now underway; • GP capacity is being impacted by workforce burnout / tiredness, pent up demand for general practice services, and due to demands of system recovery. Developed Health & Wellbeing Offer to practices launched in 2021/22 and continuing into 22/23 providing tailor resources and in reach.	12	12	12	12		→	12

Risk Key

Risk Improving ↓

Risk Worsening ↑

Risk neither improving nor worsening but working towards target →

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 2021 / 22

Area	22 Apr 2021	20 May 2021 Seminar	17 June 2021	15 July 2021 Seminar	19 August 2021	21 October 2021	16 December 2021	17 February 2022	21 April 2022	16 June 2022
Governance										
Review of Risk Register	X		X		X	X	X	X	X	X
Review of Terms of Reference (TOR)								X		
Review of Committee Effectiveness	X							X		
Contracting										
Decisions relating to GMS, PMS and APMS contracts eg: practice mergers	X		X		X	X	X	X	X	X
Local Commissioned Services						X				
Procurements	As and when required									
Demonstration of DH Health Building Notes Estimator (HBN)		X								
Pros & Cons of practices merging together		X								
Quality & Performance										

Quality and Performance Report	X		X		X	X	X	X	X	X
Finance Report										
Finance Report	X		X		X	X	X	X	X	X
Strategy										
Primary Care Strategic Review				X	X		X			
NHS Long Term Plan and Operating Plan	X					X		X		
Other papers										
Developing Primary Care workforce		X		X						
GP Patient Survey learning							X			
NCL Finance Resilience Package for Primary Care					X		X			
Extended Access scheme to PCNs by 1 April 2022						X				
New GP Contract Update								X		
PCN Development	X					X				
Covid report					X		X			
Primary Care Estates	X						X			

Borough analysis of nursing capacity across NCL								X		
London Operating Model 21/22 for the Collaborative Commissioning of Primary Care Services (GPs) review of proposed changes, from 01 04 22								X		
Domestic Abuse report (from Camden HW) (Ian B)								x		