

Primary Care Committee Meeting

Tuesday 10 March 2026

2:00pm to 3:10pm

Clerkenwell Room, 2nd Floor,

Laycock PDC, Laycock Street, Islington N1 1TH.

Item	Title	Lead	Action	Page	Time
AGENDA - Part 1					
1.	INTRODUCTION				
1.1	Welcome, Introductions and Apologies	Liz Sayce	Note	Oral	2:00pm
1.2	Declarations of Interest (<i>Not otherwise stated</i>)	All	Note	3	
1.3	Draft Minutes of the PCC meeting on 13 January 2026	Liz Sayce	Approve	8	
1.4	Action Log	Liz Sayce	Approve	17	
1.5	Matters Arising	Liz Sayce	Note	Oral	
2.	BUSINESS				
2.1	Langstone Way Surgery (Barnet) - PCN Change	Vanessa Piper	Approve	20	2:05pm
2.2	Millway Medical Practice (Barnet) - Revenue Request for Additional Space	Diane Macdonald	Approve	58	2:15pm
2.3	The Practice at 188 (Barnet) - Revenue Request for Portacabins	Diane Macdonald	Approve	75	2:25pm
2.4	Protected Learning Time (PLT) - Proposal to Extend Scheme	Carol Kumar and Cassy Bygrave	Approve	92	2:35pm
3.	GOVERNANCE				
3.1	Primary Care Committee Risk Register	Becky Kingsnorth	Note	121	2:45pm
4.	OVERVIEW REPORTS				
4.1	Primary Care Finance Report	Sarah Rothenberg	Note	131	2.50pm
4.2	Quality & Performance Report	Tamzin Jamieson	Note	144	2.55pm
5.	FOR INFORMATION				
5.1	Low risk papers (virtual approval 27/02/26) <ul style="list-style-type: none"> • Commissioning Decisions on PMS Agreement Changes • Andover Medical Centre - Direct Payments for premises reimbursable costs • Hendon Way Surgery - Direct Payments for premises reimbursable costs • The Miller Practice - Direct Payments for premises reimbursable costs • The Everglade Medical Practice - Direct Payments for premises reimbursable costs • Morris House Group Practice – Request for Additional Space 	Liz Sayce	Note	188 194 198 202 206 210	3:05pm

6.	ANY OTHER BUSINESS				
6.1	Committee Closure and Final Reflections	Liz Sayce and Sarah McDonnell-Davies	Note	Oral	3:05pm
6.2	Delegation of Minutes Approval	Liz Sayce	Approve	Oral	
	PART 2 MEETINGS				
	To resolve that as publicity on items contained in Part 2 of the agenda would be prejudicial to public interest by reason of their confidential nature, representatives of the press and members of the public should be excluded from the remainder of the meeting. Section 1 (2) Public Bodies (Admission to meetings) Act 1960.				



**North Central London ICB
Primary Care Committee Meeting
10 March 2026**

Report Title	Declaration of Interests Register – Primary Care Committee (PCC)	Agenda Item: 1.2	
Integrated Care Board Sponsor	Sarah McDonnell-Davies, Chief Transformation Officer	Tel/Email	sarah.mcdonnell1@nhs.net
Lead Director / Manager	Sarah Morgan, Chief People Officer	Tel/Email	sarahlouise.morgan@nhs.net
Report Author	Vivienne Ahmad, Board Secretary	Tel/Email	v.ahmad@nhs.net
Name of Authorising Finance Lead	Not applicable.	Summary of Financial Implications	Not applicable.
Name of Authorising Estates Lead	Not applicable.	Summary of Estates Implications	Not applicable.
Report Summary	<ul style="list-style-type: none">• Members and attendees of the Primary Care Committee (PCC) 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 Board, 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, taxpayers, healthcare providers and Parliament that ICB 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.• Members are reminded to ensure their declaration of interest form and the register recording their details are kept up to date.• Members and attendees are also asked to note the requirement for any relevant gifts or hospitality they have received to be recorded on the ICB Gifts and Hospitality Register.		

Recommendation	The Committee is asked to NOTE: <ul style="list-style-type: none"> • the requirement to declare any interests relating to the agenda. • the Declaration of Interests Register and to inspect their entry and advise the Board Secretary of any changes. • the requirement to record any relevant gifts and hospitality on the ICB Gifts and Hospitality Register.
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 ICB.
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 Committee.
Next Steps	The Declaration of Interests Register is presented to every meeting of the Primary Care Committee and regularly monitored.
Appendices	The Declaration of Interests Register.

NCL ICB Primary Care Committee Declaration of Interest Register - January 2026

Name	Current Position (s) held- i.e. ICB Board, Trust, 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												
Ms Liz Sayce OBE	Non Executive Member, Deputy Chair and member of the ICB Board							01/07/2022	current	26/08/2022	28/01/2025	
Ms Liz Sayce OBE	Chair of ICB Remuneration Committee										28/01/2025	
Ms Liz Sayce OBE	Chair of ICB Quality and Safety Committee	Action on Disability and Development International	no	yes		direct	Co Chair	26/01/2021	current	26/08/2022	28/01/2025	
Ms Liz Sayce OBE	Chair of ICB Primary Care Committee	London School of Economics	yes	yes		direct	Visiting Professor in Practice		current	26/08/2022	28/01/2025	
Ms Liz Sayce OBE	Chair NCL People Board	Royal Society of Arts	no	no	yes	direct	Fellow		current	26/08/2022	28/01/2025	
Ms Liz Sayce OBE		Government commissioned independent review of Carer's Allowance overpayments	yes	no	no	direct	Lead	01/11/2024	30/06/2025	16/10/2024	28/01/2025	
Ms Liz Sayce OBE		Furzedown Project, Wandsworth, Charity no 1076087	no			direct	Chair of Trustees	24/11/2022	current	24/11/2022	28/01/2025	
Ms Liz Sayce OBE		Consultancy roles	no	no	no	indirect	My partner offers consultancy across the UK to mental health services, sometimes working with NHS Trusts, local authorities or voluntary sector organisations		current	26/08/2022	28/01/2025	
Sarah Morgan	Chief People Officer Member of the NCL / NWL Executive Members Team		yes	yes	no	Direct	01/07/2022	04/07/2022	current	04/07/2022	24/10/2025	
Sarah Morgan	Attendee of NCL / NWL ICB Board of Members									04/07/2022	24/10/2025	
Sarah Morgan	Member of NCL ICB People Board									04/07/2022	24/10/2025	
Sarah Morgan	Voting member Primary Care Committee									04/07/2022	24/10/2025	
Sarah Morgan	Member of the Population Health Strategic Commissioning Committee									04/07/2022	24/10/2025	
Sarah Morgan	Co-Chair of the Culture and Operations Group									04/07/2022	24/10/2025	
Sarah Morgan	Attend NCL / NWL Remuneration Committee	Good Governance Institute	no	no	yes	Direct	Faculty member	01/12/2020	current	04/07/2022	24/10/2025	Manage contributions in line with ICB guidance
Sarah Morgan	Attend NCL / NWL Audit Committee	Fresh Visions People Ltd Charity no 1091627, which is hosted	no	no	yes	Direct	Trustee / Director and Chair from 6 December 2023	22/04/2022	current	04/07/2022	24/10/2025	Ensure that any contractual arrangements that may involve Fresh Visions or the parent organisation Southern Housing are declared as a conflict of interest as operate out of London
Sarah Morgan	Member of NCL Procurement Oversight Group	Kaleidoscope Health and Care (not for profit Social Enterprise)	no	yes	no	Direct	Member of a professional network of health and care professionals including alumni of the NHS general management graduate scheme	2016	current	13/12/2023	24/10/2025	Manage any contractual arrangements through procurement team
Sarah Morgan		University of Birmingham, School of Social Policy, Health Services Management Centre	no	no	yes	Direct	Honorary Associate Professor	01/10/2023	current	13/12/2023	24/10/2025	Manage contributions in line with ICB guidance
Dr Jo Sauvage	Chief Medical Officer		yes	yes	no	direct		01/07/2022	current	10/07/2022	17/11/2025	
Dr Jo Sauvage	Member of NCL / NWL ICB Board		no	yes	no	direct			current	10/07/2022	17/11/2025	
Dr Jo Sauvage	Member of NCL / NWL Executive Management Team	London Clinical Executive Group	no	yes	no	direct	NCL Clinical Representative		current	10/07/2022	17/11/2025	
Dr Jo Sauvage	Member of ICS Community Partnership Forum	London Primary Care School Board	no	yes	no	direct	ICS Representative		current	10/07/2022	17/11/2025	
Dr Jo Sauvage	Member of NCL Primary Care Committee	London Primary Care Board	no	yes	no	direct	ICS Representative		current	10/07/2022	17/11/2025	
Dr Jo Sauvage	NCL Quality and Safety Committee and NWL Performance Committee	London Urgent and Emergency Care Board	no	yes	no	direct	NCL Representative		current	10/07/2022	17/11/2025	
Dr Jo Sauvage	NCL Population Health Strategic Commissioning Committee and NWL Strategic Commissioning Committee	Greener NHS England, London	no	yes	no	direct	Clinical Director		current	10/07/2022	17/11/2025	
Dr Jo Sauvage	Attendee of NWL Finance and Contracting Committee	NCL ICB Sustainability Clinical Network	no	yes	no	direct	Clinical Lead		current	10/07/2022	17/11/2025	
Dr Jo Sauvage	Expert Advisory Group for Evidence based interventions. Hosted by Academy of Royal Colleges	Hosted by Academy of Royal Colleges	no	yes	no	direct	Member		current	10/07/2022	17/11/2025	
Dr Jo Sauvage	attend sub committees of the Board as and when required	Net Zero Clinical Transformation Advisory Board	no	yes	no	direct	Member		current	01/02/2025	17/11/2025	
Dr Jo Sauvage	Clinical Director Greener NHS, NHS England London		no	yes	no	direct	Clinical Director		current	06/07/2023	17/11/2025	
Dr Jo Sauvage		City Road Medical Practice	yes	yes	yes	direct	salaried GP	01/03/2024	current	01/02/2025	17/11/2025	Excluded from discussions involving City Road Medical Centre
Dr Jo Sauvage		NHS England London	yes	yes	no	direct	Clinical Director, interest pertains to clinical leadership at London regional level	05/11/2018	current	10/07/2022	17/11/2025	Financial remuneration for the sessions worked; same terms and conditions as ICB office holder excluded from discussions involving City Road Medical Centre
Dr Jo Sauvage	Employed as GP	Islington GP Federation	no	yes	no	direct	Employee of Islington GP Federation	01/04/2024	current	01/02/2024	17/11/2025	
Dr Jo Sauvage	Employed at City Road Medical Centre	South Islington PCN	no	yes	no	direct	GP Practise is a member	01/07/2019	current	01/02/2024	17/11/2025	
Jennifer Roye	NCL / NWL Chief Nursing Officer	none	no	no	no	none				13/11/2025		
Jennifer Roye	Member of NCL / NWL ICB Board, voting									13/11/2025		
Jennifer Roye	Member of NCL / NWL Executive Management Team									13/11/2025		
Jennifer Roye	Member of Quality and Safety Committee,									13/11/2025		
Jennifer Roye	Member of NCL Pop Health SCC									13/11/2025		
Jennifer Roye	Member of Primary Care Committee									13/11/2025		
Jennifer Roye	Member of NWL Performance and Finance Committee									13/11/2025		
Jennifer Roye	attend other committees as when required									13/11/2025		

NCL ICB Primary Care Committee Declaration of Interest Register - January 2026

Sarah McDonnell-Davies	Chief Transformation Officer	No interests declared	no	no	no	no			20/06/2018	current	20/06/2018	11/11/2025	
Sarah McDonnell-Davies	NCL / NWL ICB Board attendee											11/11/2025	
Sarah McDonnell-Davies	Member of the NCL / NWL ICB Executive Management Team											11/11/2025	
Sarah McDonnell-Davies	Member of the ICB Primary Care Contracting Committee											11/11/2025	
Sarah McDonnell-Davies	Member of the NCL ICB Population Health Strategic Commissioning Committee and NWL ICB Strategic Commissioning Committee											11/11/2025	
Sarah McDonnell-Davies	Member of NCL ICS Digital Board											11/11/2025	
Sarah McDonnell-Davies	Member of NCL System Management Board											11/11/2025	
Sarah McDonnell-Davies	Member of the London Neighbourhood Board.											11/11/2025	
Sarah McDonnell-Davies	Attend other committees as required											11/11/2025	
Sarah Rothenberg	Deputy Director Finance Business Partnering (Primary Care). Member of NCL ICB Primary Care Committee and attendee Integrated Medicines Optimisation Committee								01/07/2022	current	05/09/2022	01/07/2025	
Non- Voting Participants and Observers													
Sarah McIlwaine	Director of Primary Care Attend Participant Primary Care Committee and other committees as	None	N/A	N/A	N/A	N/A	none				09/10/2018	04/03/2025	
Jenny Goodridge	Director of Quality and Clinical Standards		No	No	No	n/a					13/02/2018	04/02/2026	
Jenny Goodridge	Member of Quality and Safety Committee.											04/02/2026	
Jenny Goodridge	Member of Strategy and Development Committee											04/02/2026	
Jenny Goodridge	Member of Primary Care Committee											04/02/2026	
Jenny Goodridge	attend other committees as when required											04/02/2026	
Vanessa Piper	Assistant Director for Primary Care Contracting	None	No	No	No	No	Nil Return		13/09/2020	current	23/08/2021	21/10/2025	
Michelle Malwah	Healthwatch Enfield, Manager	none	N/A	N/A	N/A	N/A	N/A				26/11/2024		
John Pritchard	Senior Communications and Engagement Manager - Place and Primary Care Attendee of Primary Care Committee.	None	N/A	N/A	N/A	N/A	None				12/10/2018	31/01/2025	
Lorna Reith	Community Participant	Chair of Haringey Citizens Advice	No	Yes	No	Direct	Chair			current	10/11/2023		
Mark Agathangelou	Community Participant	No interests declared	No	No	No	No	Nil Return		13/10/2020	current	16/10/2021	08/09/2022	
Clare Henderson	Director of Place (East)	No interests declared	No	No	No	No	Nil Return				08/09/2022	13/02/2025	
Carol Kumar	Assistant Director for Primary Care Planning Improvement and Operations	Five Development Consultancy LLP	yes	n	yes	direct	self and partner		2014	current	02/10/2017	02/04/2025	organisation not related to NHS business
	NCL PC C&C team- Practice case logs EOG Primary Care Committee Part 1 and 2 LMC informal and SLN Various other meetings for ICB as needed	Vita Et Pax Parents Friends Association Charity number: 1185988	no	no	no	direct	Trustee and Secretary		16/07/1905	current	07/09/2022	02/04/2025	organisation not related to NHS business
Anthony Marks	Primary Care Contracting Senior Manager GP Primary Care Commissioning & Contracting	No interests declared	No	No	No	No	Nil return				30/10/2018	30/06/2025	
Simon Wheatley	Director of Place (West: Barnet & Camden):	no interests declared	No	No	No	No	Nil return				28/05/2019	31/07/2024	
Su Nayee	Primary Care Contracting Senior Manager GP Primary Care Commissioning & Contracting	No interests declared	No	No	No	No	Nil return				20.10.2018	07/07/2025	
Rebecca Kingsnorth	Assistant Director for Primary Care Programmes and Transformation Will occasionally deputise for the Director of Primary Care at the Primary Care Committee. Attendee of Primary Care Operations Group, Primary Care Strategy Group and other primary care related meetings.	Yes	No	No	Yes	Indirect	My sister-in-law is a salaried GP at one practice in North Central London		Dec-17	current	18/10/2018	06/08/2025	I will ensure I am not involved in any commissioning decisions related specifically and solely to this practice.
		Sing Up Foundation	no	no	yes	direct	trustee / director		01/06/2024 / 05/02/2025	current	02/07/2024	06/08/2025	I am involved in service commissioning in primary care services and so would flag and alert my manager if there any potential conflict and excuse myself from any relevant discussions in the ICB
Kirsten Watters	Director of Public Health - Camden Council	Yes	No	No	Yes	Indirect	Husband is partner and shareholder at DWF LLP which is on the NHS legal resolution panel lot 1.				11/10/2022		
Ken Kanu	Chief Executive, Help on Your Doorstep		yes	yes	yes	direct	Chief Executive and Company Secretary		2009	current	25/01/2023		
		NCL VCSE Alliance				direct	Member		2022	current	25/01/2023		
		Help on Your Doorstep					Delivery of social prescribing services in Islington		2019	current	25/01/2023		
		Help on Your Doorstep					Delivery of community Wellbeing Project in Islington		2019	current	25/01/2023		

NCL ICB Primary Care Committee Declaration of Interest Register - January 2026

Jamie (James) Wright	Director of Primary Care (NWL & NCL)- LMC	Local Medical Committee (Londonwide)	yes	yes	no	direct	employee of LMC		current	14/11/2022		
Deirdre Malone	Interim Director of Quality and Clinical Standards	none	none	none	none	none			current	21/11/2016	05/08/2025	
Deirdre Malone	Attend the following committees in relation to ICB business: •ICB Quality and Safety Committee •GOSH Retained Services oversight group •Quality meeting RNOH •Specialised Commissioning Quality Committee hosted by NHSE •NCL ICB PCC •Member of CAG •NCL ICB IMOC •NCL ICB Medicines reference group. •NCL ICB IPC/AMS Committee •NCL ICB POG •NCL ICB Flow Board	CMC HYGEA, Manufacturer of Healthcare products in the Republic of Ireland.	none	none	yes	indirect	Brother in law is CEO of CMC HYGEA	03/12/2015	current	21/11/2016	05/08/2025	I am not directly involved in the procurement of healthcare products in my role, therefore no mitigations are required
Tamzin Jamieson	Head of Primary Care Strategy and Change Chief Medical Officer (CMO) and Place Directorate	none	N/A	N/A	N/A	N/A				31/03/2022	17/09/2025	
Dan Rogers	Public Voice	CEO	yes	yes	yes	direct	host organisation for local Healthwatch in NCL)	01/10/2022	current	14/10/2025		Attend meetings as deputy to local Healthwatch Manager, in Healthwatch capacity
Dan Rogers		Deputising as member of three Committee meetings: -Primary Care Committee -Quality and Safety Committee -Community Partnership Forum -Community Engagement Steering Group.							current	14/10/2025		
Dan Rogers		Public Voice					Public Voice is commissioned by NCL ICB to deliver projects as part of the Inequalities Fund		current	14/10/2025		It is understood no decisions are made in the committees attended regarding the Inequalities Fund
Paul Addae												
Dudzile Sher Arami	Director of Public Health, London Borough of Enfield	attendee Primary Care Committee	yes	yes	no	direct	Enfield Council			16/11/2022		
		Co Chair of Enfield Inequalities Delivery Board	no	yes	no	direct	co-chair			16/11/2022		
		Member of Enfield Borough Partnership	no	yes	no	direct	member			16/11/2022		
		Co Chair of Enfield Screening and Immunisation Delivery Board	no	yes	no	direct	co-chair			16/11/2022		
Jonathan O'Sullivan	Acting Director of Public Health, Islington Council	attendee Primary Care Committee	yes	yes	no	direct	Islington Council					
		Sexual Health for London – City of London Corporation	no	yes	no	direct	Director		current	28/11/2022		
		Health Determinants Research Collaborative, NIHR (lead, award to Islington Council)	no	yes	no	direct	Lead	01/10/2020	current	28/11/2022		
Dr Tamara Djuretic	Director of Public Health and Prevention, Barnet Council	attendee Primary Care Committee	yes	yes	no	direct	Barnet Council		current	11/12/2022		
		Population Health and Inequalities Steering Group	no	yes	no	direct	Member		current	11/12/2022		
		Borough Partnership Executive and Delivery Board	no	yes	no	direct	member		current	11/12/2022		
		other committees attend by rotation on behalf of DsPH.	no	yes	no	direct	member		current	11/12/2022		
	Director of PH at the Royal Free Group	Director of PH at the Royal Free Group	yes	yes	no	direct	Royal Free Group		current	11/12/2022		
Donna Turnbull	VCSE Alliance rep - Strategy and development Committee and Primary Care Committee	Voluntary Action Camden	yes	yes	no	direct	Health and Partnership Development Manager		current	26/07/2023		
		Managing and developing social prescribing service. Capacity building with Camden VCSEs to engage with health transformation /address health inequalities.							current	26/07/2023		
		AGE UK Camden	yes	yes	no	direct	Sub contractor of Age UK Camden for Camden's NCL commissioned Care Navigation and Social Prescribing Service	01/10/2018	current	26/07/2023		
		Community Action Research (Health Inequalities projects)	yes	yes	no	direct	Health Inequalities projects	01/10/2022	30/04/2023	26/07/2023		

NCL ICB PRIMARY CARE COMMITTEE (PCC)

Draft Minutes of Meeting held on Tuesday 13 January 2026 between 9:30am and 11:00am

NCL ICB, Clerkenwell Room, 2nd Floor, Laycock Centre, Laycock St, London N1 1TH.

Voting Members	
Ms Liz Sayce	Non - Executive Member & Committee Acting Chair
Ms Sarah McDonnell-Davies	Executive Director of Place & Executive lead for the Committee
Dr Josephine Sauvage	Chief Medical Officer
Ms Sarah Louise Morgan	Chief People Officer
Ms Sarah Rothenberg	Deputy Director Finance Partnering - Primary Care (Deputised for Anthony Browne - Director of Finance Business Partnering)
Ms Jenny Goodridge	Director of Quality and Clinical Standards (Deputised for Jennifer Roye - Chief Nurse Officer)
Non – Voting Participants	
Ms Sarah Mcilwaine	Director of Primary Care
Ms Vanessa Piper	Assistant Director for Primary Care Contracting
Mr Anthony Marks	Primary Care Contracting Senior Manager
Ms Su Nayee	Primary Care Contracting Senior Manager
Ms Carol Kumar	Assistant Director for Primary Care Planning, Operations and Improvement
Ms Rebecca Kingsnorth	Assistant Director for Primary Care Strategy & Change
Ms Tamzin Jamieson	Head of Primary Care Strategy and Change (item 4.1)
Ms Diane Macdonald	NCL Deputy Director of Strategic Estates Finance
Mr Mark Agathangelou	Community Participant
Ms Lorna Reith	Community Participant
Mr Paul Addae	Healthwatch Representative
Mr Andrew Tillbrook	MS Teams Live Producer
Ms Vivienne Ahmad	Board Secretary (Minutes)
Apologies:	
Ms Frances O’Callaghan	Chief Executive Officer
Dr Katie Coleman	Clinical Director for Primary Care
Ms Donna Turnbull	VCSE Alliance Representative
Mr Jamie Wright	LMC Representative
Mr Ken Kanu	VCSE Alliance Representative
Mr John Pritchard	Senior Communications and Engagement Manager – Place and Primary Care

1.	INTRODUCTION
1.1	Welcome & Apologies
1.1.1	<p>The Chair welcomed everyone to the meeting.</p> <p>Apologies were recorded as above.</p> <p>The Committee was quorate.</p> <p>The Chair reminded everyone that members of the public can attend committee meetings. It is important to note that this is a meeting held in public, it is not a 'public meeting'. This means that members of the public can:</p> <ul style="list-style-type: none"> ➤ Attend meetings, in person or virtually. ➤ Listen to the proceedings and observe the decision-making process. ➤ Ask questions relating to items listed on the agenda in advance by email. <p>Where appropriate, questions would be addressed in the introduction to relevant agenda items. No questions from the public were received for this meeting.</p>
1.2	Declarations of Interests (not otherwise stated)
1.2.1	<ul style="list-style-type: none"> • Committee Members were invited to note their entries on the Register of Declarations of Interest. No additions were made. • The Chair also invited members of the Committee to declare any interests in respect to the items on the agenda. No declarations were made. • The Chair invited members of the Committee to declare any gifts and hospitality received. No gifts and hospitality items were declared.
1.2.2	The Committee NOTED the Declarations of Interest.
1.3	Draft Minutes of the PCC meeting on 14 October 2025
1.3.1	The minutes of the Primary Care Committee (PCC) Meeting on 14 October 2025 were agreed as a true record of the meeting.
	The Committee APPROVED the minutes.
1.4	Action Log
1.4.1	The Committee reviewed the action log.
	The Committee APPROVED the action log.
1.5	Matters Arising
1.5.1	The Chair announced positive developments regarding the Clinical Waste procurement. A collaborative procurement involving 24 ICBs was suspended in December 2024 following a legal challenge, but the ICBs have since successfully lifted the suspension and prevented the expedition of the main hearing, with partial cost recovery anticipated. The next steps are to proceed with contract signatures, notify incumbent providers, and mobilise the new suppliers. The preferred bidder for NWL is PHS Ltd and for NCL is Sharpsmart Ltd, and it was noted that the ongoing challenge is now limited to damages.
2.	BUSINESS
2.1	Ordnance Unity Centre for Health (Enfield) – APMS Contract Performance Review Update

2.1.1	<p>Vanessa Piper presented the paper and asked the Committee to note the practice performance over the last 12 months.</p> <p>The following was highlighted:</p> <ul style="list-style-type: none"> • The Committee previously approved a five-year contract extension in October 2024, with the contract now running until March 2030, based on improved performance. • Members sought assurance across four key areas: <ul style="list-style-type: none"> ○ Patient satisfaction and access: Improvements noted, with reduced waiting times and above-average performance for face-to-face and telephone appointments; two access areas remain slightly below average. ○ GP online access and home visits: Performance remains marginally below the ICB average. ○ Personalised Care Adjustment (PCA) rates: Overall reduction from 11 to six high-rate registers; the remaining six registers continue to show high PCA levels (15%–62%) and require further improvement. ○ Flu vaccination: A decline in coverage was noted, and the practice is expected to strengthen actions to improve uptake.
2.1.2	<p>In considering the paper, the Committee noted:</p> <ul style="list-style-type: none"> • While declining flu vaccination uptake reflects a national trend, the level of decline (26%) remains a concern. The Committee emphasised that this should not be accepted solely as a national issue and agreed on the importance of maintaining focus on improving flu coverage, both for this practice and more broadly across the system. • There was a positive overall trend, with the practice addressing the full range of performance domains. Concerns about flu vaccination uptake were reiterated, with agreement that it should remain under close review and that outreach activity may need strengthening. Improvements to date were recognised as evidence-based and well documented, and the practice was commended for the progress made. • The practice’s current performance against key performance indicators (KPIs) is achieving Band A, B, and C across relevant domains and will continue to be closely monitored. • The regular primary care performance process was recognised for its value in reviewing a range of indicators and providing early identification of practices that may benefit from support before contractual action is required.
	<p>The Committee NOTED the report.</p>
2.2	<p>Staunton Group Practice (Haringey) – APMS Contract Expiry & Strategic & Performance Review</p>
2.2.1	<p>Anthony Marks presented the paper and asked the Committee to approve the following: (i) Option 1 – PSR Permitted Contract Modification (extension of the contract), (ii) Extend for a further 5 Year extension (2nd term) (1 November 2026 to 31 October 2031), (iii) Apply conditions regarding the performance. The case will be referred back to the Committee earlier than the end of the 5-year term if the conditions are not met.</p> <p>The following was highlighted:</p> <ul style="list-style-type: none"> • The practice commenced a five-year APMS contract on 1 November 2021, which is now approaching expiry. • Performance to date shows improvements across KPIs, health outcomes, QOF, screening, and immunisations, though some immunisation rates remain below ICB averages and national targets.

	<ul style="list-style-type: none"> • GP appointments exceed recommended baselines. The CQC rating remains <i>Requires Improvement</i>. Patient satisfaction continues to present challenges; however, the Patient Participation Group meets regularly and engages effectively with patients. • The recommendation is to proceed with Option 1, extending the contract for a full five years, with conditions for the practice to address under-performing areas, maintain Band B KPI achievement, and improve performance to meet ICB and national targets.
2.2.2	<p>In considering the paper, the Committee noted:</p> <ul style="list-style-type: none"> • Patient choice was discussed, including the influence of CQC ratings, with recognition that re-inspections are prioritised by CQC and may be delayed. • Contracts were noted to be intentionally challenging due to the high-need area, with emphasis on improving patient registration, access, communication, and outreach, including engagement with stakeholders such as Healthwatch. • Concerns were raised about non-clinical KPIs, particularly how appointments are counted and the impact of patient complexity on appointment length; any KPI changes would require Committee approval. • Newer APMS contracts already separate GP and nursing KPIs from other workforce roles, while older contracts do not. • The purpose of the paper is to consider whether the terms should be standardised across all APMS contracts, rather than applying changes to only one. A short paper proposing this as a minor contract variation may be appropriate. <p>It was noted that Option 1 was being approved with the specified conditions. A follow-up note will need to be provided regarding changes to align KPIs with newer APMS contracts. Progress made by the practice was also recognised.</p>
2.2.3	<p>Action:</p> <ul style="list-style-type: none"> • To explore potential for alignment of the access KPIs across all versions of the contracts. (<i>Anthony Marks</i>).
	<p>Subject to specified conditions and review of KPIs in the contract, the Committee APPROVED the following:</p> <ul style="list-style-type: none"> (i) Option 1 – PSR Permitted Contract Modification (extension of the contract); (ii) (ii) Extend for a further 5 Year extension (2nd term) (1 November 2026 to 31 October 2031); (iii) (iii) Apply conditions regarding the performance. The case would be referred back to the Committee before the end of the five-year term should the conditions not be met.
2.3	Cricklewood Health Centre (Barnet) – APMS Contract Expiry & Strategic & Performance Review
2.3.1	<p>Su Nayee presented the paper and requested Committee approval of Option 1 – PSR: Permitted Contract Modification. The proposal is to extend the contract for two years to 30 November 2028, with conditions relating to performance, access, and list growth. It was noted that the case will be referred back to the Committee if key improvements are not achieved and conditions are not met within one year.</p> <p>The following was highlighted:</p> <ul style="list-style-type: none"> • The Cricklewood APMS contract, held by Penceat Medical Limited, expires on 30 November 2026. The practice has shown mixed performance: improvements in bowel screening, breast screening, childhood immunisations, and patient satisfaction, but declines in flu vaccination rates and access KPIs. Enhanced access KPI, agreed as part of decommissioning of the walk in service, has not been met. The patient list remains below ICB expectations.

	<ul style="list-style-type: none"> The recommendation is to extend for two years under conditions to address under-performance, improve access, ensure financial viability, and link KPI payments to achievement rather than upfront.
2.3.2	<p>In considering the paper, the Committee noted:</p> <ul style="list-style-type: none"> The practice's circumstances were recognised, including local population needs, mixed performance, and very positive patient feedback. Option 1, a two-year contract extension, was supported to allow the practice time to improve. The decline from Band A to Band D was acknowledged, and additional staff have been recruited to address KPIs. Performance will continue to be monitored, with referral back to the Committee if further decline occurs. There were concerns raised about the practice's patient list and size. While high patient satisfaction may reflect patients who moved with the practice, the list includes patients from Barnet, Camden, and those inherited with the contract. The practice has taken on additional patients and continues to achieve very good satisfaction. Future analysis of patient geography using practice data was suggested. The practice undertook a list cleansing initially and is now actively seeking to grow the list through local engagement, advertising, and collaboration with the council and MPs. Patients should be encouraged to register locally rather than traveling further afield. Changes in management were also noted. Support was expressed for the two-year extension as necessary to address KPI performance and patient list growth. Key areas requiring focus include long-term condition management, GP access (currently Band D), and patient list size. Without demonstrable improvement in these areas, there would be a strong case for re-procurement. Steep declines in flu vaccinations for both under and over-65s were noted. While recognising this as part of a wider issue, it was highlighted that the practice had temporarily lost focus on flu delivery, but additional staff have been recruited, and forthcoming data is expected to show improvement.
	<p>The Committee APPROVED Option 1 – PSR: Permitted Contract Modification (extension of the contract) to extend for 2 years up to 30 November 2028 with conditions regarding the performance, access and list growth. The case would be referred back to the Committee if key improvements were not seen and conditions not met within 1 year.</p>
2.4	Hendon Way (Barnet) - Practice Relocation
2.4.1	<p>Diane Macdonald presented the paper and asked the Committee to approve the recommendation to relocate Hendon Way Surgery to the new site at West Hendon Broadway with a commencing rent of £73,562pa and an estimated £35,310 pa respectively (rates based on 26/27 Gov.UK estimator of 48%), subject to the District Valuer valuation and confirmation of the Primary Care Utilisation and Modernisation Fund (UMF) from FY26/27. The reimbursement total is capped at £108,872 and must not exceed this amount.</p> <p>The following was highlighted:</p> <ul style="list-style-type: none"> This is a proposal to relocate Hendon Way Practice to a new site approximately 100 metres from its current location as part of a wider regeneration development. The current premises are constrained, and the proposed site would provide improved facilities, including additional consulting and treatment rooms, to support future population growth. The new premises will be secured over a 60-year term, providing long-term security for NHS use, with fit-out costs of £1.64m funded through NHS capital. The relocation represents the most cost-effective option, with alternative sites being more expensive and requiring additional NHS funding.

	<ul style="list-style-type: none"> • Patient engagement will take place following the PCC decision. • The Committee is asked to approve the relocation, subject to a maximum increase in reimbursements of £48,570 and not to exceed £108,872.
2.4.2	<p>In considering the paper, the Committee noted:</p> <ul style="list-style-type: none"> • The proposed revenue increase is relatively modest and that significant work has been undertaken to minimise financial impact, including leasing the premises on a shell basis and using NHS capital for fit-out. Overall revenue pressures are monitored across the estate portfolio. • Clarification was provided that the 60-year term includes an initial ‘not to exceed’ rent, with future rent reviews managed through a formal process and agreed by the District Valuer. • Capital funding was discussed, with assurance that the scheme is on the priority list and that opportunities are being explored to secure funding early, reducing pressure in future years. The risks associated with capital funding were considered low and will be monitored through established governance arrangements. • The Committee expressed strong support for the proposal, noting that the revenue represents good value for modern, fit-for-purpose premises, particularly given the poor condition of the existing building and the urgent need to progress the relocation. • The importance of monitoring delivery timescales, capital risks, and any potential disruption was highlighted, with a request for updates should any risks emerge. • Alongside the estates improvement, the practice’s performance and the Primary Care Network (PCN) arrangements will continue to be monitored, including access, utilisation of PCN services, and quality of care, supported by patient and stakeholder engagement and equality impact assessment work. • The wider need for modern, affordable, and flexible general practice estate in Barnet was reaffirmed, recognising estates constraints as a key system challenge alongside performance considerations.
	<p>The Committee APPROVED the recommendation to relocate Hendon Way Surgery to the new site at West Hendon Broadway with a commencing rent of £73,562pa and an estimated £35,310 pa respectively (rates based on 26/27 Gov.UK estimator of 48%), subject to DV valuation and confirmation of UMF for FY26/27. The reimbursement total is capped at £108,872 and must not exceed this amount.</p>
2.5	Barnsbury Medical Practice (Islington) - time-limited request for additional rooms
2.5.1	<p>Diane Macdonald presented the paper and asked the Committee to approve (i) the formulisation of tenancy arrangements for the minor procedure suite [F7,9,10], the remaining capacity of the bookable consulting room [G13] and the retention of Offices F24 and F25 and (ii) the associated increase in rent reimbursement for the additional space for a time-limited period until 31 March 2028. This arrangement is pending phase 2: an internal reconfiguration, which will be funded through the 2026/27 Utilisation and Modernisation Fund capital.</p> <p>The following was highlighted:</p> <ul style="list-style-type: none"> • Approval was sought for a relocation and space reconfiguration at Barnsbury Medical Practice, based at Bingfield Primary Care Centre. • The practice currently operates from three consulting rooms with a registered list size of 6,592. Capacity planning indicates a requirement for five consulting rooms. • The proposal includes the addition of two consulting rooms and improved utilisation of existing space. • Retention of two office rooms was requested, with the current subsidy due to expire in March 2026.

	<ul style="list-style-type: none"> • A two-year, time-limited extension of the office room subsidy was proposed. • The proposal requires an increase in reimbursable costs of £74,393 pa over a two-year period.
2.5.2	<p>In considering the paper, the Committee noted:</p> <ul style="list-style-type: none"> • This may be an internal administrative matter, as the Committee had previously approved some of the rooms in 2023. It was therefore important to ensure there was no duplication of payments by reconciling the figures previously approved with the current request for an extension to the additional rent reimbursement. The subsidy for the two office rooms is due to end and is included in the proposal.
	<p>The Committee APPROVED:</p> <p>(i) The formulation of tenancy arrangements for the minor procedure suite [F7,9,10], the remaining capacity of the bookable consulting room [G13] and the retention of Offices F24 and F25:</p> <p>(ii) The associated increase in rent reimbursement for the additional space for a time-limited period until 31 March 2028. This arrangement is pending phase 2: an internal reconfiguration, which will be funded through the 2026/27 Utilisation and Modernisation Fund capital.</p>
3.	GOVERNANCE
3.1	Primary Care Committee Risk Register
3.1.1	<p>Rebecca Kingsnorth presented the paper and asked the Committee to note and provide feedback on the identified risks, and highlight any strategic gaps within the Committee's remit, including any additional strategic risks or areas for inclusion in the review.</p> <p>The following was highlighted:</p> <ul style="list-style-type: none"> • One risk met the threshold for escalation to the Committee: PERF32 – Failure to procure clinical waste collection services for operationalisation on 1 April 2025. However, recent changes to the procurement position mean the nature of this risk requires review. This will be actioned for the next meeting. • A second previously escalated risk; PERF15: Failure to address variation in Primary Care Quality and Performance across NCL, has been significantly reduced, as per discussions at the last meeting, given the strengthened data-driven approach and early signs of improvement in patient satisfaction shown in the ONS Health Insights Survey. • All primary care related risks have been retained in the report for information, even when they fall below the Committee threshold. • General practice estates risks have also been included to provide context for the Committee when considering estates-related decisions.
3.1.2	<p>In considering the paper, the Committee noted:</p> <ul style="list-style-type: none"> • There had been positive improvements in reducing variation, addressing inequities, and improving access over time. <p>The Committee agreed that the risks had been appropriately captured and acknowledged the significant work undertaken to manage and improve longstanding primary care risks, including those relating to access and estates. The previously challenging risks are now much improved, reflecting effective risk management. Appreciation was expressed for these efforts.</p>
	The Committee NOTED the current risk register.

4.	OVERVIEW REPORTS
4.1	Primary Care Finance Report
4.1.1	<p>Sarah Rothenberg presented the report and asked the Committee to note the 2025/26 financial position as at Month 8 (November 2025).</p> <p>The following was highlighted:</p> <ul style="list-style-type: none"> • The report covers the delegated primary care budget up to the end of November 2025, following the last financial update in August 2025. • At the end of November 2025, year to date spend was £350k over budget at £241.7m, due to timing delays in reimbursement for some Primary Care Networks (PCN) test sites. • The full-year position remains on track to break even. • Although there was a commitment to provide a financial update on the Primary Care aspects of the planned ICB merger, detailed financial planning has not yet commenced. • To note, both North West London and North Central London ICBs are slightly underfunded against the national benchmark for delegated primary care and moving in the same direction will be helpful to support future integration. • The West and North London ICB first draft budget was submitted in December 2025.
4.1.2	<p>In considering the paper, the Committee noted:</p> <ul style="list-style-type: none"> • The recognition of the primary care team’s work in supporting GP practices, managing delegated budgets, delivering GP access initiatives, and contributing to a national pilot, all while remaining on budget. This was acknowledged as a considerable achievement, particularly given financial pressures elsewhere in the system.
	The Committee NOTED the paper.
4.2	Quality & Performance (Q&R) Report
4.2.1	<p>Tamzin Jamieson presented the paper and asked the Committee to comment on the data presented and to note the focus topics for future PCC meetings.</p> <p>The following was highlighted:</p> <ul style="list-style-type: none"> • All patient contact types are now included in the reporting, providing improved visibility of how practices are adopting digital approaches to managing patient demand. The report now also includes video consultations, which were previously excluded due to the absence of agreed recording criteria. While recording has improved, some under-recording remains. • Clear definitions have been included in the report to distinguish between video consultations, online consultations, appointments, and contacts, which is important for contractual purposes. Video consultations have increased significantly over the past two years, and online consultations rose by 57% in the year to September 2025. The provision of online consults is now a contractual requirement of practices during core hours. • Data is drawn from the national dashboard and supports collaborative performance discussions. Some outlier practices across three boroughs have not yet been contacted about being discussed in collaborative meetings or offered targeted support. Once this has happened, these practices will be named and monitored in future PCC meetings. The report also includes information on resilience funding.

	<ul style="list-style-type: none"> Organisational restructuring over the coming months may impact the pace of progress with the ICB Q&P Dashboard, but access to the national dashboard provides improved oversight of general practice activity.
4.2.2	<p>In considering the paper, the Committee noted:</p> <ul style="list-style-type: none"> Not all practices offer video appointments, which function similarly to Zoom consultations rather than telephone calls. How these appointments are captured and recorded depends on the practice, while webinars or patient group sessions are recorded separately. Patients require a smartphone or similar device to participate. Video appointments are used for both non-clinical and clinical purposes, including assessments such as respiratory observations, rashes, and cognitive evaluations during COVID-19. Platforms such as Accurx support two-way communication, image sharing, and text messaging, improving efficiency and convenience, particularly for housebound patients. Progress and collective insights gained from individual practices were acknowledged. Concerns were raised about potential knowledge loss in the coming months, with a commitment sought to ensure a safe and smooth transition. A further review of the data will clarify trends regarding whether face-to-face activity is holding steady or increasing as the programme progresses. Benchmarking should assess practice accessibility across all consultation types, including face-to-face, online, and walk-ins. Benchmarking against NCL and national averages was recommended. Small deviations should be explored further, and patient feedback considered to ensure the consultation mix meets patient needs. The proposed deep dive should be outcomes-focused, potentially reviewing existing data to identify common themes across practices to inform the analysis.
	The Committee NOTED the report.
5.	FOR INFORMATION
5.1	Low risk paper (virtual approval 02/12/25) – Commissioning Decisions on PMS Agreement Changes
	The Committee NOTED the paper.
5.2	<p>Low Risk Papers (virtual approval 19/12/25)</p> <ul style="list-style-type: none"> Cornwall House Surgery - Direct Payments for premises reimbursable costs Evergreen Primary Care Centre – Decant Plan for Rainbow Practice, Evergreen Surgery & Chalfont Practice Commissioning Decisions on PMS Agreement Changes
	The Committee NOTED the papers.
6.	ANY OTHER BUSINESS
6.1	The Chair informed the Committee that the next meeting, originally scheduled for 10 February 2026, will be rescheduled to 10 March 2026, from 2:00 pm to 3:30 pm, to better align with key business timelines.
7.	DATE OF NEXT MEETING
7.1	10 March 2026



North Central London
Integrated Care Board

North Central London ICB
Primary Care Committee Meeting
Part 1 Action Log – March 2026

On Agenda	
Needs Urgent Update	
In Progress	
Completed	

Meeting Date	Action Number	Minutes Reference	Action	Lead	Deadline	Update
13.01.26	1	2.2.3	APMS Contracts – KPI variation - To explore potential for alignment of the access KPIs across all versions of the contracts.	Anthony Marks	Q2 or Q3 2026/27	20.02.26 – This action will be brought back to a future PCC meeting, once the dates are confirmed.
14.10.25	1	1.4.2	Action Log – To consider a Primary Care Committee seminar across NCL/NWL once national contracts forms relevant to primary care have been released.	Sarah McIlwaine	Q2 2026/27	<p>20.02.26 – This action will be carried forward into the new structure. No public timeframe has yet been announced for the release of two new national contracts, though these are expected in due course. Consultation with stakeholder groups on the core GP contract is ongoing.</p> <p>30.12.25 - There is no definitive date for the release of national contract forms, but these are expected to be consulted on in 2026/27. When the seminar is held, it should incorporate the wider</p>

						context for PC from the 10-Year Plan.
14.10.25	2	2.1.3	General Practice Protected Learning Time (PLT) Proposal – Mid Point Evaluation (January – June 2025) - To bring a proposal to the February PCC meeting to extend the PLT scheme for an additional year.	Carol Kumar and Cassy Bygrave	March 2026	13.01.26 - This item has been added to the March agenda. 01.12.25 – This item will be added to the February agenda.
12.08.25	2	4.2.3	Quality & Performance Report – To reflect key trends in the next workforce report including monitoring flexible hours and skill mix.	Tamzin Jamieson & Sarah Morgan	March 2026	13.01.26 – The workforce report has now been added to the March agenda. 11.09.25 – The Committee is asked to support the production of a workforce report for February 2026 (moving from December 2025).
12.08.25	3	5.1.5	Quality Strategy for Primary Care - To bring a progress update on the Quality Strategy in six months' time.	James Avery & Ginika Achokwu	TBC	15.12.25 – This will be brought back to the Committee later in the year. 07.10.25 This will be added to the February 2026 agenda.
24.06.25	1	2.3	Welbourne Medical Practice (Haringey): APMS Contract Expiry & Strategic & Performance Review: review of option 1 (contract modification) should return to the Committee within six to nine months to inform long-term planning.	Vanessa Piper	Q2 or Q3 2026	20.02.26 – The contract expires 31 March 2028. A review of the commissioning options has nearly concluded and will be brought back to a future PCC, once the dates are confirmed. 01.08.25 – A paper will be brought forward no later than April 2026. Key committee points will be addressed with contract holders, and improvements made while longer-term commissioning options are assessed.

11.02.25	4	3.1.3	<p>Primary Care Committee Risk Register – Estates</p> <p>- To bring an estates paper to the August meeting discussing the opportunities for 2025-26 and beyond about the increase in capital for general practice estate and as assessment of what that means for revenue commitments.</p>	Diane Macdonald	April 2026	<p>18.07.25 - Once the ICB structure is finalised and implications of the new Capital framework are understood, Estates will bring a paper covering the plan beyond 25/26. Estates continue to deliver priority schemes for 25/26.</p> <p>Estates schemes continue to be delivered alongside strategic estates planning and resourcing models.</p>
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**North Central London ICB
Primary Care Committee Meeting
10 March 2026**

Report Title	Langstone Way Surgery – Request to change Primary Care Networks	Date of report	20 February 2026	Agenda Item	2.1
Lead Director / Manager	Vanessa Piper, Assistant Director of Primary Care	Email / Tel		Vanessa.piper@nhs.net	
Board Member Sponsor	Sarah McDonnell-Davies, Chief Transformation Officer				
Report Author	Vanessa Piper	Email / Tel		Vanessa.piper@nhs.net	
Name of Authorising Finance Lead	Sarah Rothenberg, Deputy Director of Finance Business Partnering (Primary Care) NCL ICB	Summary of Financial Implications			
		PCN4 25/26 funding allocation is £2,227,704 and Langstone Way Surgery registered list accounts for 13% of the total budget. Transferring Langstone Way Surgery to PCN3 means a PCN4 reduction in allocation of £300,413 per annum.			
Name of Authorising Estates Lead	Not applicable	Summary of Estates Implications			
		Not applicable			
Report Summary	<p>Langstone Way Surgery is in the Borough of Barnet, list size 7283 patients (raw January 2026), managed under a GMS contract. The new partners of the contract have submitted an application to move the practice from Primary Care Network (PCN) 4 to PCN 3, following the change in contract holder.</p> <p>Langstone Way Surgery historically has had challenges with access, patient satisfaction and delivery of services, which has required contractual oversight and monitoring by the ICB. The practice has remained with a rating of Overall Requires Improvement for five years by The Care Quality Commission (CQC).</p> <p>Due to these performance issues in October 2025, the GMS contract holder status changed from a single hander to a new partnership of 3 GPs; under GMS regulations this change is not approved by Primary Care Committee; the ICB though has the responsibility to assess that the proposed new contract holders are eligible to hold the GMS contract, in line with the regulations. The ICB has also imposed on the new partnership service improvement actions, which continue to be monitored and reported through PCC.</p> <p>The new partnership of Langstone Way Surgery are also the contract holders for Wentworth Medical Centre in Barnet, and PCC (October 2025) approved a merger of the two contracts, which resulted in the Langstone contract terminating, patients merged on to the Wentworth contract which is then varied and retained.</p>				

The Langstone premises site has remained open, to become a branch site of Wentworth Medical Centre (they are less than 1 mile apart); the site was retained to also ensure patient services were not destabilised and the new partnership could focus on the service improvements required.

The merger came into effect from 2nd February 2026. Patient and stakeholders including local practices were engaged with during August and September 2025, prior to the decision being taken by PCC.

To further align services, the new partners have requested to move Langstone Way Surgery from PCN4 to PCN3, from 1st April 2026, in line with the PCN DES terms. Both PCNs were requested to work together to submit a joint application which was supported by the London Wide Local Medical Committee.

Implications to PCN4 if PCC approve Langstone practice to move to PCN3

List size

PCNs should retain a minimum and maximum list of 30,000 – 50,000 although the ICB has agreed higher PCN list size in line with the DES specification. Both PCN3 and PCN4 change in list size will exceed 30,000 patients if PCC approve Langstone's practice change of PCN.

Post the change PCN4 list size will reduce from 54,489 patients to 47,206. PCN3 list will increase 79,510. The size of PCNs will have wider implications, the NHS 10 Year Health Plan outlined the introduction of two new Neighbourhood contracts set to be introduced in 2026, Single Neighbourhood Provider contracts designed to have a targeted population size of 50,000 and multi-neighbourhood provider (MNP) 250,000 or more. Both contracting types will be designed to enhanced community-based health care delivery and integrating services across local populations.

Geographical Contiguous (PCN network area)

Langstone Way Surgery's premises location is more geographically contiguous to PCN4, but the catchment area for Wentworth Medical Practice overlays Langstone patient catchment area. Therefore, both practice sites are geographically contiguous based on where the patients reside.

Neighbourhood Boundary

Barnet neighbourhood provider services are segmented into five geographical areas with a registered population. Wentworth is located in West Finchley, North Barnet and Langstone Surgery, Mill Hill in West Barnet.

North Finchley and Mill Hill are Neighbouring wards, and the practice sites are 1.4 miles apart, therefore the move in PCN should not create a significant change to the neighbourhood provider services and population geographical alignment.

Financial implications

PCN4 25/26 funding allocation is £2,227,704 and Langstone surgery registered patient list accounts for 13% of the total budget, a reduction of £300,413 per annum.

The ARRS budget accounts for 58% (£174,508) of the Langstone Budget, PCN4 state there are 20 staff who work 0.5 – 1 day a week, for the Langstone patient

list. These staff are either employed by external organisations or the practice. PCN4 are currently working with a HR team to mitigate any risks to these staff.

PCN3 have been requested to liaise with PCN4 regarding any staff impacted but as some of the staff are employed by external organisations further negotiations will need to be had. This had not been concluded at the time of writing this paper.

Services impacted

The PCN is required to deliver the following:

- Enhanced access (6.30-8pm Monday to Friday, 9am – 5pm Saturdays, (60-minute appointments per 1000 PCN adjusted patients)
- Additional Primary Care Roles booked appointments
- Tackling Health Inequalities – Learning Disability and Cancer indicators

There will be a low impact as the above services will transfer and be the responsibility of PCN3, the funding allocation to maintain these services will be available to the PCN from 1st April 2026.

Patient engagement

Langstone Way Surgery patients were engaged with during January to February 2026 over four weeks, there were 65 respondents and the highest response rates have been summarised below

- 51% (33) were aware of the PCN services and role
- 46% (30) had been referred to a Physician associate
- 25% (16) had been referred to a Physiotherapist
- 32% (21) had been referred to a Clinical Pharmacist
- 49% (32) were not aware that they could book routine appointments outside of core hours and on the weekends
- 68% (44) had not been offered an appointment with a GP or Nurse outside of core hours
- 65% (42) had also indicated that they had not been offered an appointment with a different kind of healthcare professional at another surgery within the PCN
- 43% (28) health checks/ routine appointments were the most common advice and treatment received
- 61% (40) felt they were offered an appointment of choice
- 80% (52) felt they would like more flexibility at being offered other health care appointments by the PCN or at the PCN Hub

With the change in location from PCN4 to PCN3

- 66% (43) stated they would travel by car
- 35% (23) would travel by public transport
- 68% (44) stated it would take 10 -20 minutes to travel from home

In summary

PCC is requested to consider the request to move Langstone Way Surgery from PCN4 to PCN3.

The partners have requested this change to consolidate the service improvement changes that are being implemented at Langstone Way Surgery and to better align patient services within PCN3, where the main site Wentworth

	<p>Medical Centre is operating. Staff are working across both sites therefore there are more benefits to align all services, as well as the services offered by PCN3.</p> <p>There will be implications to PCN4 from this change, there will be a reduction in the allocated PCN funding by 13%, the PCN are seeking HR advice to mitigate and manage the risks to ARRS staff employed.</p>
Recommendation	<p>PCC is requested to APPROVE: -</p> <ol style="list-style-type: none"> 1. Langstone Way to move from PCN4 to PCN3 2. Effective from 1st April 2026
Identified Risks and Risk Management Actions	<p>Risk: Continuity of Patient services</p> <p>Mitigation: Funding allocation is based on weighted list size and will transfer to PCN3</p>
Conflicts of Interest	Not applicable
Resource Implications	PCN4 reduction of 13% (£300,413 per annum) of allocated funding in 25/26, from the movement of Langstone (patient list 5089 patients)
Engagement	Patient and stakeholder engagement was conducted during February 2026 for four weeks and the report is appended to this paper.
Equality Impact Analysis	An equality impact assessment has been appended to this report.
Report History and Key Decisions	October 2025 PCC approved a merger of Wentworth Medical Centre and Langstone Way Surgery contract
Next Steps	<p>If approved by PCC</p> <ol style="list-style-type: none"> 1. Notify the PCN4 and PCN3 2. Request the change form to be completed by the PCNs 3. Notify Primary Care Support England
Appendices	<ol style="list-style-type: none"> 1. Map of Barnet 2. Patient engagement and Equality Impact assessment report

Terms of the Primary Care Network (PCN) Directed Enhanced Service (DES)

The PCN DES specifies, following a contract merger, where two or more Core Network Practices of a PCN intend to merge and the resulting single practice does not intend to be a Core Network Practice of the same PCN (6.8.6), the commissioner should consider the consequences of any merger/split on PCN membership which should include:

- a) the likely consequences for the registered patients of the practices
- b) the impact of any consequences on the PCN's financial entitlements due under this Network Contract DES Specification
- c) If consent for the change was provided, any relevant PCN would satisfy the criteria for a for the
 - PCN List size on 1 January 2025 is between 30,000 and 50,000
 - More than one core network practice
 - PCN has a nominated payee
 - Network agreement is in place
 - Accountable Clinical Director
 - Network area is geographically contiguous and sustainable taking into account the services to be delivered

Implications of the change request

Below sets out the ICB analysis from the request to move Langstone Way Surgery from PCN4 to PCN3.

Patient and Stakeholder Engagement

The previous contract holder Dr Ruben submitted a request in July 2025 to merge his GMS contract with Wentworth Medical Practice, to come into effect in February 2026. Prior to the merger, Dr Ruben requested to vary his GMS contract to add the Wenworth partners to his contract on 15 October 2025 and Dr Ruben would then resign from the contract on 16 October 2025.

The merger application was received on 12 September 2026 and patients, stakeholders and local practices including PCN4 (Langstone existing PCN) were written to during August to September 2025, to seek their views on the merger and any impact, from this change.

The PCN change application was received on 18 December 2025 and further engagement with patients and stakeholders was carried out during February 2026 for four weeks on the request to change PCNs. The report has nee appended to the paper.

Impact on the PCN registered list

The change from PCN4 to PCN3 will result in both PCN list sizes remaining within the DES minimum and maximum list size of 30,000 to 50,000. An ICB can waiver the higher maximum PCN list size if there are clear beneficial outcomes, i.e. geographically, patients and services.

Langstone Way surgery is currently in PCN4 with three other practices, the total PCN list size is 54,489 (raw). If PCC approve Langstone Way Surgery splitting from PCN 4, the new PCN4 list size will reduce to 47,206, therefore will remain within the recommended list size.

PCN 4 – Total list size 54,489

PracticeName	Contract	Raw List size Jan-26	Weighted List size Jan-26
Millway Medical Practice	PMS	24897	23095.93

Penshurst Gardens	GMS	7493	7041.06
Langstone Way Surgery	PMS	7283	6024.61
Lane End Medical Group	GMS	14816	13294.87

PCN3 existing list size is 72,227 (raw), with the addition of Langstone Way surgery the PCNs list will increase to 79,510.

PCN 3 – Total list size 72,227

Practice Name	Contract	Raw List size Jan-26	Weighted List size Jan-26
Lichfield Grove Surgery	PMS	6111	5005.51
Squires Lane Medical Practice	GMS	4938	4491.07
The Old Courthouse Surgery	GMS	10254	10531.04
Cornwall House Surgery	GMS	5373	4944.23
Longrove Surgery	PMS	17472	17807.48
Wentworth Medical Practice	PMS	18186	16895.62
Addington Medical Centre	GMS	9893	9746.56

Geographical Contiguous (PCN network area)

The network practice area should cover a common boundary, aligned to the local community and other providers.

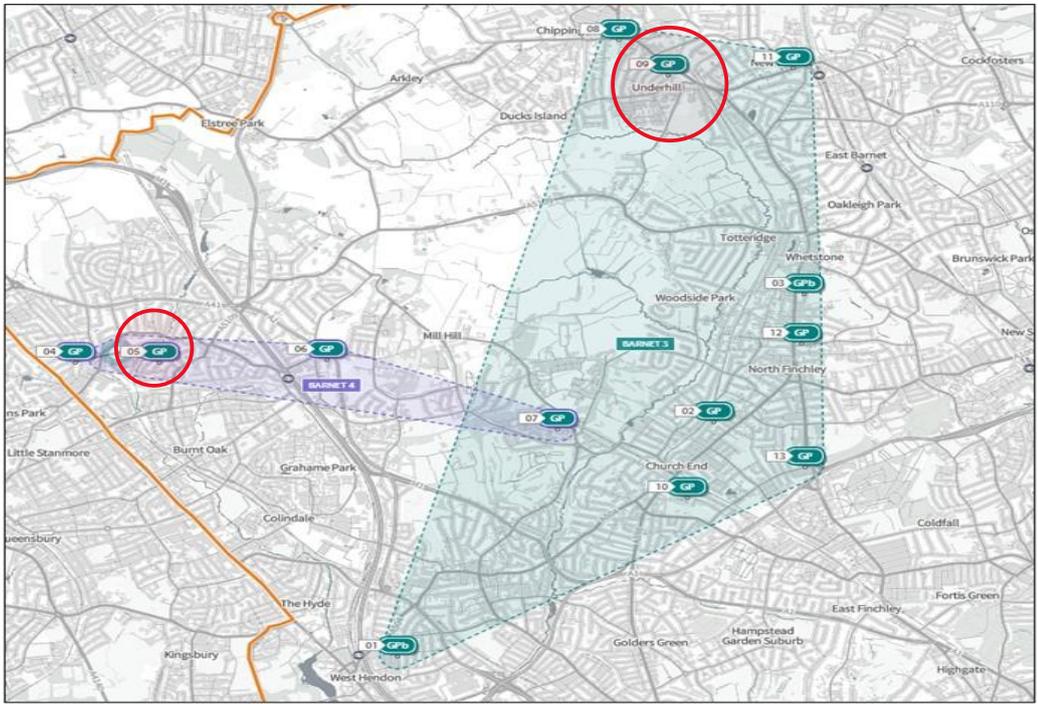
Langstone Way Surgery is more geographically aligned to PCN4 (Map 1), although their catchment area is within Wentworth Medical Practice, practice boundary (map 2).

Langstone is located in Mill Hill, West of Barnet and Wentworth practice is in West Finchley (North Barnet). Although they are in different wards, the practice sites are 1.4 miles apart (30-minute walk, 18 minutes by public transport and 6 minutes by car), the Langstone site will remain open, and patients will be able to access services across both sites.

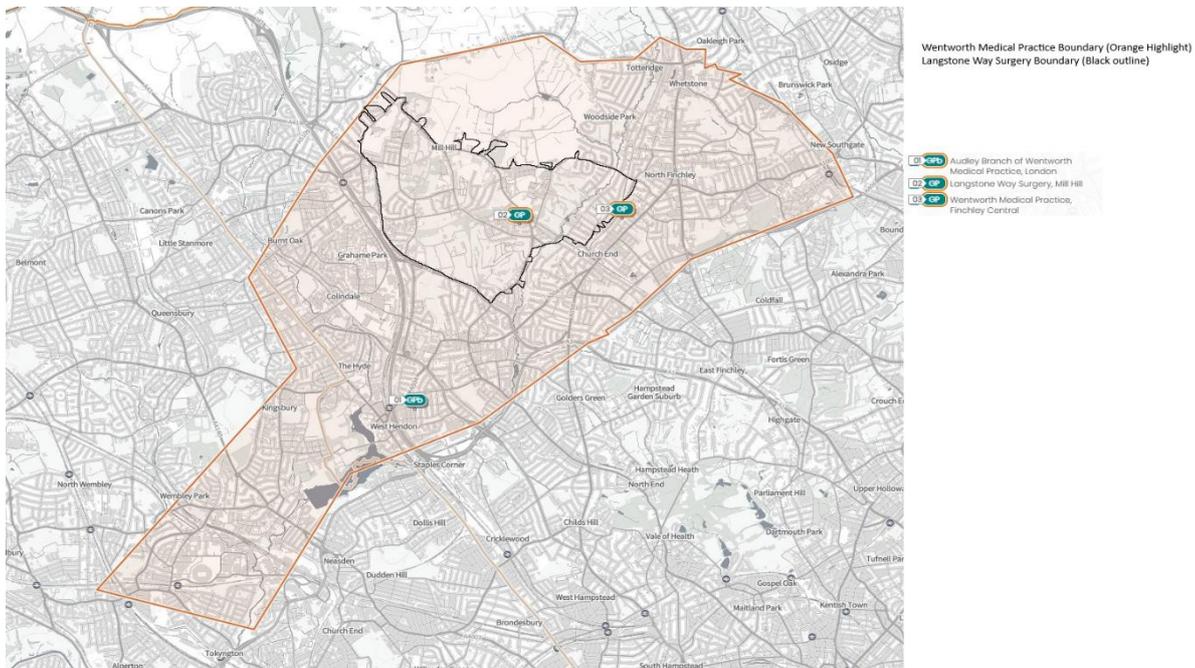
If PCC approve Langstone Way Surgery to move PCNs it will not be geographically contiguous to PCN3's network area (Map 1), based on the practice site locations, but the Wentworth's practice catchment area overlaps, Langstone Way catchment area (Map 2), therefore they are aligned based on where patients reside and the practices catchment areas.

Map 1 – PCN3 and PN4 Geographical area

(Point 5 – Langstone Way Surgery and Point 9 – Wentworth Medical Practice)



Map 2 – Langstone and Wentworth Practice – Catchment areas



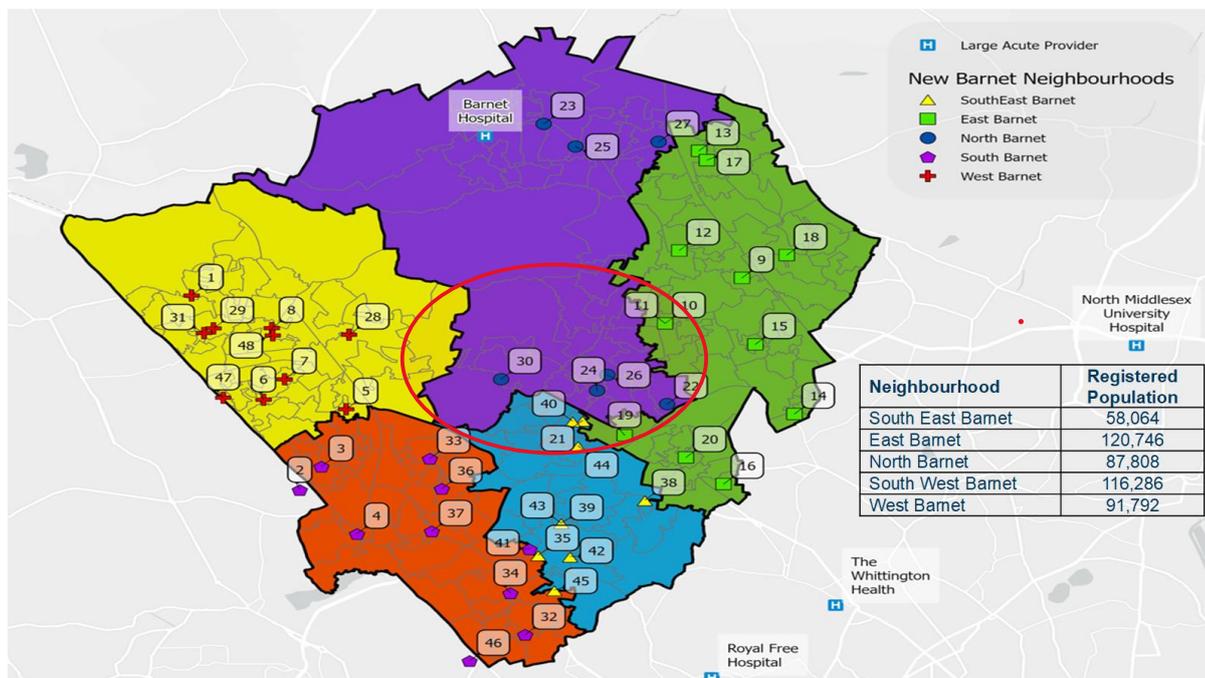
(Wentworth – orange catchment area and Langstone – black outline)

Neighbourhood boundary

There will be no implications to the neighbourhood alignment to primary care and other health, social care and voluntary providers.

Barnet neighbourhoods are segmented into five geographical areas; Wentworth is in the North Barnet, West Finchley and Langstone practice in the West Barnet, Mill Hill.

Mill Hill and West Finchley are neighbouring wards (appendix a) therefore the move in PCN should not create a significant change to the neighbourhood provider services and population geographical alignment.



Financial Implications

PCN4 25/26 funding allocation shows with the removal of the Langstone patient list (7283) and budget, the PCN4 will no longer have access to £300,413 per annum. This funding relates to the allocation for the:-

- Clinical Director £0.758 prp
- Leadership and Management fund £0,733 pap
- Core PCN Fund £1.51prp
- ARRS £26.631pwp
- Enhanced Access £8.523pap
- Investment and Impact fund £0.204prp
- Capacity and Access Incentive payment £1.375pap
- Capacity and Access Support Payment 70% £3.208 pap
- Network Participation Payment £1.761pwp
- Care Home Premium £130.253 per bed (not applicable to Langstone practice)

The total 25/26 funding allocation for PCN 4 is £2,227,704 therefore Langstone practice PCN allocation equated to 13% of the total PCNs budget.

Services impacted - Enhanced Access and Impact and Investment Fund

Enhanced Access hours should be provided by a PCN between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays and is calculated based on 60 minutes of appointments per 1000 PCN adjusted patients per week.

These additional hours would transfer to PCN 3, quantified on the Langstone patient list therefore patients should not see a reduction in the additional hours (Enhanced access), but there will be a change in the location and staff delivering the services.

The impact of these changes has been captured in the outcome of the patient survey.

Investment and Impact Fund refer to Learning Disability and Cancer indicators for Tackling Health Inequalities. There will be a low impact to the Langstone patients as the delivery of these indicators should move from PCN4 to PCN3.

The 25/26 Langstone practice allocation for these indicators is £1,598 per annum, which equates to 0.07% of the total PCN budgets, therefore a low impact.

Implication to ARRS staff

The ARRS staff allocation is based on the weighted list size, PCN 4 employs a total of 27.8 WTE ARRS staff for the four practices currently in the PCN and 54,489 patients.

The ARRS staff budget (25/26 allocation) for Langstone Way surgery patients is £174,508 per annum for 20 staff working 0.5 – 1 day per week (table 1). This equates to 8% of PCN4 total 25/26 allocation. This funding allocation will no longer be available for PCN4 and would transfer to PCN3, if the move is approved.

PCN4 ARRS staff are employed by a mix of organisations listed below, the employers hold contracts with the staff and pay them directly from their own payroll accounts, PCN4 is then invoiced who then claims the reimbursement from their annual PCN allocation.

- Barnet Federation
- Agency
- Age UK
- Barnet Enfield Haringey, Mental Health Trust (BEH MHT)
- Practice

PCN4 have indicated that they have been working with a HR company to assess any staff that are at risk due to a reduction in the allocated funding of £174,508 per annum. As the staff are not directly employed by PCN4, PCN3 have been requested to liaise with the employer and PCN4 in relation to the staff.

Table 1 – Langstone Way Surgery ARRS staff employed

Job role	F/T or P/T (if P/T, no of days/ hrs per wk for the PCN)	Is staff member allocated to LW (Y/N)	If allocated to LW, no of days/hrs per wk for the practice	Employing authority (e.g. PCN, lead practice, fed, external organisation, agency etc)
SENIOR CP	F/T	N	-	Federation
CP	F/T	Y	1 day	Federation
CP	F/T	Y	1 day	Agency
PTECH	F/T	Y	0.5day	Agency
CP	P/T -16	N	-	Agency
DTL	F/T	Y	1 day	Federation
FCP	F/T	Y	0.5day	Federation
FCP	F/T	Y	1 day	Agency
HWBC	P/T - 30	Y	0.5day	Federation
HWBC	F/T	Y	0.5day	Federation
HWBC	P/T -22.5	Y	0.5day	Federation
HWBC	F/T	Y *	0.5day	Federation
MHP	F/T	Y	1 day	BEHMT
SPLW	P/T – 22.5	Y	0.5 day	AGE UK
SPLW	F/T	Y	0.5 day	AGE UK
SPLW	P/T – 22.5	Y	1 day	AGE UK
SPLW MGR	P/T - 10	N	0	AGE UK
C/C	F/T	Y *	1 day	Federation
C/C	F/T	Y	1 day	Federation
C/C	P/T -20	Y	0.5 day	Federation
C/C	F/T	Y	1 day	Federation
C/C	F/T	N	-	Practice
C/C	F/T	N	-	Practice
C/C	F/T	N	-	Practice
C/C	F/T	N	-	Practice
GP ARRS	P/T – 8.33	Y	1 session	Practice

In conclusion

Langstone Way Surgery partners have requested to move the practice to PCN3 due to the additional service improvements, workforce and access changes that were required. The patient list has now merged with Wentworth Medical Centre list, although the Langstone site will remain a branch surgery.

Where patients reside between the two practices are geographically contiguous, the catchment areas overlap and the geographical will have minimal implications on the neighbourhood provider landscape.

Appendix A – Map of Barnet Borough

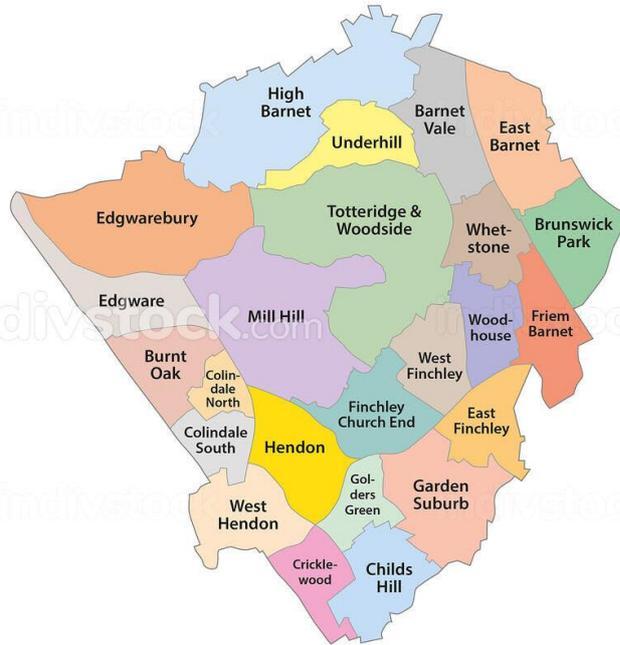
Wentworth Medical Centre – located in West Finchley

Langstone Way Surgery – located in Mill Hill



LONDON

**Borough of
Barnet**



Proposed Change of Primary Care Network (PCN) for Langstone Way Surgery Patient survey: Summary report

This report was created on Monday 02 March 2026 at 13:21 and includes 66 responses.

The activity ran from 30/01/2026 to 26/02/2026.

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What is your full postcode?	2
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2. Are you aware of your current Primary Care Network's (PCN) role, which consists of 4 practices in the Barnet?	2
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select all that apply	3
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Some questions about you	16
Question 27: Which of the following best describes how you think of yourself?	17
Some questions about you	17
Question 28: Which, if any, of the following best describes your religion?	17
Some questions about you	17

Question 1: Please note that this survey should only be completed by patients (or family, friends or carers on behalf of the patient) who are registered at the Langstone Way Surgery Please confirm if you are a:

Your views



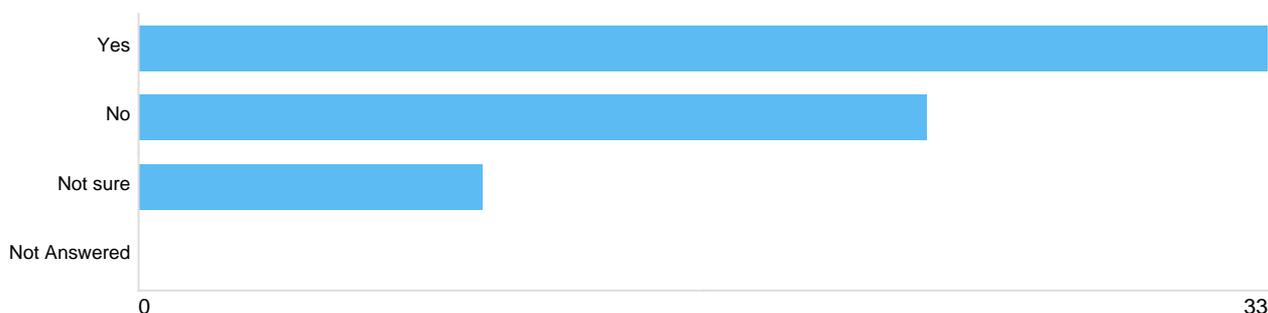
Option	Total	Percent
Patient registered at Langstone Way Surgery	66	100.00%
Relative and/or carer of a patient registered at Langstone Way Surgery	0	0.00%
Not Answered	0	0.00%

What is your full postcode?

There were **56** responses to this part of the question.

Question 2: Are you aware of your current Primary Care Network's (PCN) role, which consists of 4 practices in the Barnet?

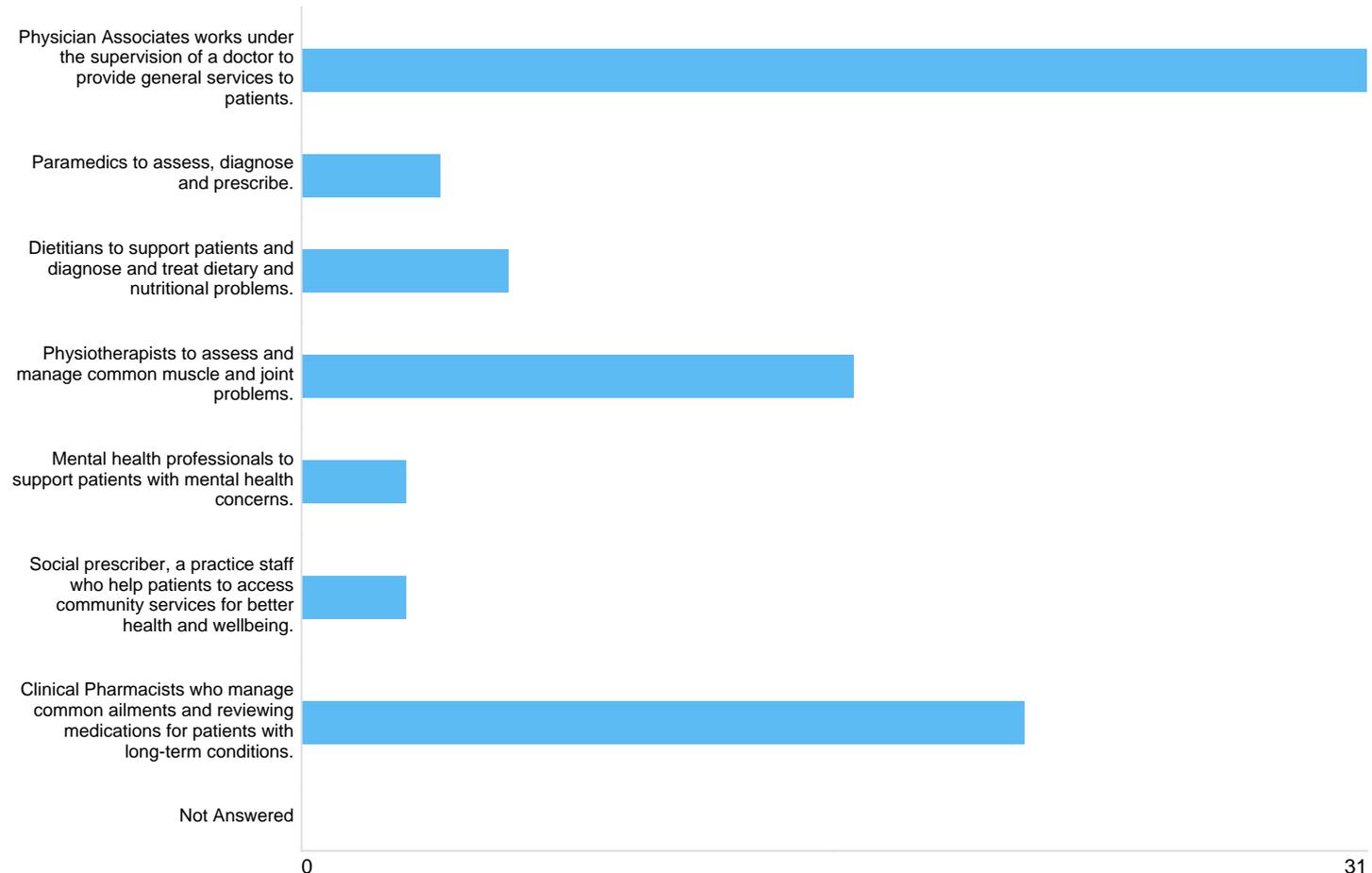
2. Are you aware of your current Primary Care Network's (PCN) role, which consists of 4 practices in the Barnet?



Option	Total	Percent
Yes	33	50.00%
No	23	34.85%
Not sure	10	15.15%
Not Answered	0	0.00%

Question 3: Have you been referred by your GP practice to any of the following staff?

select all that apply



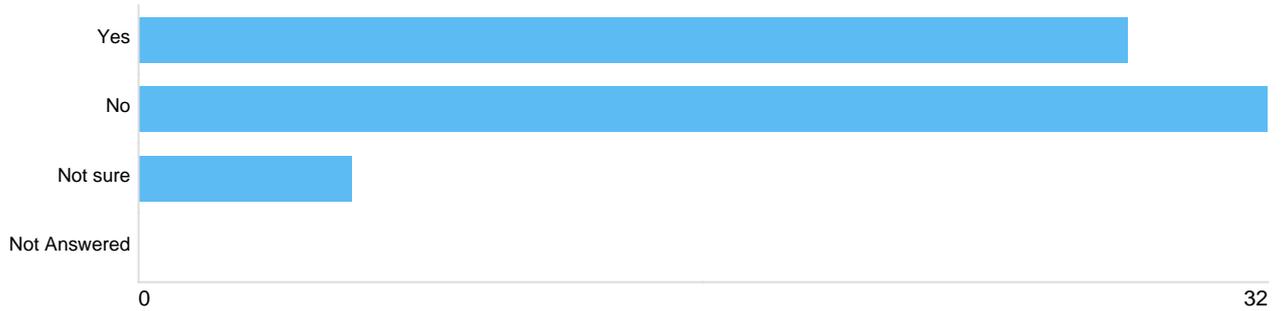
Option	Total	Percent
Physician Associates works under the supervision of a doctor to provide general services to patients.	31	46.97%
Paramedics to assess, diagnose and prescribe.	4	6.06%
Dietitians to support patients and diagnose and treat dietary and nutritional problems.	6	9.09%
Physiotherapists to assess and manage common muscle and joint problems.	16	24.24%
Mental health professionals to support patients with mental health concerns.	3	4.55%
Social prescriber, a practice staff who help patients to access community services for better health and wellbeing.	3	4.55%
Clinical Pharmacists who manage common ailments and reviewing medications for patients with long-term conditions.	21	31.82%
Not Answered	0	0.00%

Have you been seen by any other Primary Care staff that is not listed above?

There were **31** responses to this part of the question.

Question 4: Are you aware your practice can book routine appointments outside regular hours, such as early morning, evening, or weekends, within their Primary Care Network?

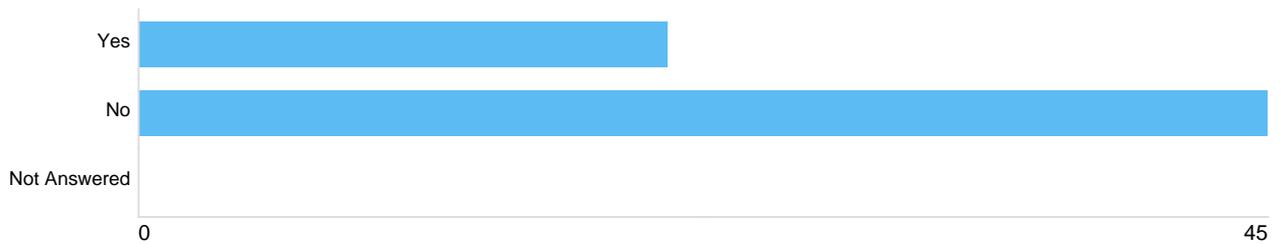
Access to Primary Care Network (PCN) services



Option	Total	Percent
Yes	28	42.42%
No	32	48.48%
Not sure	6	9.09%
Not Answered	0	0.00%

Question 5: Have you been offered a GP or Nurse appointment outside regular hours of our GP surgery, before 8am or after 6.30pm?

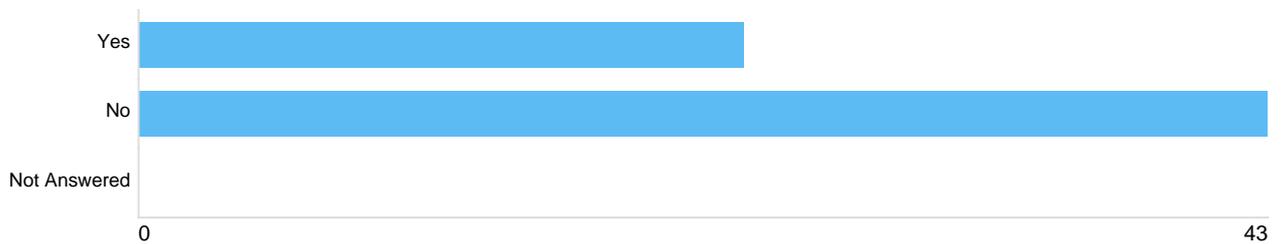
Access to Primary Care Network (PCN) services



Option	Total	Percent
Yes	21	31.82%
No	45	68.18%
Not Answered	0	0.00%

Question 6: Have you been offered an appointment with a different kind of healthcare professional (for example, a pharmacist) at another GP surgery outside our GP surgery opening hours?

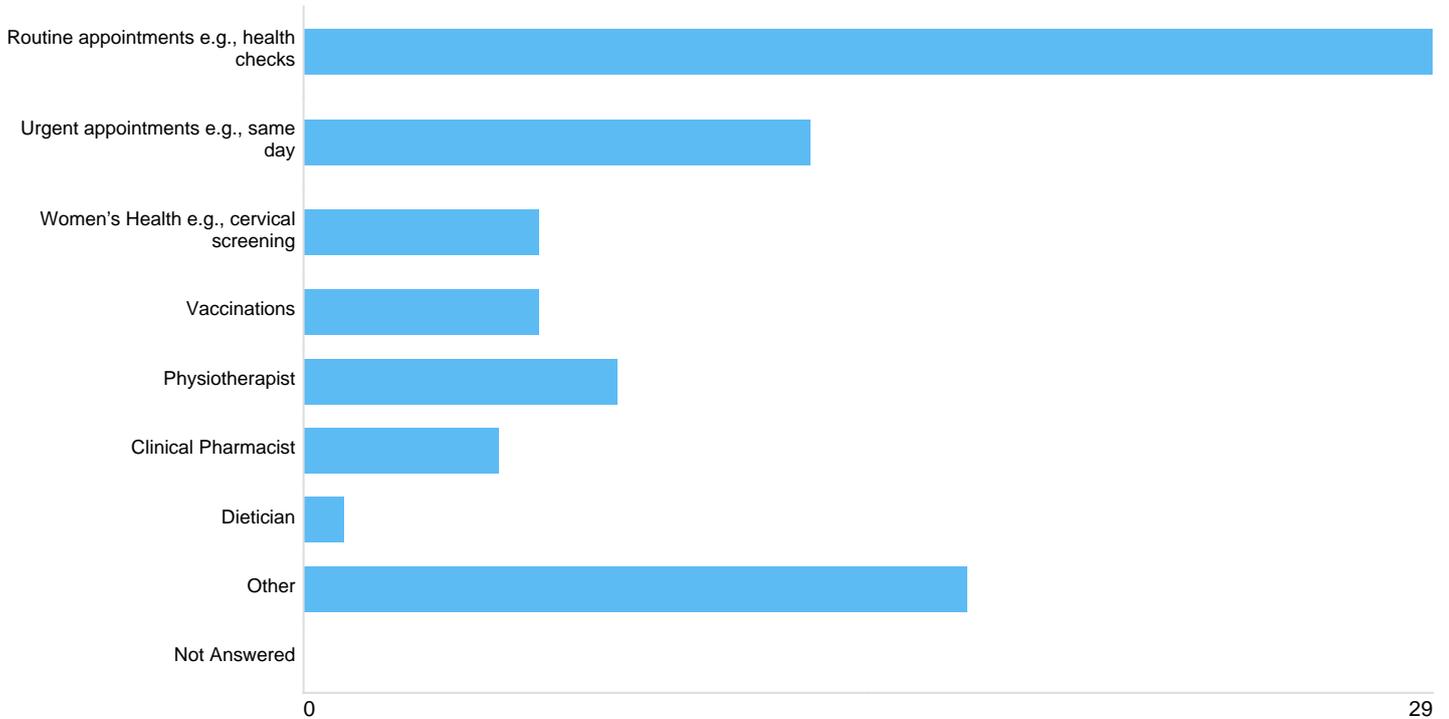
Access to Primary Care Network (PCN) services



Option	Total	Percent
Yes	23	34.85%
No	43	65.15%
Not Answered	0	0.00%

Question 7: What advice and treatment did you receive at this appointment?

Access to Primary Care Network (PCN) services



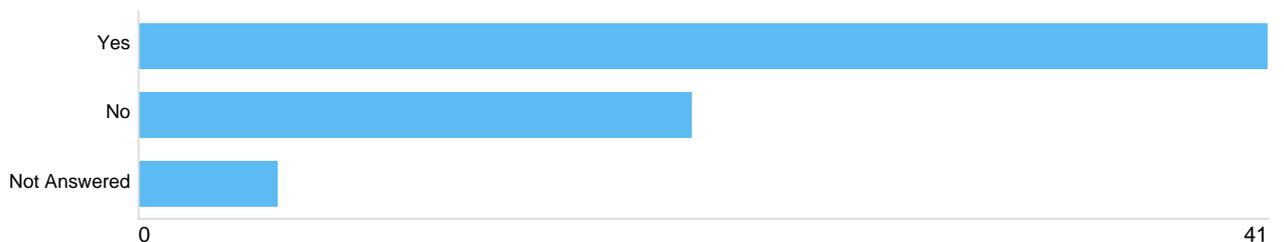
Option	Total	Percent
Routine appointments e.g., health checks	29	43.94%
Urgent appointments e.g., same day	13	19.70%
Women's Health e.g., cervical screening	6	9.09%
Vaccinations	6	9.09%
Physiotherapist	8	12.12%
Clinical Pharmacist	5	7.58%
Dietician	1	1.52%
Other	17	25.76%
Not Answered	0	0.00%

Please state, if other

There were **20** responses to this part of the question.

Question 8: Did you receive an appointment type of your choice?

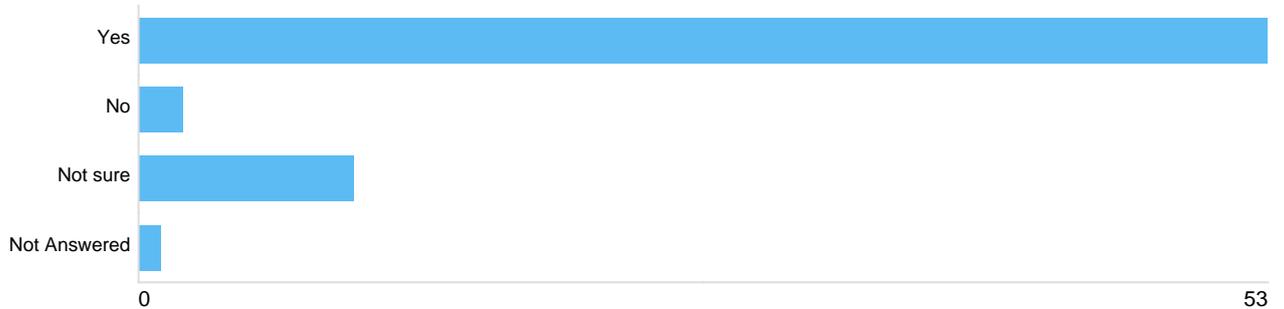
Access to Primary Care Network (PCN) services



Option	Total	Percent
Yes	41	62.12%
No	20	30.30%
Not Answered	5	7.58%

Question 9: Would you like the flexibility of being able to choose to attend other healthcare appointments delivered by the PCN and PCN hub, at a time and place that suits you?

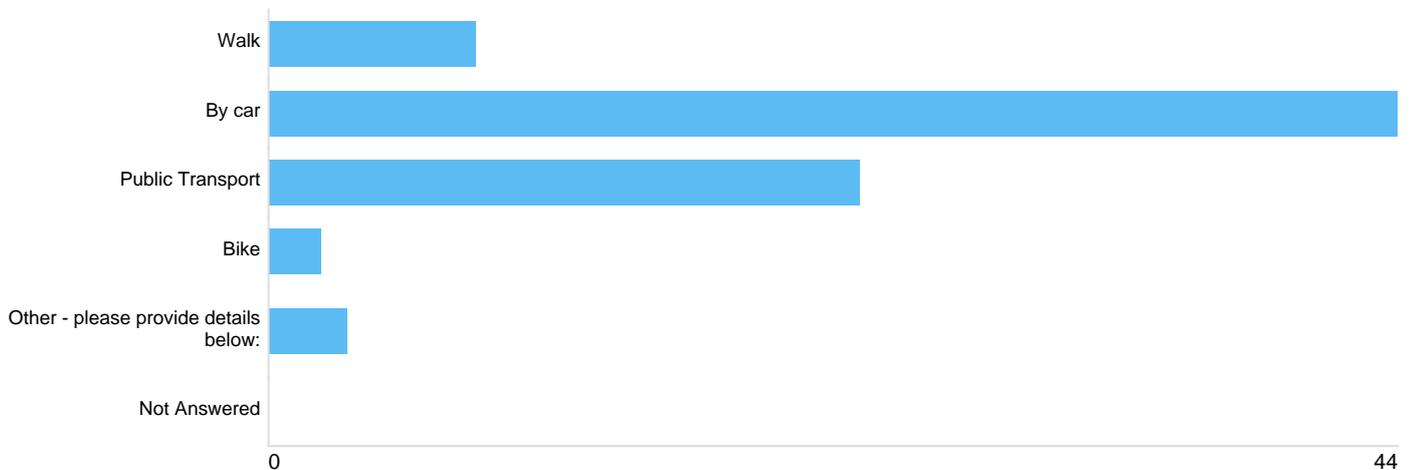
Access to Primary Care Network (PCN) services



Option	Total	Percent
Yes	53	80.30%
No	2	3.03%
Not sure	10	15.15%
Not Answered	1	1.52%

Question 10: How would you travel to PCN3 hub, at Wentworth Medical practice if you were offered an appointment there?

Other - please provide details below:



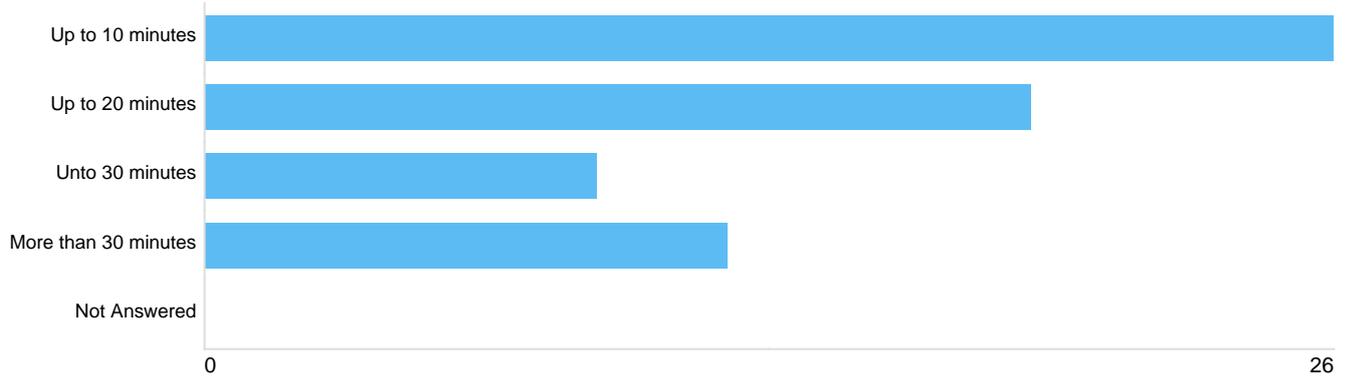
Option	Total	Percent
Walk	8	12.12%
By car	44	66.67%
Public Transport	23	34.85%
Bike	2	3.03%
Other - please provide details below:	3	4.55%
Not Answered	0	0.00%

Other - please provide details below:

There were 5 responses to this part of the question.

Question 11: How long would it take for you to travel from your home to PCN3 Hub? Please select only one item

Please select only one item



Option	Total	Percent
Up to 10 minutes	26	39.39%
Up to 20 minutes	19	28.79%
Unto 30 minutes	9	13.64%
More than 30 minutes	12	18.18%
Not Answered	0	0.00%

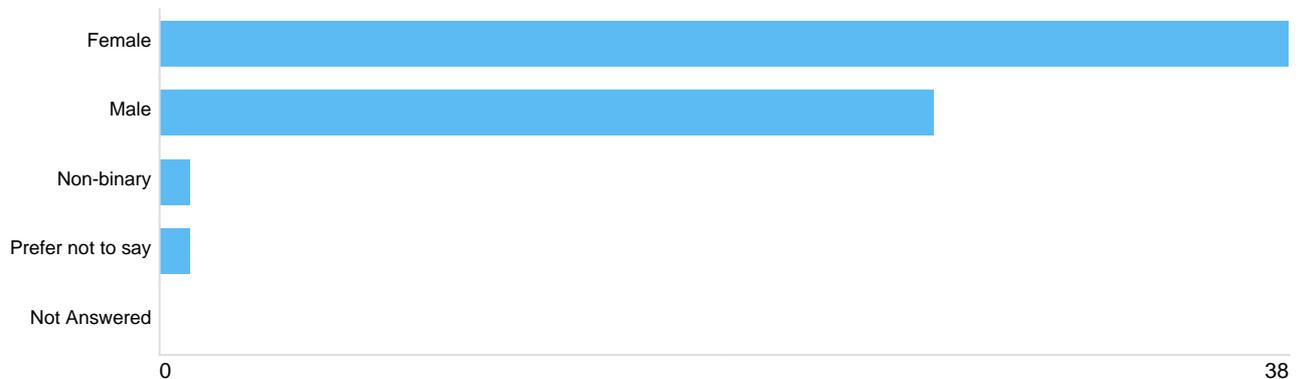
Question 12: Is there anything you would like to tell us about Langstone Way Surgery leaving PCN 4 to join PCN 3?

Is there anything you would like to tell us about Langstone Way Surgery leaving PCN 4 to join PCN 3?

There were **36** responses to this part of the question.

Question 13: Which of the following best describes you?

Some questions about you The following questions will help us to see if experiences vary between different patient groups. We will keep your answers completely confidential, and they will not be linked to your medical records.



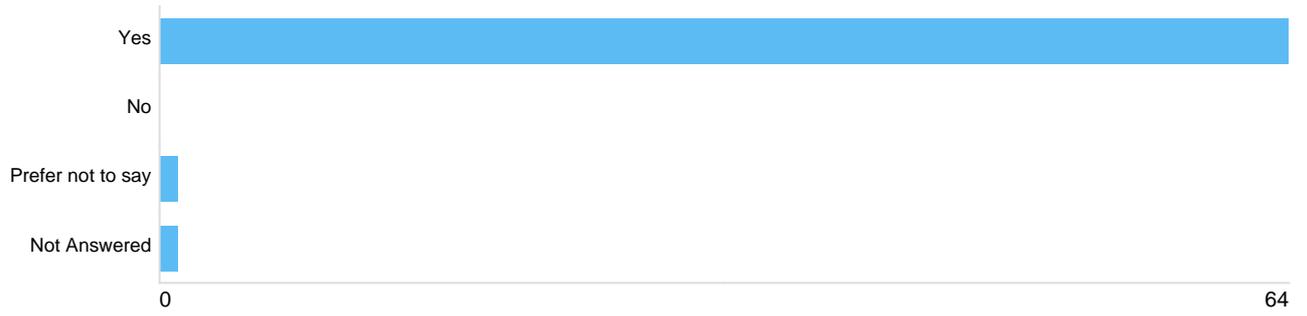
Option	Total	Percent
Female	38	57.58%
Male	26	39.39%
Non-binary	1	1.52%
Prefer not to say	1	1.52%
Not Answered	0	0.00%

Prefer to self-describe

There were **0** responses to this part of the question.

Question 14: Is your gender identity the same as the sex you were registered at birth?

Some questions about you



Option	Total	Percent
Yes	64	96.97%
No	0	0.00%
Prefer not to say	1	1.52%
Not Answered	1	1.52%

Question 15: Do you consider yourself to have a disability?

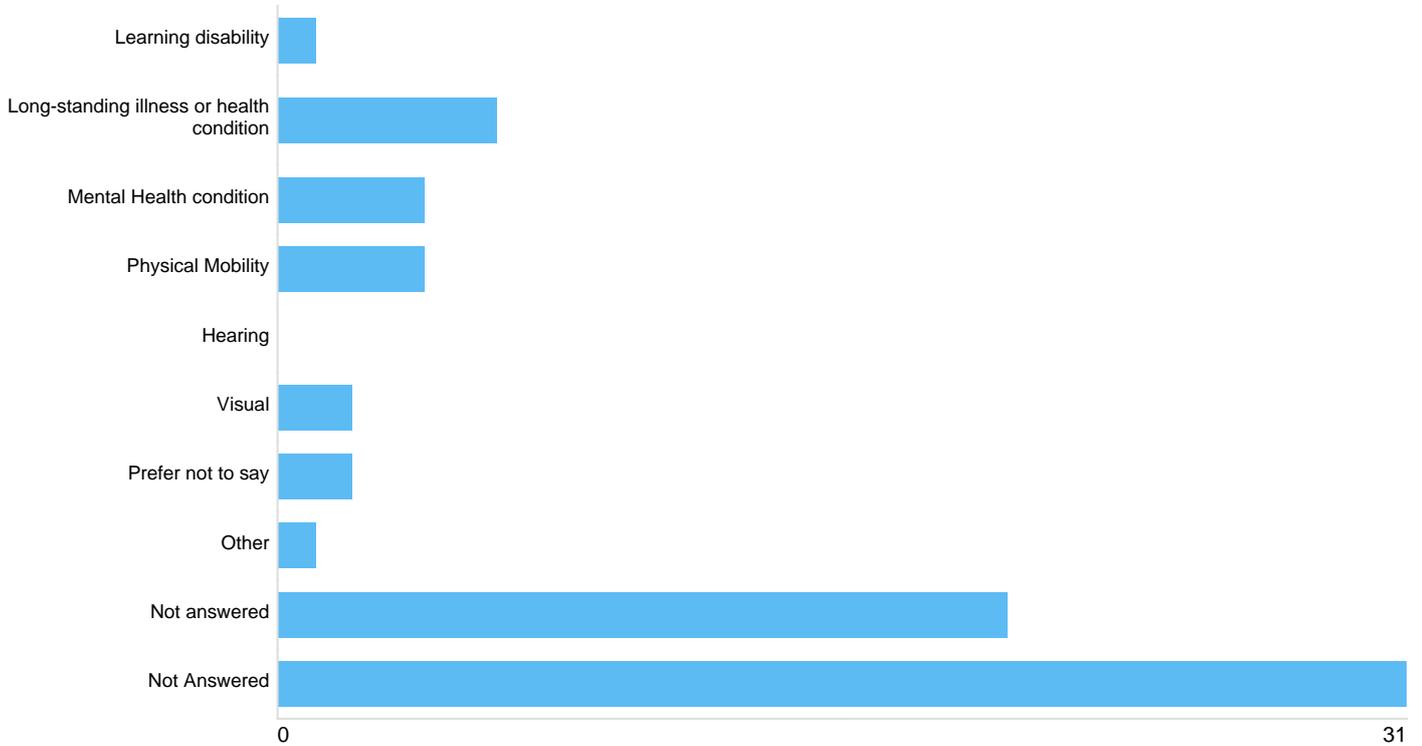
Some questions about you



Option	Total	Percent
Yes	12	18.18%
No	50	75.76%
Prefer not to say	3	4.55%
Not Answered	1	1.52%

Question 16: If you have said yes to the above, what type of disability do you have

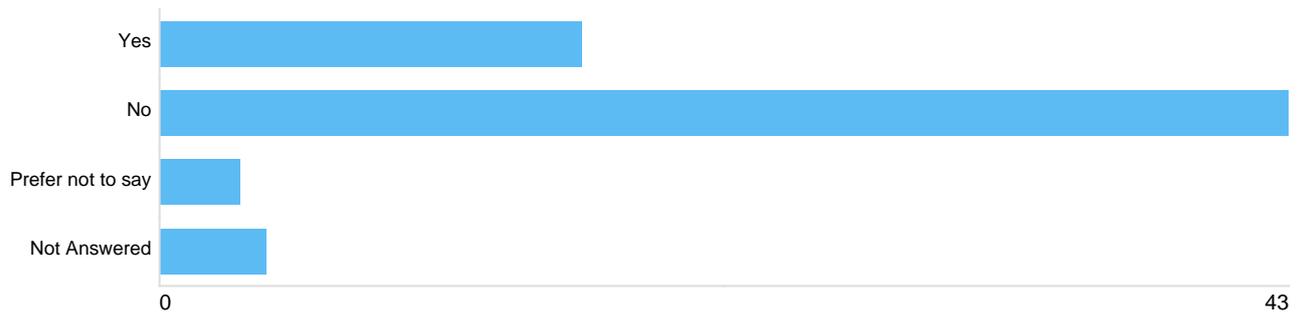
Some questions about you



Option	Total	Percent
Learning disability	1	1.52%
Long-standing illness or health condition	6	9.09%
Mental Health condition	4	6.06%
Physical Mobility	4	6.06%
Hearing	0	0.00%
Visual	2	3.03%
Prefer not to say	2	3.03%
Other	1	1.52%
Not answered	20	30.30%
Not Answered	31	46.97%

Question 17: Do you or someone you care for have long-term conditions?

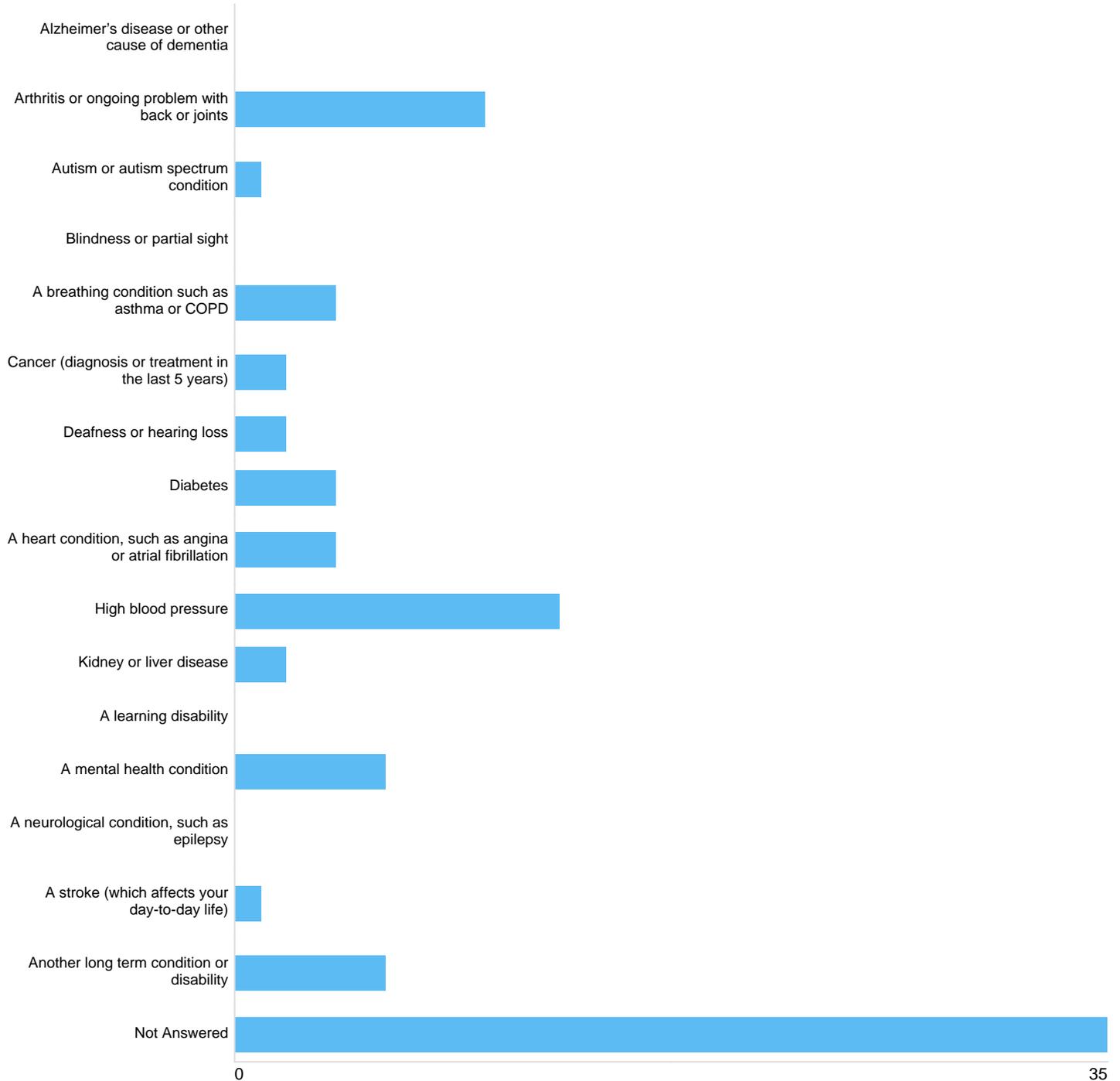
Some questions about you



Option	Total	Percent
Yes	16	24.24%
No	43	65.15%
Prefer not to say	3	4.55%
Not Answered	4	6.06%

Question 18: Which, if any, of the following long term conditions do you or the person that you care for have?

Some questions about you



Option	Total	Percent
Alzheimer's disease or other cause of dementia	0	0.00%
Arthritis or ongoing problem with back or joints	10	15.15%
Autism or autism spectrum condition	1	1.52%
Blindness or partial sight	0	0.00%
A breathing condition such as asthma or COPD	4	6.06%
Cancer (diagnosis or treatment in the last 5 years)	2	3.03%
Deafness or hearing loss	2	3.03%
Diabetes	4	6.06%
A heart condition, such as angina or atrial fibrillation	4	6.06%
High blood pressure	13	19.70%
Kidney or liver disease	2	3.03%
A learning disability	0	0.00%
A mental health condition	6	9.09%
A neurological condition, such as epilepsy	0	0.00%
A stroke (which affects your day-to-day life)	1	1.52%
Another long term condition or disability	6	9.09%
Not Answered	35	53.03%

Prefer to self-describe

There were 13 responses to this part of the question.

Question 19: Do you or someone you care for have difficulty speaking, reading or understanding English?

Some questions about you



Option	Total	Percent
Yes	1	1.52%
No	63	95.45%
Prefer not to say	0	0.00%
Not Answered	2	3.03%

Question 20: Do you or someone you care for usually need an interpreter when speaking with a doctor, nurse or other practice staff?

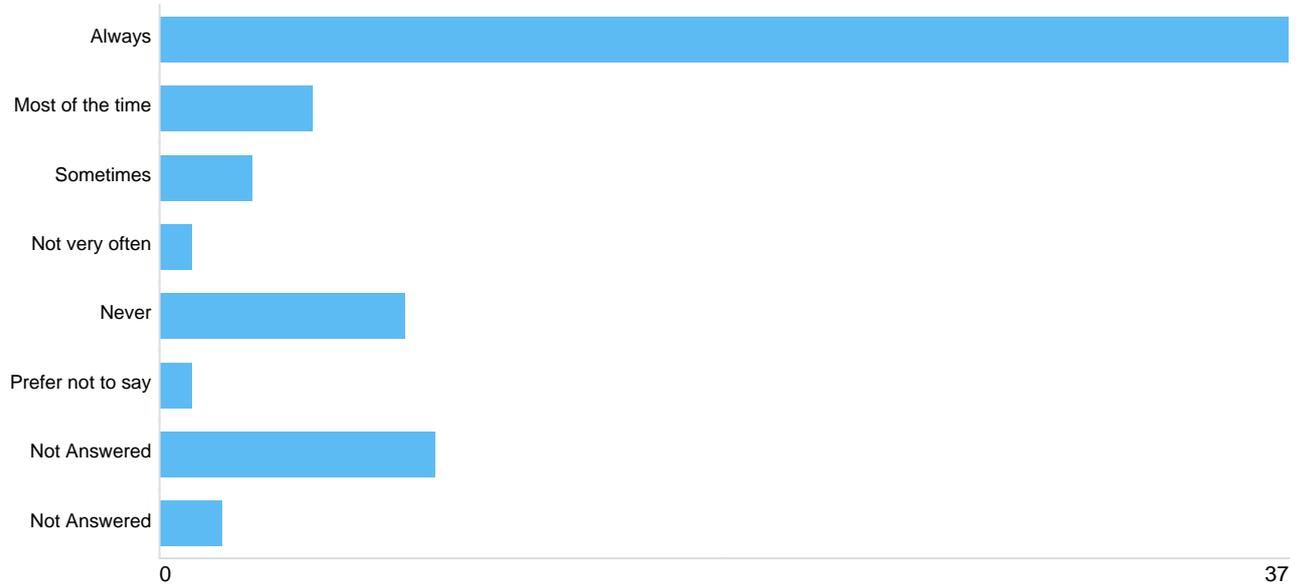
Some questions about you



Option	Total	Percent
Yes	1	1.52%
No	60	90.91%
Prefer not to say	2	3.03%
Not Answered	3	4.55%

Question 21: Do you get information from the doctors in a way you can understand? For example, easy read, braille, audio?

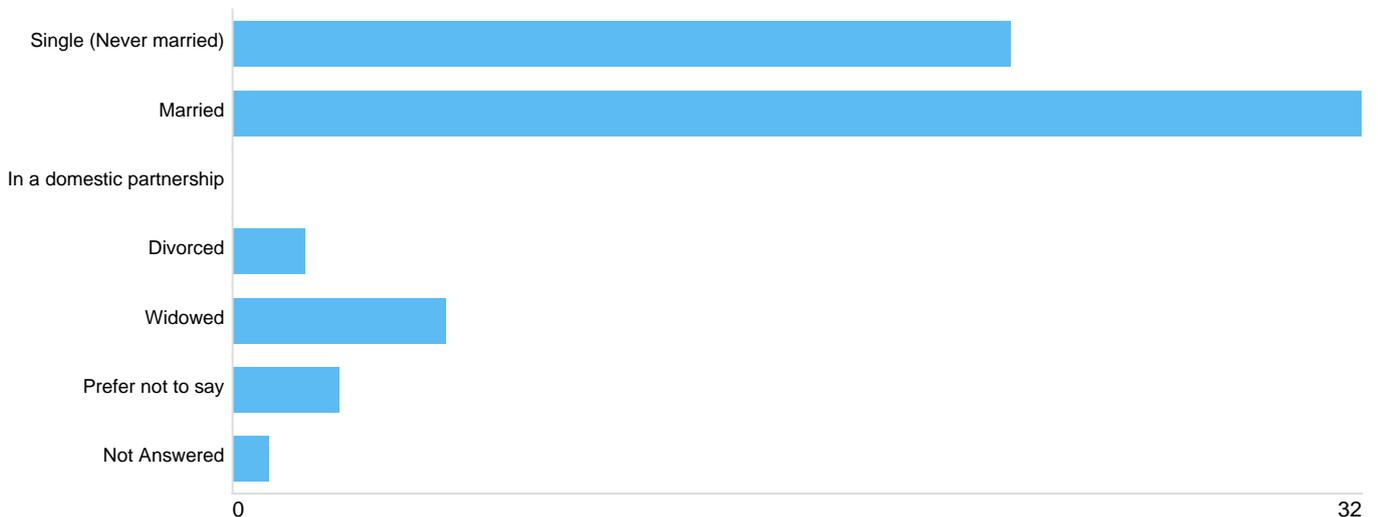
Some questions about you



Option	Total	Percent
Always	37	56.06%
Most of the time	5	7.58%
Sometimes	3	4.55%
Not very often	1	1.52%
Never	8	12.12%
Prefer not to say	1	1.52%
Not Answered	9	13.64%
Not Answered	2	3.03%

Question 22: What is your Marital Status?

Some questions about you



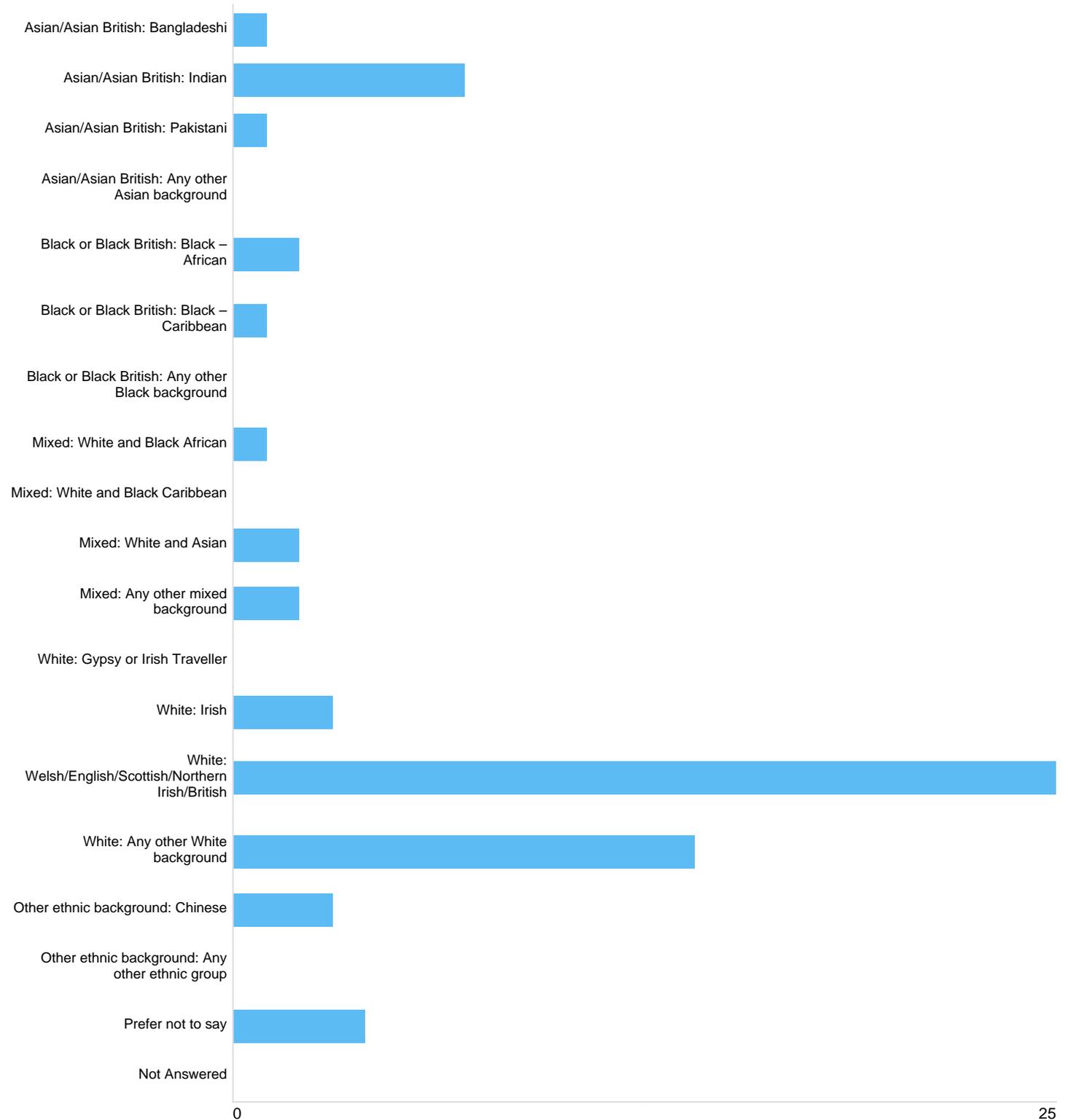
Option	Total	Percent
Single (Never married)	22	33.33%
Married	32	48.48%
In a domestic partnership	0	0.00%
Divorced	2	3.03%
Widowed	6	9.09%
Prefer not to say	3	4.55%
Not Answered	1	1.52%

Some questions about you

There was 1 response to this part of the question.

Question 23: What is your ethnic group?

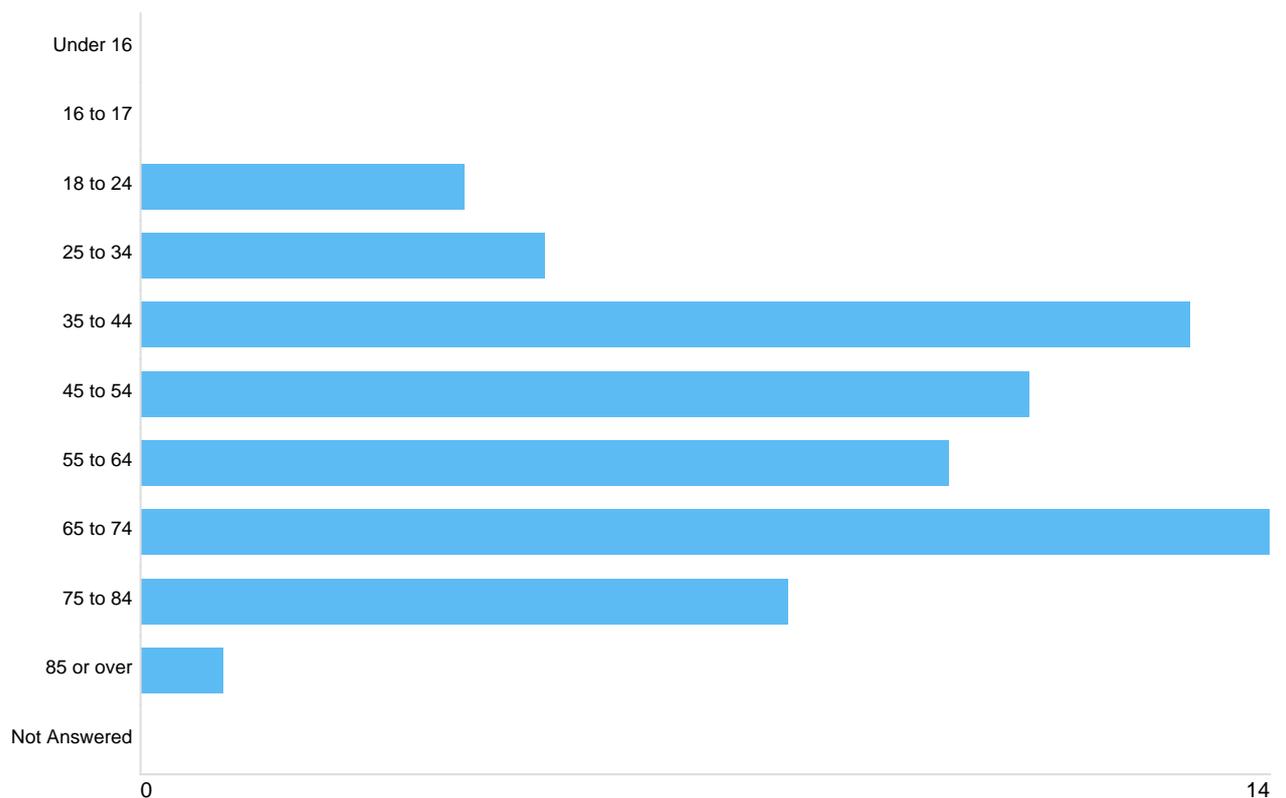
Some questions about you



Option	Total	Percent
Asian/Asian British: Bangladeshi	1	1.52%
Asian/Asian British: Indian	7	10.61%
Asian/Asian British: Pakistani	1	1.52%
Asian/Asian British: Any other Asian background	0	0.00%
Black or Black British: Black – African	2	3.03%
Black or Black British: Black – Caribbean	1	1.52%
Black or Black British: Any other Black background	0	0.00%
Mixed: White and Black African	1	1.52%
Mixed: White and Black Caribbean	0	0.00%
Mixed: White and Asian	2	3.03%
Mixed: Any other mixed background	2	3.03%
White: Gypsy or Irish Traveller	0	0.00%
White: Irish	3	4.55%
White: Welsh/English/Scottish/Northern Irish/British	25	37.88%
White: Any other White background	14	21.21%
Other ethnic background: Chinese	3	4.55%
Other ethnic background: Any other ethnic group	0	0.00%
Prefer not to say	4	6.06%
Not Answered	0	0.00%

Question 24: How old are you?

Some questions about you



Option	Total	Percent
Under 16	0	0.00%
16 to 17	0	0.00%
18 to 24	4	6.06%
25 to 34	5	7.58%
35 to 44	13	19.70%
45 to 54	11	16.67%
55 to 64	10	15.15%
65 to 74	14	21.21%
75 to 84	8	12.12%
85 or over	1	1.52%
Not Answered	0	0.00%

Question 25: Are you a deaf person who uses sign language?

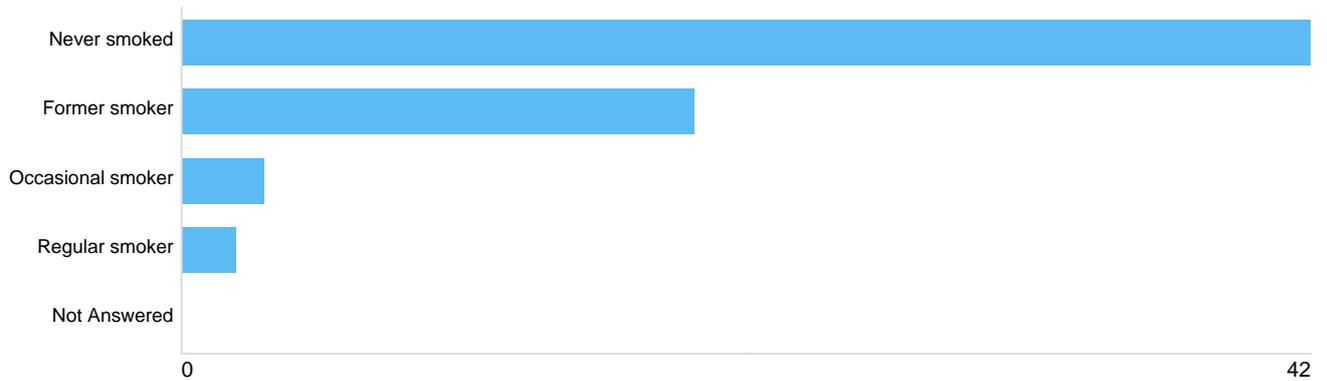
Some questions about you



Option	Total	Percent
Yes	0	0.00%
No	64	96.97%
Not Answered	2	3.03%

Question 26: Which of the following best describes your smoking habits?

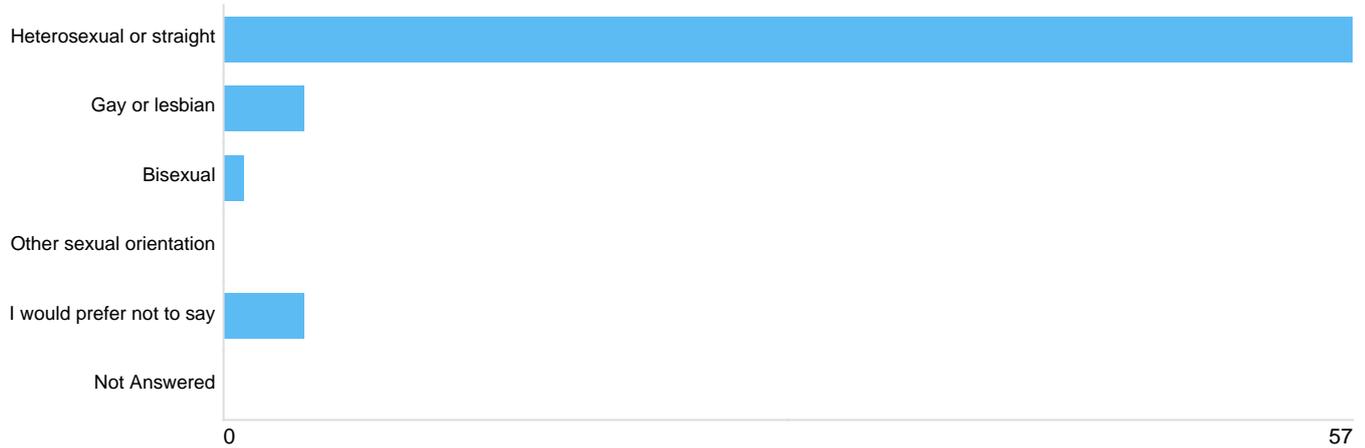
Some questions about you



Option	Total	Percent
Never smoked	42	63.64%
Former smoker	19	28.79%
Occasional smoker	3	4.55%
Regular smoker	2	3.03%
Not Answered	0	0.00%

Question 27: Which of the following best describes how you think of yourself?

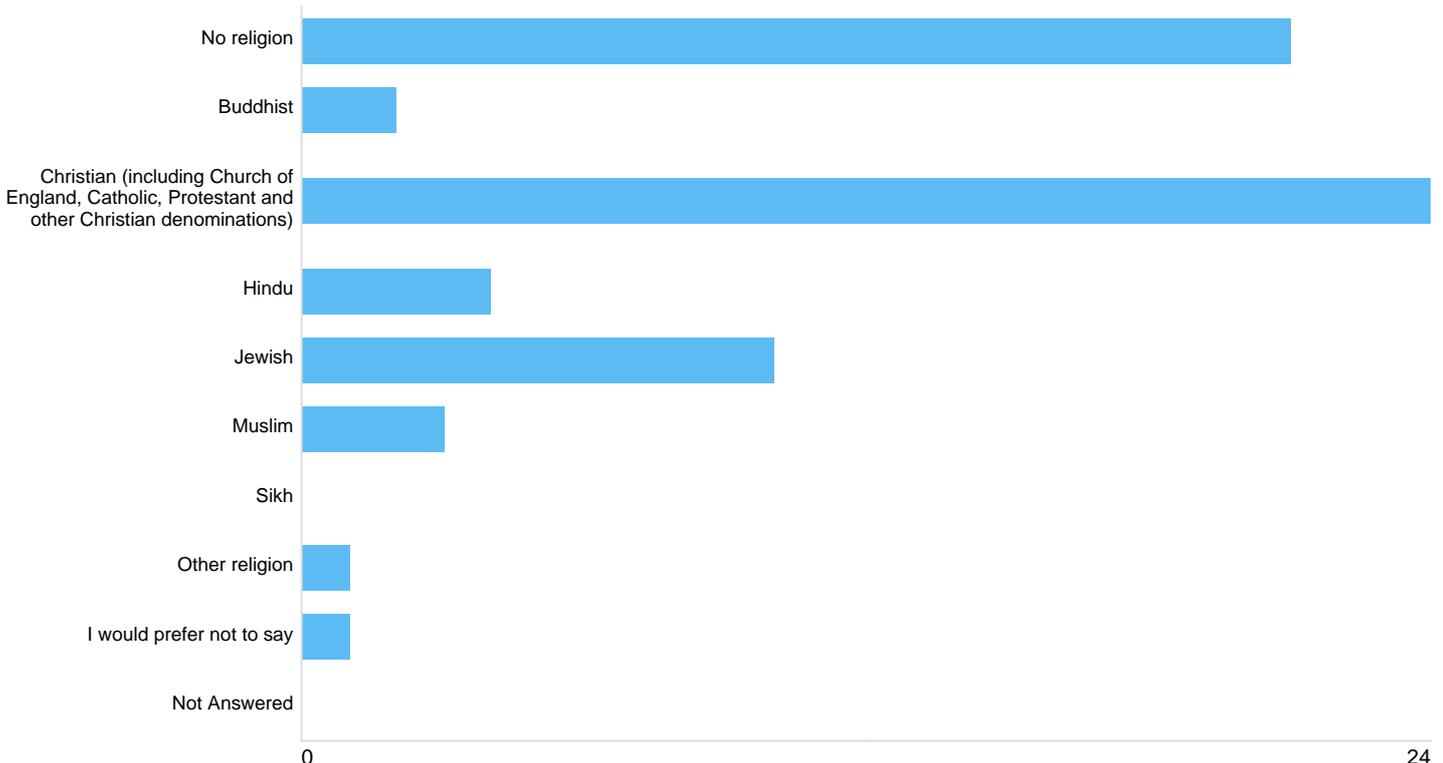
Some questions about you



Option	Total	Percent
Heterosexual or straight	57	86.36%
Gay or lesbian	4	6.06%
Bisexual	1	1.52%
Other sexual orientation	0	0.00%
I would prefer not to say	4	6.06%
Not Answered	0	0.00%

Question 28: Which, if any, of the following best describes your religion?

Some questions about you



Option	Total	Percent
No religion	21	31.82%
Buddhist	2	3.03%
Christian (including Church of England, Catholic, Protestant and other Christian denominations)	24	36.36%
Hindu	4	6.06%
Jewish	10	15.15%
Muslim	3	4.55%
Sikh	0	0.00%
Other religion	1	1.52%
I would prefer not to say	1	1.52%
Not Answered	0	0.00%

Langstone Way Surgery

Change in PCN

Equality Impact Assessment

Report

North Central London ICB

27 February 2026

Equality Impact Assessment and Patient survey results

EQIA Background

The ICB wrote to all patients over the age of 16 seeking their views via a survey over four weeks (30 January to 26 February). The survey data captured patient views and experiences on the use of Primary Care Network (PCN) services used by patients registered at Langstone Way Surgery and the change in location:

- Awareness of the PCN roles
- Referral to PCN staff
- Access to routine appointments outside core hours
- Mode of travel to PCN3 at Wentworth Medical practice
- Time taken to travel to PCN3 site at Wentworth Medical practice.

Equality Impact Assessment (EQIA) data was also captured to assess the demographic of the patients who responded, and those with protected characteristics compared to the total registered list and to help analyse the survey responses and patient need. The data that was captured related to:

- Gender identity
- Disability
- Ethnicity
- Age
- Employment status
- Carers
- Parental or Legal Guardian Status
- Hearing and sign language
- Smoking habits
- Religion

Patient feedback and EQIA

Langstone Way Surgery has recently merged with Wentworth Medical Practice. Prior to the merger, which took place on 2nd February, the practice list size was 7283 patients (raw), managed under a GMS contract. The practice comprised of 3 partners and is a member of PCN3. Two of partners who joined the contract are from Wentworth Medical Practice and they have submitted an application to move the practice from PCN3 to PCN4. This move has been requested on the basis that the following the merger, Wentworth Medical Practice will have one contract, and one list and Langstone Way Surgery contract will be terminated. The request is therefore a move of the Langstone Way list into PCN3 of which the Wentworth Medical Practice is a core member.

GP practice demographics

Langstone Way Surgery is located, Mill Hill ward, in the West of Barnet. The 2021 Census showed that Mill Hill ward has a population of 18,307, with 42% of the population from a BAME groups, of which 18.9% Asian, 8.6% black, and 9.5% other ethnic groups, 79% of the population's main language is English. 12.5% of the population is disabled under the Equality Act in Mill Hill. 86.8% of the population is in very good or good health and 3.9% of the population who are in bad or very bad health.

Langstone Way Surgery has a predominantly young population, with 63% (age 0-44), 24% aged 45-64 and 12% over the age of 65. From national GP practice profiles, the combined overall ethnicity profile of the practice is approximately 62.7% white, 6.0% mixed, 21.9% Asian, 9.4% black.

Patients were informed that they would be able to access extended hours appointments, in-house physiotherapy services and mental health practitioner services at Wentworth Medical Practice and patients would continue to access clinical pharmacist appointments at Langstone Way surgery.

There were 65 patients' surveys completed, representing 0.9% of the Langstone Way Surgery practice population.

The make-up of the patients who responded to the survey is similar to the combined ethnicity profile, though there were fewer patients from an Asian and Black background who responded to the survey. Although a small proportion of (0.9% of the practice population completed the survey, it provides a small representative group of the demographics of the patients registered on the list.

The practice registered list was 7283 (PCSE January 2026), there were 65 patients who responded to the survey (0.9% of the list), which is low compared to other NCL ICB surveys that have a response rate of 2-4% of the list.

- 48 responses were from the online survey
- 17 paper surveys were returned to the practice

There were 65 respondents who completed the EQIA demographic survey questions.

The highest group by demographic that responded to the survey were:

Age

- 6.15% - 18-24 years
- 6.15% - 25-34 Years
- 20.00% - 35-44 years
- 16.92% - 45 -54 years
- 15.38% - 55-64 years
- 21.54%% - 65-74 years
- 12.31% - 75-84 years
- 1.54% - 85 or over

Gender

- 56.92% - Female
- 40.0 % - Male
- 1.54% - non-binary

Ethnicity

- 13.85% - Asian/Asian British: Bangladeshi, Indian, Pakistani
- 4.62% - Black or Black British: Black – African / Caribbean
- 7.7% - Mixed background (all)
- 6.15% - other ethnic background
- 44.08%% - White: Welsh/English/Scottish/Northern Irish/British
- 20.00% - White: Any other Background

Disability status

- 18.46% - Yes, considered themselves to have a disability
- 75.38% responded No to this question
- 4.62% preferred not to say

For those who stated that they had a disability

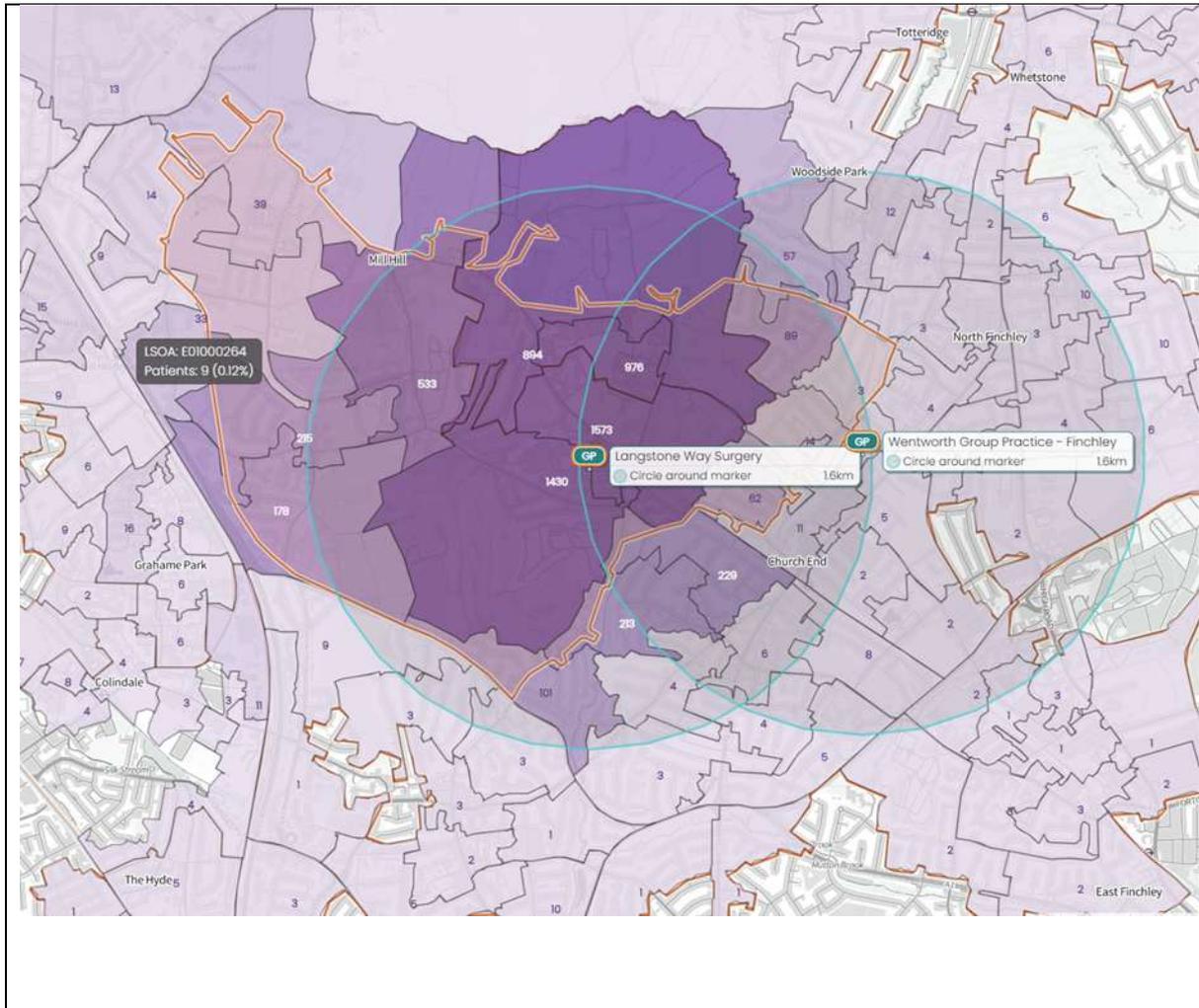
- 9.23% - Long term illness or health condition
- 6.15% - Mental Health Condition
- 6.15% - Physical Mobility
- 3.08% - Visual
- 46% - did not answer this question

When measuring the impact to patients the ICB has taken into consideration the EQIA data, groups of respondents and their needs to assess and mitigate any potential impact to the change of delivery of services from PCN3 hub at Wentworth Medical Practice.

Where patients reside compared to PCN3 Hub site

Wentworth Group Practice, host the PCN3 Access Hub, if approved by PCC patients will now have to travel to this site, to receive enhanced access appointments. The map below shows that patients registered with Langstone Way Surgery reside within 1 mile (20-minute walk) of Wentworth Practice.

Langstone Way is currently in PC4, the access Hub is provided by Millway Medical Centre, and which is 2.5 miles distance (55-minute walk) from the Langstone way Surgery.



Mode of travel to Wenworth Medical Centre PCN3 Hub	
<p>The main impact to patients will be the change in location of PCN services, from PC4 to PCN3, based on where patients reside between the two sites, the different modes of transport and distance of travel was reviewed to assess the impact.</p> <p>Wenworth Medical Practice is approximately 1.4 miles from Langstone Way Surgery</p> <ul style="list-style-type: none"> - 6 minutes by car - 30 minutes walking distance - 18 minutes by bus - There are two bus routes between the two sites: 382, 221 <p>Patients who responded to the survey stated the following</p> <p>When assessing the impact on the mode of travel, most patients indicated they would travel by car or public transport if needed to travel to Wentworth practice site to access PCN services offered.</p>	
Mode of travel	Access services at PCN3 site at Wenworth

Walk	12.31%
By Car	66.15%
Public transport	35.38%
Bike	3.08%

Access PCN services and ARRS staff

PCN funding is based on weighted list size, therefore if the PCN change is approved by PCC the funding will be allocated to PCN3 for the Langstone surgery patient list, on this basis it was deemed that the impact on patients being able to access the wider ARRS workforce should be low, we therefore assessed which ARRS staff groups patients are currently being referred to for services, this information will then be shared with PCN3 to ensure there would be no reduction in the provision of services.

The PCN ARRS staff Langstone patients had been referred to and the most common staff groups seen were: -

- Physician Associates – 46.15%
- Paramedics – 6.15%
- Dieticians – 9.23%
- Physiotherapists – 24.62%
- Mental Health professionals – 4.62%
- Social Prescribers – 4.62%
- Clinical Pharmacists – 32.31%

The practice has confirmed patients would continue to be able to access Physician Associates and clinical pharmacists from the Langstone Way surgery site.

PCN Enhanced Access appointments

PCNs are required to deliver Enhanced access outside core hours from 6.30- 8pm, Monday to Friday, 9am -5pm Saturdays (60-minute appointments per 1000 patients). The impact again should be low as the PCN funding would continue to be allocated to the Langstone List and PCN3 would have to ensure that there was sufficient staffing capacity to deliver the additional appointments.

We therefore assessed patient's awareness of their practice offer to book routine appointments outside core hours, including early morning, evening, or weekends, within their Primary Care Network, this would be shared with PCN3 to ensure they take patient's needs into account when planning services.

Most patients were unaware they could access appointments outside of core hours the response included:

- Yes – 41.54%%
- No – 49.23%

Unsure – 9.23%

Two thirds of the patients who responded reported that they had not been offered a GP or nurse appointment outside of core hours

Yes – 32.31%

No - 67.69%

When asked about whether patients had been offered an appointment with other ARRS staff, a higher proportion of patients reported they had not been offered appointments with ARRS staff

Yes – 35.38%

No – 64.62%

If they answered yes, they were asked what advice and treatment they received

Routine appointments	- 43.08%
Urgent /same day appointments	- 20.00%
Women's Health/ cervical screening	- 7.69%
Vaccinations	- 7.69%
Physiotherapist	- 12.31%
Clinical Pharmacist	- 7.69%
Dietician	- 1.54%
Other	- 26.15%

Patients who responded related to collections of forms, prescriptions or stating non applicable.

Services and Long-term Condition management

Services and access to appointments

There will be no change to the services and core access under the terms of the GMS contract. Following the change of PCNs, patients will continue to have access to the same services as PCN4, in addition patients will have access to:

- Spirometry
- ECG
- 24hr BPs
- New diabetic reviews with Health and well-being coach
- Hope corner LD reviews with Nurse associate, CLCH Dietician, Barnet Mencap, Barnet Carers, health and wellbeing UCP engagement
- Hope corner SMI reviews with Nurse associate, CB Plus check, social prescribers.
- Weight management
- Pancreatic cancer pilot
- Menopause clinics

There is a high count of Langstone Way Surgery patients on the QOF Long Term Disease register (3858), with the highest prevalence of disease for the following registers and table

1, this provides an indication of patient demand, access to services and appointments at the practice and other PCN ARRS staff.

- Asthma
- Chronic Obstructive Pulmonary disease
- Diabetes
- Chronic Kidney disease
- Mental Health
- Stroke Cancer
- Coronary Heart Disease
- Hypertension
- Nondiabetic Hyperglycaemia
- Obesity

There were 63.1% respondent who stated they never smoked, 39.2% former smoker and 4.62% occasional smoker.

IND_CODE	FIELD_NAME	VALUE
EP001	Epilepsy Register	32
CAN001	Cancer Register	271
DEM001	Dementia Register	49
HYP001	Hypertension Register	861
LD004	Learning Disabilities v2 Register	33
PAD001	Peripheral Arterial Disease Register	23
COPD015	Chronic Obstructive Pulmonary Disease Register	63
AF001	Atrial Fibrillation Register	84
DM017	Diabetes Mellitus Register	416
PC001	Palliative Care Register	58
STIA001	Stroke or Transient Ischaemic Attacks (TIA) Register	84
CHD001	Coronary Heart Disease Register	186
HF001	Heart Failure Register	59
MH001	Mental Health Register	78
AST005	Asthma Register	303
CKD005	Chronic Kidney Disease Register	255
OST004	Osteoporosis v2 Register	41
RA001	Rheumatoid Arthritis Register	29
NDH002	Non-diabetic hyperglycaemia register	417
OB003	Obesity Register	516

Face to face and Remote consultations (February 2026 data)

The practice is currently providing above the ICB average and below National average for face to face appointments, and a lower percentage being provided remotely.

	Practice	ICB Average	National Average

Face to Face	59%	55%	67%
Remote	41%	45%	33%

Recommendations / Mitigating actions

It is deemed the impact to patients and ones with protected characteristics will be low, the area with the highest impact was the mode of travel, as most patients reported they would travel to the PCN3 hub via car or public transport and travel time reported ranged from 38% reporting 10 mins, 29% reported up to 20 minutes and 14% reporting up to 30 minutes.

There is on street parking available in the area surrounding the practice, though it should be noted that there are parking restrictions between 2 – 3 pm.

There is no change in services to be delivered under the Wentworth Medical Practice GMS contract, the Langstone Way Surgery site continues to operate as a branch site.

For patients that may need assistance getting to the surgery, a flag can be placed on their medical records to highlight that they need assistance and are reliant on a carer or a family member. This would alert the practice to review the range of appointments available which could accommodate the carer or family member.

Where patients are too ill to travel to practice for a face-to-face appointment, they may request a home visit, the practice in December 2025 provided slightly above the ICB and fewer National average for home visits.



North Central London
Integrated Care Board

**North Central London ICB
Primary Care Committee Meeting
10 March 2026**

Report Title	Millway Medical Practice – Strategic Case for Rent Reimbursement of Second-Floor Space	Date of report	16 February 2026	Agenda Item	2.2
Lead Director / Manager	Sarah McIlwaine, Director of Primary Care	Email / Tel		sarah.mcilwaine@nhs.net	
Board Member Sponsor	Not applicable.				
Report Author	Henry Claridge, Strategic Estate Lead, Camden and Barnet	Email / Tel		Henry.claridge@gbpconsult.co.uk	
Name of Authorising Finance Lead	Sarah Rothenberg, Deputy Director Finance Business Partnering – Primary Care	Summary of Financial Implications			
		<p>The proposed additional rent reimbursement for 64m2 of second floor space is £15,904 per annum.</p> <p>Therefore, total reimbursement for the practice would increase from £267,215.00 per annum to £283,119.00 per annum.</p> <p>Proposed new reimbursement to be applied following PCC approval.</p>			
Name of Authorising Estates Lead	Nicola Theron, Director of Estates	Summary of Estates Implications			
		<p>The practice is seeking occupation of 64 m2 of additional administrative, management and medical secretarial space on the second floor of their current site. This space is available because of Central London Community Healthcare NHSE Trust (CLCH) vacating the space following the change in the Health Visiting and School Nursing contract (now delivered by Vaccination UK).</p> <p>The NHSE PID estimator estimates a physical space Net Internal Area (NIA) requirement of 1,258 m2 for a practice list size of 24,850 (the current Millway list). The practice currently operates from 923 m2 of NIA and therefore by this metric would be eligible for additional support space.</p>			

Report Summary	<p>The practice has submitted a Project Initiation Document (PID) for Procurement & Development of Primary Care Premises by GP Contractors that forms the Appendix for this application.</p> <p>Millway Medical Practice is a high-performing, rapidly growing GP practice in Mill Hill with a current registered population of 24,850 patients, increasing at an average rate of 6.1% annually. To meet rising demand, accommodate the expanding PCN workforce, and maintain safe operational capacity, the practice has undergone a significant estates reconfiguration.</p> <p>Using the NHS London Improvement Grant (LIG), the practice has converted its first-floor former administrative area into four additional clinical rooms, increasing capacity from 20 to 24 clinical rooms. This space already formed part of the reimbursable estate footprint and is therefore cost-neutral, with no additional rent reimbursement sought for this area.</p> <p>To facilitate this clinical expansion, administrative, management and medical secretarial teams were relocated to the second floor, previously sublet to CLCH. CLCH has vacated this space following the change in the Health Visiting and School Nursing contract (now delivered by Vaccination UK). As a result, Millway Medical Practice now becomes responsible for the rent for this second-floor area from 01 November 2025.</p> <p>This submission seeks reimbursement of the rent for the two rooms on the second-floor space only, which is a new, necessary, and unavoidable cost arising from the clinically essential LIG-funded expansion.</p> <p>Rent reimbursement is appropriate because:</p> <ul style="list-style-type: none"> • The space is essential for delivering primary medical services • It is required to house practice and PCN operational functions • It enables safe clinical expansion • It represents a new, unavoidable cost to the practice • It offers value for money as compared to external office rental
Recommendation	<p>The Primary Care Committee is asked to APPROVE the increase in demised space for Millway Medical Practice by 64m² and the increase of reimbursed rent by £15,904 per annum to £283,119.00 per annum.</p>
Identified Risks and Risk Management Actions	<p>Financial - If reimbursement is not approved, the practice would absorb an additional £15,904 per annum in estate costs, which poses a financial pressure given rapid list growth and high clinical demand.</p> <p>Operational – lack of suitable accommodation to house primary care administrative, management and medical secretarial services.</p>
Conflicts of Interest	<p>Not applicable.</p>
Resource Implications	<p>Not applicable.</p>
Engagement	<p>The practice are actively engaged with their PPG and meet with them on a regular basis. Recent meetings have highlighted strong patient support for expanding clinical capacity, improving access and ensuring continuity of care. The rationale for estates optimisation and the need for additional space has been discussed with the PPG, who expressed clear support for any measures that increase appointments and clinical availability.</p>
Equality Impact Analysis	<p>Not applicable.</p>

Report History and Key Decisions	Not applicable.
Next Steps	Not applicable.
Appendices	None

Millway Medical Practice – Strategic Case for Rent Reimbursement of Second-Floor Space

1. Strategic Context

Millway Medical Practice is a high-performing, rapidly growing GP practice in Mill Hill with a current registered population of 24,850 patients, increasing at an average rate of 6.1% annually. To meet rising demand, accommodate the expanding PCN workforce, and maintain safe operational capacity, the practice has undergone a significant estates reconfiguration.

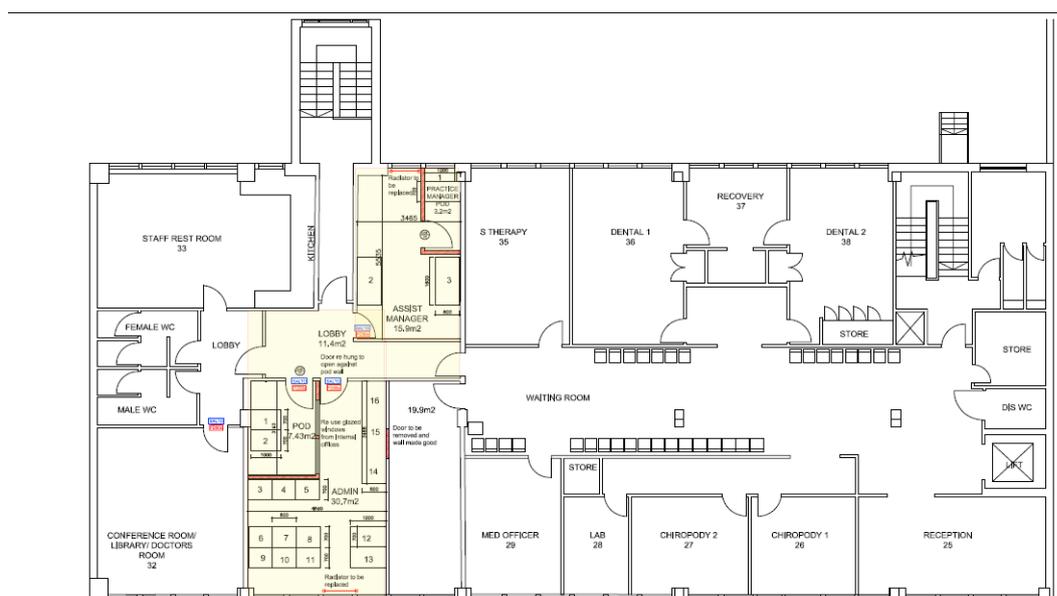
Using the NHS Lease Improvement Grant (LIG), the practice has converted its first-floor former administrative area into four additional clinical rooms, increasing capacity from 20 to 24 clinical rooms. This space already formed part of the reimbursable estate footprint and is therefore cost-neutral, with no additional rent reimbursement sought for this area.

To facilitate this clinical expansion, administrative, management and medical secretarial teams were relocated to the second floor, previously sublet to CLCH. CLCH has vacated this space following the change in the Health Visiting and School Nursing contract (now delivered by Vaccination UK). As a result, Millway Medical Practice now becomes responsible for the rent for this second-floor area from 01 November 2025.

2. Analysis

Millway Medical Practice is a GP practice in Mill Hill with a current registered population of 24,850 patients.

This submission seeks reimbursement of the rent for the two rooms on the second-floor space (highlighted in yellow below). The space is office space, previously sublet to CLCH. CLCH has vacated this space following the change in the Health Visiting and School Nursing contract (now delivered by Vaccination UK). As a result, the space reverted to landlord and became available for practice use



The practice proposes to use the space to support the Admin team, Medical secretaries, Management and operations team, PCN administrative functions, Education/supervision space for trainees and ARRS clinicians. It outlines the space is required to

- Maintain safe operational functioning
- Support 60 staff and an expanded PCN workforce
- Provide supervision and training environments
- Ensure robust administrative capacity to support nearly 25,000 patients
- Allow the clinical conversion in line with LIG conditions

Premises Conditions

Millway Medical Practice is one of only 4 Core primary care facilities in Barnet. The PCN Estate Strategy commission in 2022 describes the site as Condition Grade B, with very good internal condition. The practice is a key asset in the North-West of Barnet due to the condition of surrounding practices and the size of the facility. The site is leased from a private Landlord, with the current lease expiring in 2041.

The table below outlines the current space and rental reimbursement for the practice.

Floor	Area (m ²)	£/m ²	FI Factor %	Total
Ground	399.9	£ 248.50		£ 99,375.15
First	415.2	£ 248.50		£ 103,177.20
Second	108.1	£ 248.50		£ 26,862.85
Total Area	923.2		Sub-total	£ 229,415.20
Parking	No. of spaces	£/space		
Standard	56	£ 675.00		£ 37,800.00
Total Parking	56		Sub-total	£ 37,800.00
Total				£ 267,215
Total Valuation				£ 267,215

Capacity and Access

a. Space Considerations

The table below sets out the current, proposed and estimated space requirement for Millway Medical Practice.

Site	Space
Current – Millway Medical Practice	932 sqm
Proposed – Millway Medical Practice + 2 rooms	996 sqm
NHSE PID Estimator for practice current list of 24,850	1,258 sqm

Using the NHSE PID estimator as a gauge of space required to support a practice list of this size, it would indicate the practice would be eligible for additional support space to support primary care service delivery.

b. Revenue impact

The proposed additional rent reimbursement for 64m² of second floor space is £15,904 per annum.

Therefore, total reimbursement for the practice would increase from £267,215.00 per annum to £283,119.00 per annum.

c. Practice Provision

Millway Medical Practice is compliant with contractual opening hours and is open from 07:30 – 18:30 Monday to Friday and until 19:30 on Tuesday and Wednesday and 08:30 – 13:00 alternate Saturdays (EAS). There will be no change to opening hours if the newly procured contract is contracted to the new premises.

The practice house a total of 60 staff (including clinical)

d. Patient Engagement

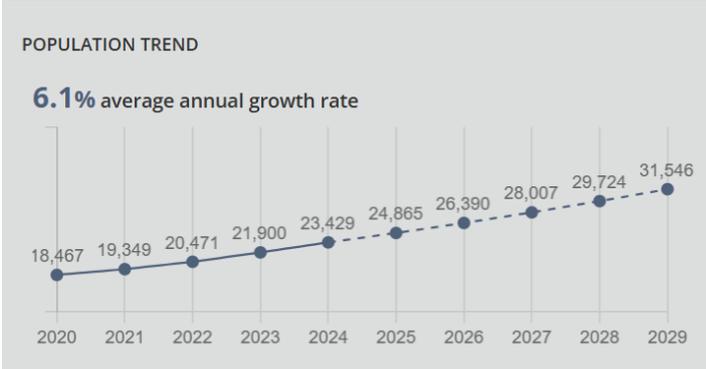
The practice are actively engaged with their PPG and meet with them on a regular basis. Recent meetings have highlighted strong patient support for expanding clinical capacity, improving access and ensuring continuity of care. The rationale for estates optimisation and the need for additional space has been discussed with the PPG, who expressed clear support for any measures that increase appointments and clinical availability.

3. Conclusion and recommendation

Approval is sought to increase the demised space for Millway Medical Practice by 64m² and the subsequent increase of reimbursed rent by £15,904 per annum to £283,119.00 per annum.

NCL

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

PRACTICE NAME & CODE	MILLWAY MEDICAL PRACTICE E83016																						
PRACTICE ADDRESS	2 HARTLEY AVENUE LONDON NW7 2HX																						
CURRENT PRACTICE LIST SIZE Include the current raw list size Include information on how many patients access your branch site(s) – if applicable	24,850 (expected to be 25,000 by the end of 2025 and more than 26,000 by the end of 2026)  <table border="1"> <caption>POPULATION TREND</caption> <thead> <tr> <th>Year</th> <th>Population</th> </tr> </thead> <tbody> <tr><td>2020</td><td>18,467</td></tr> <tr><td>2021</td><td>19,349</td></tr> <tr><td>2022</td><td>20,471</td></tr> <tr><td>2023</td><td>21,900</td></tr> <tr><td>2024</td><td>23,429</td></tr> <tr><td>2025</td><td>24,865</td></tr> <tr><td>2026</td><td>26,390</td></tr> <tr><td>2027</td><td>28,007</td></tr> <tr><td>2028</td><td>29,724</td></tr> <tr><td>2029</td><td>31,546</td></tr> </tbody> </table>	Year	Population	2020	18,467	2021	19,349	2022	20,471	2023	21,900	2024	23,429	2025	24,865	2026	26,390	2027	28,007	2028	29,724	2029	31,546
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2026	26,390																						
2027	28,007																						
2028	29,724																						
2029	31,546																						
STRATEGIC NEED Set out if there is a strategic case for this change. Provide as much detail as possible about the change, including any impact on your current registered patients. Please include. - Access to main site / other branch sites i.e., public transport, ease of access - Capacity at remaining sites branch sites - Booking appointments	Millway Medical Practice – Strategic Case for Rent Reimbursement of Second-Floor Space Effective from: 01 November 2025 Submitted to: North Central London ICB (Barnet Place) 1. Executive Summary Millway Medical Practice is a high-performing, rapidly growing GP practice in Mill Hill with a current registered population of 24,850 patients , increasing at an average rate of 6.1% annually . To meet rising demand, accommodate the expanding PCN workforce, and maintain safe operational capacity, the practice has undergone a significant estates reconfiguration. Using the NHS Lease Improvement Grant (LIG) , the practice has converted its first-floor former administrative area into four additional clinical rooms , increasing capacity from 20 to 24 clinical rooms . This space already formed part of the reimbursable estate footprint and is therefore cost-neutral , with no additional rent reimbursement sought for this area. To facilitate this clinical expansion, administrative, management and medical secretarial teams were relocated to the second floor , previously sublet to CLCH . CLCH has vacated this space following the change in the Health Visiting and School Nursing contract (now delivered by Vaccination UK). As a result, Millway Medical Practice now becomes responsible for the rent for this second-floor area from 01 November 2025 .																						

- Additional and Enhanced services
- LCS / other services offered.

Any other relevant information

This submission seeks reimbursement of the rent for the two rooms on the second-floor space only, which is a new, necessary, and unavoidable cost arising from the clinically essential LIG-funded expansion.

2. Strategic Rationale

2.1 Rapid Population Growth

- Registered list size: **24,850 patients**
- Annual growth rate: **6.1%**
- Growth significantly exceeds local and national averages
- Driven by major housing developments in Mill Hill, Millbrook Park, and North-West Barnet

Impact:

The demand on GP, nursing, and multidisciplinary appointments now requires a minimum of **24 clinical rooms** to maintain safe and timely access.

Supporting policy references:

- **NHS England Primary Care Access Recovery Plan (2023):** mandates increasing appointment capacity and optimising estate use.
- **GP Contract Regulations:** require practices to maintain facilities sufficient to meet reasonable patient need.

2.2 Expansion of PCN and Multidisciplinary Workforce

Millway employs **60 staff**, including:

- GPs and salaried doctors
- Nurses, HCAs and phlebotomists
- GP trainees
- Secretaries and admin staff
- Management and operations team

PCN4's ARRS workforce—hosted and supervised at Millway—includes:

- Clinical pharmacists
- Pharmacy technicians
- First Contact Physiotherapist
- Mental Health Practitioner
- Social prescribers
- Care coordinators
- Health & Wellbeing Coaches
- Digital Transformation Lead
- General Practice Assistants

Workforce expansion is mandated by:

- **Fuller Stocktake (2022)**
- **NHS Long Term Workforce Plan (2023)**
- **PCN DES contractual requirements**

All require practices to provide appropriate workspace for MDT roles.

Impact:

The former administrative area was no longer sufficient. Without relocating admin/secretaries/management to the second floor, the practice could not safely host its MDT workforce or meet PCN DES obligations.

2.3 Estates Requirements Under NHS Guidance

The following frameworks require improved clinical utilisation of GP premises:

- **NHS Premises Directions (2013)**
- **NCL Primary Care Estates Strategy (2021–25)**
- **Barnet Neighbourhood Development Priorities**
- **Fuller Stocktake: Integrated Neighbourhood Teams**

These direct practices to make maximal use of estate for **clinical delivery, PCN hosting, and neighbourhood integration.**

Impact:

Converting the first-floor admin office into clinical rooms is fully aligned with national and regional policy.

3. Conversion of First-Floor Administrative Area Into Clinical Rooms (LIG-Funded, Cost Neutral)

3.1 Description of Works

Using NHS LIG grant funding, Millway has:

- Converted the former first-floor admin office into **four fully compliant clinical rooms**
- Increased clinical capacity from **20 → 24 rooms**
- Improved fire compliance, data cabling and infection control standards
- Enabled increased GP, nursing, PCN, extended hours, and anticipatory care clinics

3.2 Cost Neutrality of First-Floor Area

- This first-floor area **already formed part of the reimbursable estate.**
- **No additional rent reimbursement is requested.**
- LIG funded capital improvements only.
- The net rent position for the first-floor space **remains unchanged** for the ICB.

3.3 Strategic Outcomes

- Increased appointment availability
- Improved capacity for LTC management

- Greater ability to host ARRS clinicians
- Enhanced resilience and safer clinical flows
- Future-proofing for expected patient growth toward 27,000+

4. Relocation of Admin, Secretarial and Management Team to Second Floor

4.1 Necessity of the Move

There is no viable alternative location within the existing practice footprint to house the administrative, secretarial and management teams once the first-floor area was converted into clinical rooms. Without access to the second-floor space, the LIG-funded expansion could not be safely operationalised, and the practice would be unable to accommodate ARRS, MDT and trainee supervision requirements, which includes:

- Admin team
- Medical secretaries
- Management and operations team
- PCN administrative functions
- Education/supervision space for trainees and ARRS clinicians

4.2 Nature of the Second-Floor Space

- Previously sublet to **CLCH** (CHP)
- Used for Health Visiting and School Nursing teams
- CLCH vacated due to contract change (new provider: Vaccination UK)
- Space reverted to landlord and became available for practice use
- From **01 November 2025**, rent is payable by Millway Medical Practice

4.3 Why This Space Is Required

The second-floor space is essential to:

- Maintain safe operational functioning
- Support 60 staff and an expanded PCN workforce
- Provide supervision and training environments
- Ensure robust administrative capacity to support nearly 25,000 patients
- Allow the clinical conversion in line with LIG conditions

This space is required **solely because of** the strategic expansion of clinical rooms.

5. Financial Case for Rent Reimbursement (Second Floor Only)

5.1 New Rent Liability

The second-floor space represents a **new cost pressure**, previously funded by CLCH.

As of **01.11.2025**, the practice must pay rent to **Curtis Medical** for this area.

5.2 Eligibility Under NHS Premises Directions

Rent reimbursement is appropriate because:

- The space is essential for delivering primary medical services
- It is required to house practice and PCN operational functions
- It enables safe clinical expansion via LIG
- It represents a new, unavoidable cost to the practice
- It offers value for money as compared to external office rental

5.3 Request to the ICB

The practice formally requests:

Reimbursement of rent for the second-floor space from 01 November 2025 onward, in accordance with NHS Premises Directions and NCL ICB Estates guidance.

No additional rent is requested for the first-floor area converted into clinical rooms.

6. Evidence Summary

Requirement	How Millway Meets It	Evidence
Population growth	24,850 patients; 6.1% annual rise	List size report
Increased demand	Need for 24 clinical rooms	Appointment utilisation analysis
MDT expansion	Large PCN ARRS workforce	PCN4 workforce especially as now 3 sites only in PCN4
Space optimisation required	First-floor conversion funded by LIG	LIG award documentation
No additional cost for clinical area	Rent position unchanged	Existing lease plan
Need for second-floor area	Admin displaced by clinical expansion	Estates layout mapping
New rent liability	CLCH vacated; rent payable from 01.11.2025	Notification from CHP/landlord
Strategic alignment	Access Recovery Plan, Fuller, ICS strategy	NHS publications

7. Conclusion

The utilisation of the second-floor space is a direct and necessary outcome of Millway's clinically essential expansion from 20 to 24 rooms, made possible through the NHS LIG scheme. With a rapidly growing population, expanded PCN workforce, and increasing service demands, this estate optimisation is required to maintain safe, accessible, high-quality primary care for the local community.

	We therefore request that NCL ICB approve and reimburse the rent for the second-floor area from 01 November 2025.
BRIEF SCHEME DESCRIPTION	As above.
LOCATION & ADDRESS OF THE NEW PREMISES Please confirm the travel distance to the new site (if applicable)	N.A.
BENEFIT TO PATIENTS Set out the benefits to patients from the change	<p>The expansion to 24 clinical rooms significantly increases appointment availability, improves access to face-to-face care, and supports safer, timelier management of long-term conditions. Patients benefit from reduced waiting times, a broader range of onsite clinicians, and more capacity for proactive and personalised care.</p> <p>The additional administrative and operational capacity housed on the second floor also supports mandatory supervision, governance and coordination of the MDT and ARRS workforce, enhancing continuity, safety and quality of patient care</p>
CAPITAL COSTS Set out whether there are any capital implications for the request. For example, - Building work - Compliance improvements - Equipment - IT equipment - Cabling	<p>This has been funded by the LIG scheme. The practice has had to fund:</p> <ul style="list-style-type: none"> - Furniture (desk / chairs) - Examination couches - Examination trolleys - Desk accessories - Consumables <p>The cost to the practice has been in excess of £20,000 for these items that the LIG has not covered which are placing a financial burden on the practice.</p>
ADDITIONAL SPACE REQUESTED If additional space or rooms are being requested, please set this out	As above.
COST ESTIMATES (Inc. VAT)	As below.

If capital is required and the practice has already sought quotes submit a copy of any costs

REVENUE

Confirm what the change in rent will be

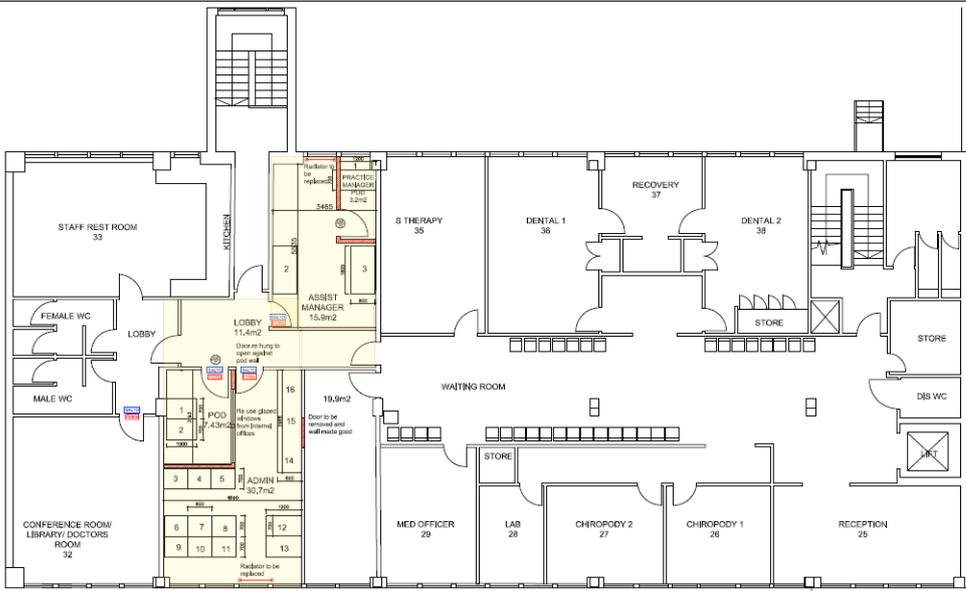
- Existing
- Expected new rent

Existing rent reimbursement and space (last rent review was 25.03.2018).

Floor	Area (m ²)	£/m ²	FI Factor %	Total
Ground	399.9	£ 248.50		£ 99,375.15
First	415.2	£ 248.50		£ 103,177.20
Second	108.1	£ 248.50		£ 26,862.85
Total Area	923.2		Sub-total	£ 229,415.20
Parking	No. of spaces	£/space		
Standard	56	£ 675.00		£ 37,800.00
Total Parking	56		Sub-total	£ 37,800.00
Total				£ 267,215
Total Valuation				£ 267,215

Existing rent to be increased due to the additional 64m² on the second floor.

Requested amount is **£15,904 per annum** – but the rent reimbursement review is well overdue and therefore this figure is below the 2025 market value. Any amount given will need to be uplifted when the next rent review takes place, and backdated reimbursement may be required for this additional space.



PRACTICE AREAS

Please confirm if there will be any change in the practices catchment area

No

CURRENT SPACE OCCUPIED

Include the total number of clinical rooms (consultation and treatment rooms)

Previous clinical rooms: 20
 Expected clinical rooms: 24 by the end of 2025
 Two new offices on second floor: Total (new/additional) space occupied on second floor = 64m²

Total square metres occupied																																															
CONFIRM IF THERE IS LEASE IN PLACE Include the length of the lease and term remaining	Yes Lease expires: 13.11.2041																																														
CURRENT RENT REIMBURSED Include the current rent that is being reimbursed	Current: £267,215.00 per annum New: £283,119.00 per annum																																														
NUMBER OF GPs AND CLINICAL SESSIONS Include the WTE GPs employed, number of sessions and appointments offered per week - if you have branch site(s), please set out per branch site	GP Partners: 7 Salaried GPs: 11 Total Sessions per week: 97-100 WTE GPs: 13 (Excludes locums and Physicians Associates) Here is the latest data: October 2025 <table border="1" data-bbox="392 1034 1109 1361"> <thead> <tr> <th colspan="6">October 2025</th> </tr> <tr> <th>System Service</th> <th>Avg weekly appts. offered per 1000 patients</th> <th>Total appointments offered</th> <th>Attended appointments</th> <th>Appointment Utilisation</th> <th>DNAs</th> </tr> </thead> <tbody> <tr> <td>GP</td> <td>86.2</td> <td>8,945</td> <td>8,004</td> <td>89%</td> <td>171</td> </tr> <tr> <td>Nurse</td> <td>5.0</td> <td>521</td> <td>443</td> <td>85%</td> <td>38</td> </tr> </tbody> </table> <p data-bbox="392 1393 1489 1460">Our appointment offering is well above the national (albeit outdated) recommendation of 71 appointments per 1,000 population.</p> <table border="1" data-bbox="392 1491 1109 1787"> <thead> <tr> <th rowspan="2">Job Category</th> <th rowspan="2">Clinician Count</th> <th colspan="2">Average Weekly FTE - Based on Sessions With Booked Appts'</th> </tr> <tr> <th>Selected Month</th> <th>Change From Previous Month</th> </tr> </thead> <tbody> <tr> <td>▶ GP</td> <td>28</td> <td>13.5</td> <td>↓ -2.4 (-15.3%)</td> </tr> <tr> <td>▶ Nurse</td> <td>5</td> <td>1.3</td> <td>↑ +0.2 (+20.3%)</td> </tr> <tr> <td>▶ Other Healthcare Professional</td> <td>29</td> <td>12.7</td> <td>↓ -0.1 (-1.0%)</td> </tr> <tr> <td>▶ Admin/Clinical Support</td> <td>33</td> <td>2.0</td> <td>↓ -0.2 (-7.1%)</td> </tr> </tbody> </table> <p data-bbox="392 1818 1489 1886">Our clinician offering is well above average and national recommendations and we have a large number of staff to accommodate in the practice.</p>	October 2025						System Service	Avg weekly appts. offered per 1000 patients	Total appointments offered	Attended appointments	Appointment Utilisation	DNAs	GP	86.2	8,945	8,004	89%	171	Nurse	5.0	521	443	85%	38	Job Category	Clinician Count	Average Weekly FTE - Based on Sessions With Booked Appts'		Selected Month	Change From Previous Month	▶ GP	28	13.5	↓ -2.4 (-15.3%)	▶ Nurse	5	1.3	↑ +0.2 (+20.3%)	▶ Other Healthcare Professional	29	12.7	↓ -0.1 (-1.0%)	▶ Admin/Clinical Support	33	2.0	↓ -0.2 (-7.1%)
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NUMBER OF NURSES AND CLINICAL SESSIONS	Nurses: 3 (WTE: 2) HCA: 4 (WTE 3)																																														

<p>Include the WTE of nurses employed, number of sessions and appointments offered per week - if you have branch site(s), please set out per branch site</p>	
<p>NUMBER OF OTHER PRACTICE STAFF</p> <p>Include the WTE of other practice staff employed, number of sessions and appointments offered per week</p>	<p>Total number of staff is 60 (including clinical)</p>
<p>TYPE OF APPOINTMENTS OFFERED</p> <p>Provide the percentage of appointments that are offered remotely and face to face per week</p>	<p>Face to Face: 46%</p> <p>Telephone: 29%</p> <p>Digital: 20%</p> <p>Home Visits: 3%</p> <p>Admin: 2%</p>
<p>REMOTE WORKING ACROSS STAFF</p> <p>Provide the percentage of the practice workforce that will be required and has the ability to work remotely</p>	<p>20%</p>
<p>CONFIRM THE PRACTICE OPENING HOURS</p> <p>If the practices closes during or ½ day what access improvements will be made, to bring the opening hours in line with core hours</p> <p>Revision of the workforce could be include here</p>	<p>07:30 – 18:30 Monday to Friday and until 19:30 on Tuesday and Wednesday</p> <p>08:30 – 13:00 alternate Saturdays (EAS)</p>
<p>BENEFIT OR IMPACT TO OTHER</p>	<p>We are able to accommodate our PCN staff in our premises, especially as Langstone Way is merging with Wentworth Medical and therefore our PCN will lose a large estate.</p>

<p>LOCAL PRACTICES / PCN</p> <ul style="list-style-type: none"> - Factors to take into consideration. - If there is any changes to the practice boundary - if there will be any changes to PCN payments etc. - Access to local pharmacies, etc 	
<p>PATIENT ENGAGEMENT</p> <p>Set out what engagement the practice has undertaken to seek patient views. Please include as much detail as possible.</p> <p>(ppg, drop-in sessions, practice website, facebook, twitter etc.)</p>	<p>We are actively engaged with our PPG and meet with them on a regular basis. Recent meetings have highlighted strong patient support for expanding clinical capacity, improving access and ensuring continuity of care. The rationale for estates optimisation and the need for additional space has been discussed with the PPG, who expressed clear support for any measures that increase appointments and clinical availability</p>
<p>BENEFIT TO COMMISSIONERS</p> <p>Set out what strategic, financial and other benefits will be realised</p>	<p>This development delivers clear benefits to commissioners by increasing clinical capacity within existing NHS primary care estate at no additional cost for the converted first-floor area, ensuring better utilisation of space and alignment with the Access Recovery Plan, Fuller Stocktake and NCL Estates Strategy. The expansion supports population growth without requiring external premises, enhances PCN service delivery, reduces pressure on urgent care pathways, and strengthens resilience and sustainability of a high-demand practice serving nearly 25,000 patients.</p>
<p>KEY RISKS</p>	<p>Risks to the ICB: None</p> <p>Risks to Millway Medical Practice: Risks relate primarily to the timely approval of rent reimbursement. If reimbursement is not approved, the practice would absorb an additional £15,904 per annum in estate costs, which poses a financial pressure given rapid list growth and high clinical demand. No operational or clinical risks are anticipated.</p>

ENDORSED BY:		
<p>LEAD GP(s)</p> <p>(As Business case Applicant)</p>	Organisation	MILLWAY MEDICAL PRACTICE
	Name	<p>DR NICK DATTANI</p> <p>GP PARTNER</p>

	Signature	
	Date	25.11.2025



North Central London
Integrated Care Board

**North Central London ICB
Primary Care Committee Meeting
10 March 2026**

Report Title	The Practice at 188 – Request for installation of portakabins at current site	Date of report	16 February 2026	Agenda Item	2.3
Lead Director / Manager	Sarah McIlwaine, Director of Primary Care	Email / Tel		sarah.mcilwaine@nhs.net	
Board Member Sponsor	Not applicable				
Report Author	Henry Claridge, Strategic Estate Lead, Camden and Barnet	Email / Tel		Henry.claridge@gbpconsult.co.uk	
Name of Authorising Finance Lead	Sarah Rothenberg, Deputy Director Finance Business Partnering – Primary Care	Summary of Financial Implications The proposed additional rent reimbursement for a maximum of 6 years, for 4 additional clinical rooms provided through the installation of portacabins is £24,180 per annum. Therefore, total reimbursement for the practice would increase from £25,350 to £49,350 for a 6-year period.			
Name of Authorising Estates Lead	Nicola Theron, Director of Estates	Summary of Estates Implications The practice currently operates from 3 clinical rooms for a list size of 10,724 patients. ICB led PCN Strategies commissioned in April 2022 highlighted the capacity pressure at this site. Based on the NHSE PID Estimator and space assessment, the practice requires additional clinical capacity in order to deliver quality services effectively, especially when converting remote consultations to face-to-face appointments. The practice is in the catchment for the proposed new Brent Cross Town development and has expressed their intention to relocate through the initial Expression of Interest (EOI) process that is supporting the development of this scheme. As an interim measure, the practice is proposing the installation of Portakabins in the garden of The Practice At 188. This will provide 4 additional consultation space, allowing the practice to deliver in line with patient demand, and allow a sustained			

		<p>position whilst the purpose-built health centre in Brent Cross Town is developed.</p> <p>A five-year rental + on-going annual renewal agreement would be signed by the practice with Darwin Group who are providing the Portakabins. The break clause would require one calendar month notice for termination once the hire contract is agreed. If the contract is terminated early, the practice would be liable to pay the remaining value of the hire contract. This would enable relocation to a new site prior to the end of the agreement should this occur.</p>
<p>Report Summary</p>	<p>The practice has submitted a Project Initiation Document (PID) for Procurement & Development of Primary Care Premises by GP Contractors that forms the appendix to this report.</p> <p>Rationale for change In recent years, the practice has seen 25 % patient list growth since February 2021. The estate is now beyond capacity for modern general practice, with overcrowded and outdated premises. The lack of clinical space constrains our ability to deliver quality services effectively, especially when converting remote consultations to face-to-face appointments.</p> <p>The estates survey commissioned by the ICB and conducted by Hawnby Group in April 2022 (Appendix 1) identified need for an additional 15 clinical rooms across our PCN. Since then through sustained growth and the incorporation of two new practices, we've seen our patient list size increase by 30%, without the addition of any additional clinical consulting space.</p> <p>As an interim measure, the practice is proposing the installation of Portakabins in the garden of The Practice At 188. This will provide 4 additional consultation spaces, allowing the practice to deliver in line with patient demand, and allow a sustained position whilst the purpose-built health centre in Brent Cross Town is developed.</p> <p><u>Operation of Portakabins</u></p> <p>Access</p> <ul style="list-style-type: none"> • The Portakabins will be situated within the garden of an existing site. This ensures seamless access for patients already traveling to this location for services. The site is well-served by public transport and has established travel routes for patients. <p>Capacity</p> <ul style="list-style-type: none"> • The practice current operates from 3 clinical rooms. • The Portakabins will provide an additional 4 clinical rooms taking the practice's total clinical capacity up to 7 rooms for a list size of 10,724. • There is capital requirement of £32,000 to support the installation. <p>Lease</p> <ul style="list-style-type: none"> • Existing leases are in place and remain unaffected by this business case. • A five-year rental + on-going annual renewal agreement would be signed with Darwin Group who are providing the Portakabins. The break clause would require one calendar month notice for termination once the hire contract is agreed. If the contract is terminated early, the practice would be liable to pay the remaining value of the hire contract which we confirm we are willing to do, should the need arise (i.e. a development becomes available in Brent Cross Town). 	

Recommendation	The Primary Care Committee is asked to APPROVE the proposed additional rent reimbursement for a maximum of 6 years, for 4 additional clinical rooms provided through the installation of portacabins of £24,180 per annum.
Identified Risks and Risk Management Actions	<p>Temporary Operational Disruptions: The setup of Portakabins, including connection of utilities, could cause brief disruption to operations in the current building. This will be mitigated through careful planning and construction through dedicated access.</p> <p>Long-Term Uncertainty: Although this is an interim measure, the ongoing need for a permanent solution remains crucial to prevent further space-related constraints impacting service delivery. This will be mitigated through medium-term plans to move into purpose-built premises in Brent Cross Town. We are already in active discussions with the ICB estates team in this regard.</p> <p>GPIT: The setup of Portakabins will require resource from the GPIT team to expand the practice network and supply, install and support four new workstations.</p>
Conflicts of Interest	Not applicable.
Resource Implications	Not applicable.
Engagement	No specific patient engagement has been undertaken for this scheme, as it does not involve any negative changes to patient access or service delivery.
Equality Impact Analysis	Not applicable.
Report History and Key Decisions	Not applicable.
Next Steps	Not applicable.
Appendices	<p>Appendix 1 – Practice PID document</p> <p>Appendix 2 – Patient testimonials</p>

The Practice at 188 – Request for installation of portakabins at current site.

1. Strategic Context

The Practice at 188 has seen 25% patient list growth since 2021. The estate is now beyond capacity for modern general practice, with overcrowded and outdated premises. The lack of clinical space constrains our ability to deliver quality services effectively, especially when converting remote consultations to face-to-face appointments.

The estates survey commissioned by the ICB and conducted by Hawnby Group in April 2022 identified need for an additional 15 clinical rooms across the PCN. Since then through sustained growth and the incorporation of two new practices, we've seen our patient list size increase by 25%, without the addition of any additional clinical consulting space.

As an interim measure, the practice is proposing the installation of Portakabins in the garden of The Practice At 188. This will provide 4 additional consultation space, allowing the practice to deliver in line with patient demand, and allow a sustained position whilst the purpose-built health centre in Brent Cross Town is developed.

2. Analysis

The Practice at 188 has practice list of 10,724 and operates from a converted residential property in the South-West of Barnet.

As an interim measure, the practice is proposing the installation of Portakabins in the garden of The Practice At 188. This will provide 4 additional consultation space.

The practice proposes to use the portakabins to

- Increase capacity for face-to-face consultations, and improve patient experience and clinical outcomes.
- Enhance the ability of our PCN ARRS GPs and EA service to deliver more services efficiently.
- Reduce waiting times for appointments and allowing for a more balanced service between remote and in-person care.
- Ensure continuity of care, as patients will be able to continue attending the site they are familiar with.

Premises Conditions

The Practice at 188 operates from a converted residential property and is designated as a tail property. The PCN Estate Strategy commissioned in 2022 identified need for an additional 15 clinical rooms across PCN 6 and therefore outlines the estate capacity pressure faced by this PCN.

The medium-term strategic priority for South-West Barnet is the development of a new primary care facility as part of the Brent Cross development. In the interim, there is a requirement for additional clinical space within this part of the Borough to sustain current provision whilst the Brent Cross scheme is developed. As the Brent Cross scheme is still in the feasibility stage, it is likely that there is at least a 5 year lead in time for this option to become live.

Capacity and Access

a. Space Considerations

The table below sets out the current number of clinical rooms the practice operates from, the proposed with the Portakabins and the NHS PID Estimation for the current practice list size.

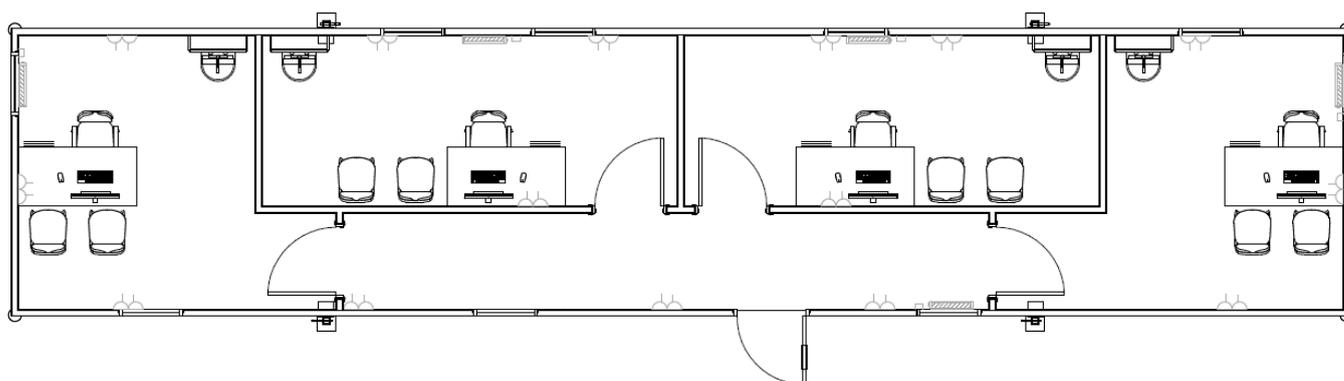
Site	No of clinical rooms & treatment rooms	Room to patient ratio
Current – Practice at 188	3	1 room: 3,575 patients
Proposed – Practice at 188 + Portakabins	7	1 room: 1,532 patients
NHSE PID Estimator for practice list of 10,724	8	1 room: 1,341 patients

According to HBN11-01 the list size warrants eight clinical rooms for primary care alone and further capacity for ARRS and registrars. On this basis, the practice would be eligible for additional clinical capacity to support primary care service delivery.

b. Operation of Portakabins

Access

- The Portakabins will be situated within the garden of an existing site. This ensures seamless access for patients already traveling to this location for services. The site is well-served by public transport and has established travel routes for patients.
- Below is an illustration of the 4 clinical rooms provided



Installation

- Enabling works – Pruning to existing shrubbery, laying foundations for temporary buildings, fixing fencing, clearing garden, delivery, and groundworks. Cost estimate - £32,000. The practice will apply for UMF or ICB Strategic capital to support the enabling works.
- IT equipment and cabling – The ICB would need to extend the current network to provide and install an additional four PCs across the four new clinical rooms. Cost – unknown (provided by NCL ICB IT team).
- Installation will be provided by Darwin Group, part of Portakabin, who are a specialist healthcare business providing flexible building solutions creating an adaptable estate across the NHS and independent sector.
- The Portkabins supplied are compliant with HBN11-01 guidance.

Lease

- Existing leases are in place and remain unaffected by this business case.
- A five-year rental + on-going annual renewal agreement would be signed with Darwin Group who are providing the Portakabins. The break clause would require one calendar month notice for termination once the hire contract is agreed. If the contract is terminated early, the practice would be liable to pay the remaining value of the hire contract which we confirm we are willing to do, should the need arise (i.e. a development becomes available in Brent Cross Town).

c. Revenue impact

The proposed additional rent reimbursement for a maximum of 6 years, for 4 additional clinical rooms provided through the installation of portacabins is £ £24,180 per annum.

Therefore, total reimbursement for the practice would increase from £25,350 to £49,350 for a 6-year period.

d. Practice Provision

The Practice at 188 is compliant with contractual opening hours and is open Monday to Friday, 8am-6.30pm with Enhanced Access services provided from 6.30-8pm during the week, and 9am-5pm on weekends.

e. Patient Engagement

No specific patient engagement has been undertaken for this scheme, as it does not involve any negative changes to patient access or service delivery.

However, the practice have provided the following:

The only change is increased and improved clinical capacity at one of our existing sites. Patients will continue to attend the same location and receive care in the same manner they do at present. This whole scheme is driven by patient concerns regarding limited space and access.

To show this, we have included in Appendix 2 a selection of patient testimonials that reflect a constant demand for improved and larger premises. These testimonials have been gathered through ongoing patient feedback mechanisms, including comments received via our websites, suggestion boxes, and conversations held during routine care. Although this proposal does not trigger a formal change in patient pathways, we remain committed to keeping our Patient Participation Groups and wider patient community informed as plans progress.

3. Conclusion and recommendation

Approval is sought for the proposed additional rent reimbursement for a maximum of 6 years, for 4 additional clinical rooms provided through the installation of portacabins of £24,180 per annum at the Practice at 188.

NCL

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

PRACTICE NAME & CODE	The Practice At 188 – E83027
PRACTICE ADDRESS	188 Golders Green Road, London, NW11 9AY
BRANCH SITE(s) If the practice has a branch site(s) provide the <ul style="list-style-type: none"> - Address - Distance from the main site - Number of clinical and consulting rooms in each branch site 	N/A
CURRENT PRACTICE LIST SIZE Include the current raw list size Include information on how many patients access your branch site(s) – if applicable	10724 (January 2026)
STRATEGIC NEED Set out if there is a strategic case for this change. Provide as much detail as possible about the change, including any impact on your current registered patients. Please include. <ul style="list-style-type: none"> - Access to main site / other branch sites i.e., public transport, ease of access - Capacity at remaining sites branch sites - Booking appointments - Additional and Enhanced services - LCS / other services offered. 	Rationale for change In recent years, our practice has seen significant patient list growth which shows no sign of slowing down. Our estate is now beyond capacity for modern general practice, with overcrowded and outdated premises. The lack of clinical space constrains our ability to deliver quality services effectively, especially when converting remote consultations to face-to-face appointments. The estates survey commissioned by the ICB and conducted by Hawaby Group in April 2022 (Appendix 1) identified need for an additional 15 clinical rooms across our PCN. Since then through sustained growth and the incorporation of two new practices, we've seen our patient list size increase by 30%, without the addition of any additional clinical consulting space. As an interim measure, we propose the installation of Portakabins in the garden of The Practice At 188. This will provide the much-needed additional clinical space and will be used for both practice and PCN-led services. This will give us capacity to deliver in line with our patient demand, and allow us to sustain our position whilst we work on our objective to move into the purpose-built health centre in Brent Cross Town. Impact on patients

Any other relevant information

The additional clinical space will have a positive impact on patient care and accessibility. We will be able to :

- Increase capacity for face-to-face consultations, and improve patient experience and clinical outcomes.
- Enhance the ability of our PCN ARRS GPs and EA service to deliver more services efficiently.
- Reduce waiting times for appointments and allowing for a more balanced service between remote and in-person care.
- Ensure continuity of care, as patients will be able to continue attending the site they are familiar with.

Access to Main Site / Other Branch Sites

- **Location & Transport:** The Portakabins will be situated within the garden of an existing site. This ensures seamless access for patients already traveling to this location for services. The site is well-served by public transport and has established travel routes for patients.
- **Ease of Access:** The site does not have suitable or compliant accessibility features, and the architecture of the building prevents us from introducing this. Accessibility is a key driver in our aim to move into purpose-built accommodation and in the meantime, this interim measure will provide additional space and improve our equity of access. As a PCN6 hub, patients from all our practices are already travelling to this site for various and expanding PCN services including EA, respiratory diagnostic hub, and ARRS GP appointments.

Capacity at Remaining Branch Sites

- The additional portakabin space will alleviate pressure on other sites, preventing PCN wide bottlenecks and mitigates the excessive demands of insufficient clinical space.
- All sites currently operate beyond full capacity. This temporary expansion is critical to ensure sustainable service delivery across the network.

Booking Appointments

- The increase in capacity will allow us to offer more appointments. By ensuring we focus on urgent and same-day slots, we will support the wider system by reducing contacts to 111 and presentations to A&E.
- Waiting times will be shorter and access to primary care services will improve.

Additional and Enhanced Services

- The Portakabins will enable the delivery of additional clinical services, including:
 - Long-term condition management (e.g., diabetes, asthma, COPD reviews)
 - Immunisations and vaccinations

	<ul style="list-style-type: none"> ○ Women’s health services (e.g., cervical screening, contraception services) ○ Enhanced access ○ Respiratory diagnostic hub <ul style="list-style-type: none"> ● PCN-led services such as enhanced access (EA) and the work of Additional Roles Reimbursement Scheme (ARRS) GPs will benefit from this additional space, supporting wider patient care initiatives. <p>Locally Commissioned Services (LCS) & Other Services Offered</p> <ul style="list-style-type: none"> ● Our practices provide several LCS and community-based services that are compromised due to space constraints. The additional Portakabins will allow: <ul style="list-style-type: none"> ○ Enhanced proactive care for frail and elderly patients ○ Higher capacity for phlebotomy and other diagnostic services ○ Expansion of mental health support services <p>Additional Considerations</p> <ul style="list-style-type: none"> ● Rapid Population Growth: Our registered patient population continues to expand due to the abundance of housing developments in the area. This intensifies the need for expanded clinical space as the problem will only get worse. ● Future Transition: Whilst our long-term plan is to move into a purpose-built health centre in Brent Cross Town, the Portakabins will provide our patients with an essential interim solution to bridge the gap in service provision. ● Regulatory Compliance & Safety: The Portakabins will be set up in full compliance with infection control, health and safety, and clinical governance requirements. <p>Our proposal presents a strategic and operationally vital solution to our current space constraints. By installing Portakabins at our existing site, we will improve service delivery, enhance patient access, and support both practice-led and PCN-led initiatives. This investment will provide substantial benefits to our ever-growing patient population whilst facilitating a smooth transition to the future Brent Cross Town health centre.</p>
<p>BRIEF SCHEME DESCRIPTION</p>	<p>We are proposing hiring Portakabins to create additional clinical space within the garden of an existing practice site.</p> <p>There is no scope to expand any of our existing buildings and new-build health centres are not affordable for the ICB. Whilst we are eager to move into the new development in Brent Cross Town, additional space is needed in the interim. Our proposal for Portakabins will achieve this.</p>

<p>LOCATION & ADDRESS OF THE NEW PREMISES</p> <p>Please confirm the travel distance to the new site (if applicable)</p>	<p>The garden area of 188 Golders Green Road, London, NW11 9AY.</p> <p>This is not a new site; our aim is to install Portakabins in the unused garden area of an existing site.</p>
<p>BENEFIT TO PATIENTS</p> <p>Set out the benefits to patients from the change</p>	<ul style="list-style-type: none"> • Improved Access to Care: With increased clinical space, patients will have more opportunities to book face-to-face appointments, reducing delays and enhancing timely interventions. • Better Management of Long-Term Conditions: Patients with chronic conditions such as diabetes, asthma, and hypertension will have more frequent and comprehensive in-person reviews, leading to better health outcomes. • Reduced Travel Burden: Since the Portakabins will be located within an existing site, patients will not need to travel to a new or unfamiliar location to access additional services. • Expanded Service Availability: More space means we can provide additional and enhanced services, including preventive care, mental health support, immunisations, and respiratory testing. • Enhanced Patient Experience: By alleviating space constraints, the practice can provide a safer, less congested and more comfortable environment, improving patient satisfaction. • Faster Appointments for Urgent Needs: With the increase in capacity, patients requiring urgent care appointments will experience shorter waiting times and improved availability.
<p>CAPITAL COSTS</p> <p>Set out whether there are any capital implications for the request.</p> <p>For example,</p> <ul style="list-style-type: none"> - Building work - Compliance improvements - Equipment - IT equipment - Cabling 	<p>Enabling works – Pruning to existing shrubbery, laying foundations for temporary buildings, fixing fencing, clearing garden, delivery, and groundworks. Cost estimate - £32,000</p> <p>IT equipment and cabling – The ICB would need to extend the current network to provide and install an additional four PCs across the four new clinical rooms. Cost – unknown (provided by NCL ICB IT team).</p>
<p>ADDITIONAL SPACE REQUESTED</p> <p>If additional space or rooms are being requested, please set this out</p>	<p>Four additional clinical rooms would be provided by the Portakabins.</p>
<p>COST ESTIMATES</p> <p>(Inc. VAT)</p> <p>If capital is required and the practice has already sought</p>	<p>See attached Appendix 2 – Darwin Group Quote detailing the capital cost of £32,000.</p>

quotes submit a copy of any costs	
REVENUE Confirm what the change in rent will be - Existing - Expected new rent	Current annual rent: £25,350 Expected new rent: £49,530
PRACTICE AREAS Please confirm if there will be any change in the practices catchment area	Practice catchment areas will remain unchanged.
CURRENT SPACE OCCUPIED Include the total number of clinical rooms (consultation and treatment rooms) Total square metres occupied	3 consulting rooms currently occupied. Data on square metres occupied was not collected when Hawaby Group did their ICB estate survey in 2022 and is therefore not available.
CONFIRM IF THERE IS LEASE IN PLACE Include the length of the lease and term remaining	Yes, existing leases are in place and remain unaffected by this business case. A five-year rental agreement would be signed with Darwin Group who are providing the Portakabins. The break clause would require one calendar month notice for termination once the hire contract is agreed. If the five-year contract is terminated early, the practice would be liable to pay the remaining value of the hire contract which we confirm we are willing to do, should the need arise (i.e. a development becomes available in Brent Cross Town).
CURRENT RENT REIMBURSED Include the current rent that is being reimbursed	Current annual rent: £25,350
NUMBER OF GPs AND CLINICAL SESSIONS Include the WTE GPs employed, number of sessions and appointments offered per week - if you have branch site(s), please set out per branch site	5.22 WTE 47 sessions 822 appointments
NUMBER OF NURSES AND CLINICAL SESSIONS Include the WTE of nurses employed, number of sessions and appointments offered per week - if you have branch site(s), please set out per branch site	2.44 WTE 22 sessions 387 appointments

<p>NUMBER OF OTHER PRACTICE STAFF</p> <p>Include the WTE of other practice staff employed, number of sessions and appointments offered per week</p>	<p>8 WTE</p> <p>72 sessions</p> <p>592 appointments</p>
<p>TYPE OF APPOINTMENTS OFFERED</p> <p>Provide the percentage of appointments that are offered remotely and face to face per week</p>	<p>20% remote</p> <p>80% face to face</p>
<p>REMOTE WORKING ACROSS STAFF</p> <p>Provide the percentage of the practice workforce that will be required and has the ability to work remotely</p>	<p>10%</p>
<p>CONFIRM THE PRACTICE OPENING HOURS</p> <p>If the practices closes during or ½ day what access improvements will be made, to bring the opening hours in line with core hours</p> <p>Revision of the workforce could be include here</p>	<p>We are open during all core hours Monday to Friday, 8am-6.30pm with Enhanced Access services provided from 6.30-8pm during the week, and 9am-5pm on weekends.</p>
<p>BENEFIT OR IMPACT TO OTHER LOCAL PRACTICES / PCN</p> <ul style="list-style-type: none"> - Factors to take into consideration. - If there is any changes to the practice boundary - if there will be any changes to PCN payments etc. - Access to local pharmacies, etc 	<p>Collaboration and Capacity Relief: The additional clinical space will ensure our PCN to more effectively deliver shared services across member practices, such as enhanced access, health checks, and long-term condition clinics. This will relieve pressure on neighbouring practices that are similarly constrained.</p> <p>Practice Boundaries: There will be no changes to our practice boundaries as part of this development.</p> <p>PCN Payments: This proposal will not impact PCN payment arrangements. All services and funding mechanisms (e.g., ARRS, IIF) will continue as per existing contractual structures. However, the increased space will improve delivery against PCN metrics.</p> <p>Pharmacy Access: There will be no negative impact on access to local pharmacies. The existing site is within close walking distance of community pharmacy services, ensuring continued ease of access for patients requiring prescriptions or over-the-counter treatments.</p>
<p>PATIENT ENGAGEMENT</p> <p>Set out what engagement the practice has undertaken to seek patient views.</p>	<p>No specific patient engagement has been undertaken for this scheme, as it does not involve any negative changes to patient access or service delivery. The only change is increased and improved clinical capacity at one of our existing sites. Patients will continue to attend the same location and receive care in the same</p>

<p>Please include as much detail as possible.</p> <p>(ppg, drop-in sessions, practice website, facebook, twitter etc.)</p>	<p>manner they do at present. This whole scheme is driven by patient concerns regarding limited space and access. To show this, we have included in Appendix 3 a selection of patient testimonials that reflect a constant demand for improved and larger premises. These testimonials have been gathered through ongoing patient feedback mechanisms, including comments received via our websites, suggestion boxes, and conversations held during routine care. Although this proposal does not trigger a formal change in patient pathways, we remain committed to keeping our Patient Participation Groups and wider patient community informed as plans progress.</p>
<p>BENEFIT TO COMMISSIONERS</p> <p>Set out what strategic, financial and other benefits will be realised</p>	<p>This proposal delivers several key benefits to commissioners across strategic, financial, and operational domains. Strategically, the additional clinical space supports the key objectives of improving access, reducing health inequalities, and delivering care closer to home. It enables our practices and the PCN to increase face-to-face activity and enhance service delivery at a time of rapid population growth, aligning with local and regional primary care development plans. Financially, the Portakabins offer a cost-effective interim solution that prevents more expensive crisis responses, such as unplanned list closures or increased reliance on secondary care due to limited primary care capacity. Operationally, it allows the practices and PCN to maximise the impact of existing funding streams, such as ARRS roles and LCS contracts, by creating the space needed to fully deliver against them. Finally, we know patients unable to access primary care will often end up calling 111 or presenting to A&E. This will help manage that avoidable burden.</p> <p>Ultimately, this investment ensures continuity of care, supports achievement of contractual targets, and helps safeguard the sustainability of local primary care services during a period of significant demographic pressure.</p>
<p>KEY RISKS</p>	<p>Risks of scheme not going ahead</p> <ul style="list-style-type: none"> • Patient List Closure Risk: Existing space constraints mean we are already at significant risk of needing to close our patient lists. Approval of this business case mitigates that risk and allows us to continue to take on new patients and meet local population needs. • Lack of face-to-face capacity: The current restricted space impacts our ability to provide increased face-to-face capacity to see patients. • Patient Dissatisfaction: If no additional space is delivered, patients will experience longer waiting times, reduced appointment availability, and disruptions to care continuity. <p>Risks of scheme implementation</p> <ul style="list-style-type: none"> • Temporary Operational Disruptions: The setup of Portakabins, including connection of utilities, could cause brief disruption to operations in the current building. This will be mitigated through careful planning and construction through dedicated access. • Long-Term Uncertainty: Although this is an interim measure, the ongoing need for a permanent solution remains crucial to prevent further space-related constraints impacting service delivery. This will be mitigated through medium-term plans to move into

purpose-built premises in Brent Cross Town. We are already in active discussions with the ICB estates team in this regard.

- **GPIT:** The setup of Portakabins will require resource from the GPIT team to expand the practice network and supply, install and support four new workstations.

ENDORSED BY:

LEAD GP(s) (As Business case Applicant)	Organisation	The Practice @ 188
	Name	Dr John Bentley
	Signature	
	Date	02/02/2026

Premises Development Project

Message ID: 188 - thepracticeat188@gmail.com

28 November 2023 at 09:00

To: "The Practice @ 188" <thepracticeat188@gmail.com>

Good Morning,

I have been a patient at this practice all my life.

I can't fault the care I receive but really the building is not fit for purpose. I have visited other practices and facilities and expectations have moved on.

The dilapidated nature actually creates a poor working environment and restricts the services that can be offered by the practice.

I have heard for a while of a proposed move. I genuinely hope that it happens.

I am happy to be fully quoted or called for further information and thoughts.

Regards

Message ID: 188

Message ID: 188

27 November 2023 at 22:37

To: "The Practice @ 188" <thepracticeat188@gmail.com>

Dear Ryan

Many thanks for giving me this opportunity to comment on the premises at 188, and the dire need for - something - whether it be reconstruction, replacement, or other.

I have been a patient at the premises at 188 Golders Green Road since about 1960. The only notable improvement since that time that I can pinpoint is the availability of the toilet for patients if required (and that probably only because of the need to be able to submit urine samples in a timely manner).

The premises have always been, sadly, unfit for purpose, in that they **cannot offer**:

1. decent disabled access (front door is angled and there is no automatic opening, raising difficulties when entering and exiting)
2. space for pushchairs, prams and buggies, both in the hallway and in the waiting areas (and the same awkward turn at the front door)
3. space for confidentiality at the reception desk
4. suitable waiting area, where carers and family members can sit without feeling they are depriving a patient
5. seating which is suitable for disabled and elderly, eg chairs with arms
6. a waiting area for a child or other with likely infectious condition
7. a nurses' room with enough room for a wheelchair, walker, buggy, carer or other accompanying person

There is a disgraceful slope to the nurses "office" if you can call a converted outside toilet or boiler room that title. There is a steep flight of stairs to negotiate for 2/3 of the patients (there is only 1 surgery room downstairs, and 2 upstairs), and while it is possible to request a downstairs appointment these are offered reluctantly. Let's face it, most people who visit the surgery are unwell in some way, and this access is not encouraging.

The waiting area upstairs is tiny, narrow and is a shared space with surgery staff.

The hallway corridor is narrow, and it is not possible to pass another patient comfortably, especially if they are disabled, overweight or obese, or with a child (in or out of a buggy)

The reception desk is uncomfortably high for many patients to speak normally to a receptionist

The overall impression given by these premises is that the practice does not care about its patients.

I do not believe this is true, and so would welcome the news that an upgrade was on the cards. Modern, bright premises, with inclusive and welcoming facilities, would reflect on both staff and patients. Staff morale would be improved, patients who felt more supported might find their health and outlook improved.

Upgraded and appropriate premises would also offer the opportunity for:

- a clear signalling system for the next patient
- better display of information notices for public health and also for services offered by the surgery
- Storage and office space which reflect adequately the size of the practice and modern requirements
- Space for supportive therapies such as social prescribing, talking therapies, test facilities, and other modern primary care routes

I am sure all these points have passed through your minds often, and probably a whole thesis could address this topic.

Kind regards

Dear Sir/Madam,

I have been a patient at the practice for twenty years now, and am astonished really that it is still expected to function at it's current site.

Firstly, there is only one consulting room on the ground floor, so if patients can't climb the stairs for one reason or another, then this makes things very difficult I would imagine in planning appointments, especially for someone with a disability. The majority of face to face appointments, therefore, have to take place on the first floor, and again there are only two consulting rooms. Three consulting rooms for the number of patients that this practice serves is wholly inadequate. Additionally, the narrow corridor on the first floor is such that in order for staff to get past when going in and out of their two offices, patients have to scoop in their legs, or get up so that they can pass, each time. Buggies have to be left downstairs in the waiting area, which means parents having to carry their children upstairs. The stairs themselves are I would say quite dangerous, as they are very steep and difficult to climb, even if you are in the best of health, and a few years ago I witnessed a patient tripping on the top steps, and nearly falling down the whole flight of stairs, which had that happened, would have caused them quite significant injury. Additionally, as there is only one small patient toilet downstairs, if you are being seen on the first floor and need to submit a sample, you have to be fit enough to go up and down the stairs to do so.

The nurses room on the ground floor is little more than a storage cupboard, and whilst there is a bed, it is not conducive at all for treating or examining patients, with barely room to move. The reception area needs to be much bigger, for both the reception team but also for patients, as when there is a queue, patients are invariably having to stand outside which is not acceptable.

In summary, therefore, the building is completely inadequate for the purposes it is being used for, and in terms of patient safety and disability access, a larger and more appropriate environment is needed, and with some urgency.

Yours faithfully

[Redacted signature]

From: [Redacted]
Sent: Thursday, November 30, 2023 6:03 PM
To: The Practice @ 188 <thepracticeat188@gmail.com>
Subject: Re: Premises Development Project

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Dear Ryan

Thank you for your email.

We moved to The Practice @ 188 because it is local to us and has a good reputation. But it is obvious that the premises are out-dated and in need of a major overhaul. The passageways are too narrow, and the only access to the first floor is by way of stairs as there is no lift. Even getting to the consultation room at the rear is difficult, as it is on a slightly different level so there is a step and ramp to negotiate. This is really not safe for patients, especially the elderly and infirm. The premises are also somewhat dingy, with inadequate lighting and ventilation.

There are no facilities for any medical treatments on the ground floor. The room used by the nurse is cluttered and not suitable for anything more than a blood test or vaccinations. A modern practice should be able to offer a range of medical treatments to avoid long A&E queues.

The location of the practice is ideal. Unfortunately it is also in a controlled parking zone so getting there by car is not very practical. Car use is important for elderly patients such as my late mother-in-law who, in her 90s, could not get to the practice any other way.

I would welcome the possibility of upgrading the practice or a move to new premises, as long as it doesn't mean moving too far away from the current location which is in the heart of the community it serves.

Kind regards

[Redacted signature]

BENTLEY, Ryan (THE PRACTICE AT 188)

From: [REDACTED]
Sent: 31 December 2023 21:53
To: thepracticeat188@gmail.com
Subject: New Premises for the surgery

You don't often get email from raksha.savla@yahoo.co.uk. [Learn why this is important](#)

This message originated from outside of NHSmail. Please do not click links or open attachments unless you recognise the sender and know the content is safe.

Hello Ryan

Apologies for the blank email however I can't find the email that the Practice forwarded some time ago regarding an email that you could forward to Barnet Council re finding new premises for the surgery.

As I advised you when we met on the 22nd]:

The premises are clearly not suitable for a surgery - the location is too small with no adequate space for patients queueing waiting to be seen - in fact patients just have to stand near the entrance thus making it impossible for callers to come in properly. Also the waiting area is just a small area which patients have to walk through to go and see the nurse at the back on the ground floor - the nurse's rooms is clearly not suitable as it is very cramped indeed with all her equipment and couch. I have had to accompany my husband there several times and it was clear to me that the nurse could hardly move around properly to examine him.

The other point I would make is that some patients have to walk up the stairs to some of the consulting rooms - the waiting area outside is not suitable at all as patients have to wait outside in a long narrow corridor close to the manager and secretary's office/kitchen. The stairs itself are clearly dangerous as patients like my husband who uses a walking stick/crutch find it extremely difficult to go up/down them. I can see that this is an accident waiting to happen - god forbid if a patient/surgery staff would fall down the stairs and injure themselves.

I look forward to attending the PPG meeting in person on 10 January.

Wishing you and all at the surgery a Peaceful, Healthy, Prosperous and Joyful New Year.

Best wishes for 2024!

[REDACTED]

From: [REDACTED]
Sent: Thursday, November 30, 2023 2:11 PM
To: The Practice @ 188 <thepracticeat188@gmail.com>
Subject: Re: Premises Development Project

This message originated from outside of NHSmail. Please do not click links or open attachments unless you recognise the sender and know the content is safe.

The premises at The Practice @188 are very inadequate and in a poor state of repair. My family and I have been patients for 40 years and it has not changed or moved with the times.

It is far too small for the number of patients. There is only one consultation room downstairs and the majority of the patients who manage to get a face to face appointment have to be seen in one of the 2 available rooms upstairs which is a steep flight of stairs to go up and down. This can be challenging for the elderly, those with disabilities and people with children. There is a very small nurse's room off the waiting room but it has very limited use due its size. No alternate therapies can be offered by this practice either. Parking is also difficult.

It is vital as a matter of urgency and long overdue that this surgery has suitable premises to meet the needs of its patients in the 21st century.

Sincerely

[REDACTED]



North Central London
Integrated Care Board

**North Central London ICB
Primary Care Committee Meeting
10 March 2026**

Report Title	Primary Care Protected Learning Time LCS (NCL Practices) 2026/28	Date of report	25 February 2026	Agenda Item	2.4
Lead Director / Manager	Sarah McIlwaine, Director of Primary Care	Email / Tel		sarah.mcilwaine@nhs.net	
Board Member Sponsor					
Report Author	Cassy Bygrave Senior Manager Mina Bance Senior Manager Carmen Harrington, Manager Carol Kumar Assistant Director, Primary Care Planning, Operations & Improvement	Email / Tel		cassy.bygrave@nhs.net mina.bance@nhs.net carmen.harrington@nhs.net carol.kumar@nhs.net	
Name of Authorising Finance Lead	Charlie Boggis Head of Finance Business Partnering – Primary Care	<p>Recurrent funding of £349,000 is available to support the delivery of the scheme. The proposal would be funded from recurrent Primary Care budgets, reflecting the strategic importance of supporting the resilience, sustainability and development of general practice teams.</p> <p>Costings are based on the delivery of:</p> <ul style="list-style-type: none"> • up to two Primary Care Network (PCN)– level Protected Learning Time (PLT) sessions per year; and • up to four practice-level PLT sessions per year, with the potential to increase this to a maximum of six sessions, subject to uptake and available funding. <p>The annual engagement payments to practices would remain unchanged and comprise:</p> <ul style="list-style-type: none"> • £300 per PLT session for each main practice site; • £100 per PLT session for each branch practice site; and • a one-off administration fee of £100 per main practice. 			

		<p>The recommended option c has a maximum cost of £346,900, based on 100% practice participation and delivery of the maximum four practice-level sessions permitted under the recommended Option C.</p> <p>Modelling has been undertaken to allow for flexibility should 100% practice participation not be achieved. An additional practice-level session could be offered from the end of Quarter 2 (Sep 2026) if there is an underspend of £54,900 within the practice-level PLT element, then one further additional session could be offered if there is another equivalent underspend by the end of Quarter 3(Dec 2026). Where an underspend of £109,800 is identified across both the practice- and PCN-level PLT elements by the end of Quarter 2, two additional practice-level PLT sessions could be offered. Any unutilised funding will not be carried forward into subsequent financial years.</p> <p>Future funding beyond the proposed period will be determined in line with priorities for General Practice.</p>
Name of Authorising Estates Lead	Not applicable	Summary of Estates Implications Not applicable
Report Summary	<p>The Primary Care Protected Learning Time (PLT) scheme was initially launched as a pilot in January 2025 and delivered over a 15-month period. Building on learning from this pilot, the proposal is to continue PLT for a further two years, delivered through a Locally Commissioned Service (LCS) from April 2026 to March 2028, which aligns with the broader proposed timeframe for reviewing enhanced services. The proposal reflects evaluation findings, stakeholder feedback, and ongoing monitoring from the initial scheme.</p> <p>This LCS applies to North Central London (NCL) practices only, consistent with the scope of the scheme during its first 15 months of operation. It is acknowledged that this approach differs from that of North West London (NWL) ICB, where an (unfunded) PLT scheme exists.</p> <p>With the merger of the two ICBs from 1 April, there is an opportunity to draw on learning from both existing approaches to Protected Learning Time to inform a more consistent and sustainable model across the new organisation. The proposal is that any considerations would be picked up as part of a review of enhanced services (across West and North London (WNL) ICB).</p> <p>At the October 2025 meeting, the Committee noted that any future iteration of the PLT model should strengthen delivery at PCN level and enhance strategic alignment and collaboration. This should include protected time for strategic planning, support for the effective use of data, and development of the skills identified as essential preparation for future contracting models. This proposal has been considered by the PLT Working Group and is endorsed by the Local Medical Committee (LMC).</p> <p>Protected Learning Time LCS</p> <ul style="list-style-type: none"> The proposal is to extend the PLT scheme and commission as an LCS, with the full service specification provided in Appendix 1. Under this 	

	<p>arrangement, NCL practices will be able to sign up for a period of up to two years. Each practice would be entitled to up to four practice-level sessions, with the potential to increase to six depending on overall sign-up and actual expenditure, and up to two PCN-level sessions. The PCN sessions are to be taken within the first six months of the financial year, to avoid duplication with other funding available to PCNs, e.g. PCN Development funding, if agreed.</p> <ul style="list-style-type: none"> • Annual engagement funding to practices will remain consistent with the previous scheme. <p>The proposal recommends four practice-level PLT sessions based on feedback and evaluation. This allows budget to be allocated to PCN-level PLT while ensuring that the indicative spend for offering both practice- and PCN-level sessions remains within the overall budget.</p> <p>The total cost of this option c is £346,900 (assuming 100% sign-up), and funding of £349,000 is available on a recurrent basis.</p> <p>Based on feedback (via returns), 19% of practices have completed four PLT sessions, 61% fewer than four, and 19% more than four. Given this distribution, the proposed reduction in practice-level sessions is expected to have minimal impact. The introduction of PCN-level PLT sessions provide additional structured development time.</p> <p>An evaluation of the first six months of the scheme, presented to PCC in October 2025, demonstrated that PLT supports teams to improve general practice, make better use of skills, and strengthen workforce, leadership and culture:</p> <p>98% of practices used PLT to explore service changes.</p> <ul style="list-style-type: none"> ○ 67% saw improvements in patient care delivery. ○ 70% reported better staff cohesion and wellbeing. <p>The recent Collaborative Practice Insights review of a sample of participating PLT practices identified consistently high positive variance across all practices reviewed, including within the GP access and experience domain. All practices in the sample had completed three or more PLT sessions.</p>
Recommendation	PCC is asked to APPROVE the proposed extension of the PLT scheme, commissioned as a Locally Commissioned Service (LCS) available to all NCL practices (option c) for two years from April 2026-March 2028.
Identified Risks and Risk Management Actions	Risks are mitigated through the ICB's formal approval process, which would require all practices to confirm their adherence to the required contractual obligations via the application form and contract variation. Practice applications would be reviewed on a case-by-case basis.
Conflicts of Interest	<p>Dr Katie Coleman, Clinical Director for Primary Care, is a GP in Islington and was consulted during this project.</p> <p>Local Medical Committee representation on the PLT Working Group to advocate for PLT in support of General Practice retention and resilience.</p> <p>COIs have been managed in line with policy.</p>

Resource Implications	<p>Delivery of this scheme generates additional workload for the ICB, including implementation, administration, commissioning and evaluation, all of which must be managed within the context of ongoing organisational change. The financial monitoring in year, to establish any under spend for commissioning further practice level PLT sessions also has resource implications.</p> <p>It is anticipated that the administrative management of the scheme will transfer to the Primary Care- Business Transfer – NCL team, in line with the broader LCS arrangements, ensuring continuity of oversight and delivery.</p>
Engagement	<p>Work to finalise scheme with Londonwide Medical Committee. Clinical engagement and advice from Dr Katie Coleman, NCL Clinical Director for Primary Care.</p>
Equality Impact Analysis	<p>Committee members are asked to note that the PLT model is designed to ensure patient services are not impacted. Practices should inform their patients and stakeholders prior to the commencement of the PLT scheme, providing reassurance that the practice will remain open, and core services will continue to be offered. The six-month evaluation showed there was no definitive negative impact from PLT sessions.</p>
Report History and Key Decisions	<ul style="list-style-type: none"> • 17 October 2023 PLT first discussed in Part 2 of PCC • 15 October 2024 a 15-month PLT funded scheme was approved by PCC • 11th February 2025 PLT update provided at PCC • 14th October 2025 PLT evaluation of first six months of the scheme presented to PCC
Next Steps	<ul style="list-style-type: none"> • March 2026: Approval of scheme for 2026/28 • March 2026: Launch of scheme for 2026/28 • April 2026: Issue Contract Variation for the PLT LCS • April 2026: Approval of practice and PCN applications • May 2026: Practices and PCNs to commence the PLT LCS
Appendices	<p>Appendix 1: The North Central London (NCL) Protected Learning Time (PLT) Locally Commissioned Scheme</p>

Primary Care Protected Learning Time 2026/28

March 2026 Report

Carol Kumar, Cassy Bygrave, Mina Bance, Carmen Harrington

Primary Care Protected Learning Time 2026/28

Introduction

The Primary Care Protected Learning Time (PLT) scheme was initially launched as a pilot in January 2025 and delivered over a 15-month period. Building on learning from this pilot, the proposal is to continue PLT for a further two years, delivered through a Locally Commissioned Service (LCS) from April 2026 to March 2028. The proposal reflects evaluation findings, stakeholder feedback, and ongoing monitoring from the initial scheme.

This LCS applies to North Central London (NCL) practices only, consistent with the scope of the scheme during its first 15 months of operation. It is acknowledged that this approach differs from that of North West London (NWL) ICB, where an (unfunded) PLT scheme exists.

With the merger of the two ICBs from 1 April, there is an opportunity to draw on learning from both existing approaches to Protected Learning Time to inform a more consistent and sustainable model across the new organisation. The proposal is that any considerations would be picked up as part of a review of enhanced services (across West and North London (WNL) ICB).

Options

Three options were considered for an PLT LCS including do nothing at the end of the 15-month scheme and continue another two years of a General Practice PLT scheme, which aligns with the wider locally commissioned services contracts.

Recommended option	Launch a PLT LCS available to all NCL practices This option enables PCN and Practice staff to have protected learning time, in their teams. <ul style="list-style-type: none">• Incorporating PCN level PLT supports Primary Care to develop strategically in line with NCL priorities.• The scale of transformation expected of Primary Care is significant, and PCN level PLT provides structured time for teams to engage with initiatives directed at them, improving the effectiveness and impact of this work. Three options were considered for practice-level PLT sessions, to incorporate PCN level PLT. <ul style="list-style-type: none">a) up to 6 practice sessions (no change) and 2 PCN sessionsb) up to 5 practice sessions (reduction of one) and 2 PCN sessionsc) up to 4 practice sessions , with potential to increase this to six and 2 PCN sessions. – recommended
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The NCL Proposal

An evaluation of the first six months of the scheme, presented to PCC in October 2025, demonstrated that PLT supports teams to improve general practice, make better use of skills, and strengthen workforce, leadership and culture:

- 98% of practices used PLT to explore service changes.
- 67% saw improvements in patient care delivery.
- 70% reported better staff cohesion and wellbeing.

Examples of changes to patient care implemented following PLT sessions are illustrated in Figure 1 (see below).



The Evaluation in the October PCC report reviewed Friends and Family Test (FFT) Experience Feedback which showed FFT data across NCL boroughs has remained consistent between 2024 and 2025. In the majority of NCL boroughs, there has been a small increase in 'good' responses and slight decreases in 'poor' and 'very poor' responses, and that PLT sessions have not had a negative impact on NCL's FFT feedback.

Collaborative Practice Insights, established as part of the broader data-driven approach to working with practices, has enabled a review of a sample of participating PLT practices, which identified consistently high positive variance across all those practices, including within the GP access and experience domain. All practices in the sample had completed three or more PLT sessions.

At the October 2025 meeting, the Committee noted that any future iteration of the model should strengthen delivery at PCN level and enhance strategic alignment and collaboration. This should include protected time for strategic planning, support for the effective use of data, and development of the skills identified as essential preparation for future contracting models. This was discussed by the PLT Working Group and the Local Medical Committee endorse this proposal.

Protected Learning Time LCS

- The proposal is to extend the PLT scheme and commission as an LCS, with the full service specification provided in Appendix 1. Under this arrangement, practices would be able to sign up for a period of up to two years, aligning with the broader timescale for locally commissioned services contracts. Each practice would be entitled to up to four practice-level sessions, with the potential to increase to six depending on overall sign-up and actual expenditure, and up to two PCN-level sessions. The PCN sessions are to be taken within the first six months of the financial year, to avoid duplication with other funding available to PCNs, e.g. PCN Development funding, if agreed.
- Annual engagement funding to practices will remain consistent with the previous scheme. Practices will continue to receive a one-off administration fee of £100 per main site, an engagement payment of £300 per PLT session (PCN or Practice level) for each main practice site, and £100 per PLT session for each branch practice site (PCN or Practice level).

Key requirements of the LCS include:

- Practices must remain open to patients and the public during PLT, in line with NCL policy and contractual requirements.
- Practices are responsible for arranging their own PLT sessions and identifying training providers.
- PCN level PLT sessions must focus on strategic ICB priority areas and cannot be used to fund activities already covered by PCN DES or other PCN funding. Practices are to give the details of their topics for these sessions on their application forms.
- Practices may choose to send key staff to PCN level sessions to support effective discussion of strategic topics.
- At least one practice level PLT session must also support a strategic priority area. Chosen from the core recommended topics list (appendix 1).
- Practices must sign up individually for both practice level and PCN level PLT sessions to meet prior approval requirements.
- Practices must return a Feedback Form for practice level sessions and may nominate a practice to submit feedback for PCN level sessions.

Finance and Session Modelling – Option C

Option C recommends four practice-level PLT sessions, based on uptake and feedback of the scheme to date. This allows budget to be allocated to PCN-level PLT while ensuring that the indicative spend for offering both practice- and PCN-level sessions remains within the overall budget.

The total cost of this option is £346,900 (assuming 100% sign-up), which is available recurrently.

Based on returned feedback forms, 19% of practices have completed four PLT sessions, 61% fewer than four, and 19% more than four. Given this distribution, the proposed reduction in practice-level sessions is expected to have minimal impact. This is further mitigated by the introduction of PCN-level PLT sessions, which provide additional structured development time.

Recommendation and Next Steps

The Committee is asked to APPROVE the extension of the PLT scheme, commissioned as a Locally Commissioned Service (LCS) available to all NCL practices (Option C) for two years from April 2026-March 2028.

Service	NCL Protected Learning Time (PLT) Locally Commissioned Scheme (LCS) 2026-28
Commissioning lead	West and North ICB
Provider lead	NCL General Practices
Period	1 April 2026- 31 March 2028
Version	1
Date of Review	Feb 2027

1. National/local context

General practice, as employers, have a responsibility to ensure that staff have access to learning and development necessary to perform their roles. However, as small, independent organisations contracted to provide continuity of service during the hours of 8am to 6.30pm, it can be particularly challenging to arrange team-based learning and development. Enabling learning across the practice team is essential to enable good quality patient care and supporting staff retention and health and wellbeing.

There is a need to focus on retention of staff in general practice with universal schemes such as this operating alongside retention schemes targeting particular cohorts of staff. Protected Learning Time (PLT) is an enabler for protecting and nurturing general practice, an essential part of the health landscape. It is a way of ensuring all staff have the opportunity to develop meaningful careers, enabling practices to retain staff.

The Integrated Care Board (ICB) has a role as commissioner in providing clear and consistent guidance on how this can be enabled without having an adverse impact on patient care. Workforce is a key enabler in the Fuller Report (2022) highlighting the need to treat Primary Care staff as a core part of the local NHS and build the resilience of the local teams and services. Providing Primary Care with access to PLT enhances efforts with retention, team building, clinical leadership and developing staff in new roles.

In GP Online (2024) Dame Fuller advocated for primary care staff wellbeing and that “one way to support healthcare professionals is to ‘bring back reflective spaces for all staff.’”

The PLT scheme also responds to the LMC paper (2023) Retention in London General Practice’. An LMC survey of London practices found 59% were carrying vacancies in December 22 up from 22% in June 2021. The LMC recommend practices are supported to “maintain effective team working in the context of unsustainable workloads and pressures”. It is important staff feel valued and have the time to adapt and adopt new working practices.

Under the NCL ICB PLT LCS, PCNs and practices are provided with an opportunity for fixed amount of protected time for learning and development. The learning activities undertaken during this time, covering a mix of clinical and non-clinical areas, are to be drawn from an NCL framework.

2. Outcomes

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

2.1 Local Defined Outcomes

Primary outcomes of the PLT LCS:

- PCN/ Practice staff have time during PLT to learn and develop
- PCN/Practice time staff have time during PLT to consider improvements to services and patient care
- PCN/Practice staff have an improved understanding of topics discussed and a better understanding of ICB/ICS priorities
- PCN/Practice staff have an improved sense of staff cohesion/ engagement/ wellbeing
- Workforce retention is supported across PCNs/practices
- PCNs/Practices agree practical changes to be implemented within specific area of working (e.g. with S.M.A.R.T. action plan) following PLT sessions

3. Scope and Service Delivery

○ Aim

The Protected Learning Time Scheme aims to provide Primary Care staff with the opportunity to come together to learn and develop as Practice and PCN teams. The overall aim of PLT sessions is to improve staff cohesion, staff retention and improve patient outcomes.

The aims and core principles of the NCL ICB PLT scheme are outlined in the Policy and Application Process document. (Appendix A).

○ Population Coverage

NCL practice and PCN teams. Patients must still be able to access primary care services as outlined in the Policy and Application Process document. (Appendix A).

○ The Provider

- Must be a GP practice and a member of PCN in North Central London

3.4 Acceptance criteria

- Practices are to make an annual application for PLT via a prior approval process (Appendix 2) detailing the dates and times of PLT sessions for the year. PCNs are to give details of the topics that will be covered.
- Practices who adhere to the contractual obligations and pre-requisites as outlined in the policy and application form (Appendix 2) will be approved.
- An essential requirement is that a practice remains open.
 - During core hours i.e. between 8.00am and 6.30pm without any gaps
 - Practice doors are open including for walk-in access as per the GP Patient Charter
 - Practice telephone lines are open
 - Patients have the ability to collect order/collect prescriptions in person if necessary
 - Patients have the ability to book/cancel pre-booked appointments by phone or in person if necessary
 - Patients can receive telephone advice from the Duty Doctor (where clinically necessary)
 - Patients can attend for face-to-face urgent appointments
 - Patients can request and obtain a home visit (where clinically necessary)
 - All staff providing cover have access to medical records
 - Online consultation tools are switched on for non-urgent appointment requests, medication queries and admin requests.
- Practices must be open during all core contracted hours before applying for approval to implement both practice- and PCN-level PLT.
- Practices should not close for a practice- or PCN-level PLT event.
- The practice is required to put in place cover arrangements to ensure the practice remains open to patients and the public during practice- and PCN-level PLT sessions
- Cover arrangements may be through:
 - existing staff from own practice (may include locum cover)¹
 - 'buddy' arrangements with another practice
 - sub-contracting arrangements

3.5 Exclusion criteria

- Practices should not close for a practice- or PCN-level PLT event.
- Practices who have not complied with contractual obligations and pre-requisites as outlined in the policy and application form.

Protected Learning Time

- Each year Primary Care teams may have protected time of
 - up four Practice-level sessions AND
 - up to two PCN-level sessions

¹ A practice may choose to access the ICB Flexible staff pool

- Each session should be up to four hours.
- Practices will need to identify the training providers and organise their PLT sessions.
- Each PCN-Level PLT session will need to focus on a strategic area of ICB priorities ('Core Recommended Topics'- Appendix C). PCN level PLT sessions should not be used to fund PCN participation which is funded through the PCN DES Practice Participation fund and any other PCN funding. To ensure productive discussion of strategic ICB topics, practices might consider sending key staff to PCN PLT sessions.
- One of the Practice Level sessions will also be required to support practices in a strategic priority area (See core recommended and suggested topics Appendix C).
- Practices must sign up individually for both the practice-level and PCN-level PLT sessions. This process ensures that each practice is meeting the prior approval requirements of PLT and has addressed the necessary prerequisites.
- Practices are required to return the Feedback Form for their practice level payments. They may choose to nominate a practice to return the Feedback Form for the PCN-level PLT sessions.
- Practices will receive PLT payments. Practices receive an one-off annual admin fee for signing up to the PLT Scheme.

A summary of the sessions and core topic cover is shown in the table below

	Practice PLT	PCN PLT
Max Number of Sessions	Up to Four sessions	Up to Two sessions
Core Topics	One	Two

A summary of the process is shown in the table below

	Practice PLT	PCN PLT
Application	Practice to complete	Practice to complete
Feedback Form	Practice to complete	Practice to complete (may nominate a practice to submit for all practices within the PCN)
Payment	Practice payment	Practice payment

4. Applicable Service Standards

4.1 Contractual requirements and expectations of practices taking part in PLT sessions are outlined in the NCL ICB PCN Policy. (Appendix A).

Patient services should not be impacted. The principles in the policy are to retain the required levels of services to meet the reasonable needs of patients during practices PLT.

The NCL scheme will ensure that practice doors remain open and practices do not close during PLT.

The policy provides the opportunity for practices to provide continuity of cover in-house or with neighbouring practices and to make alternative arrangements for telephone or physical access during core contracted hours.

The policy also outlines the contractual requirements and expectations to ensure practices adhere to core contractual requirements for remaining open during PLT, and that they act in accordance with an agreed set of prerequisites.

The PLT scheme and application process have been designed to take differing levels of practice support into account. Practices will be required to adhere to core contractual requirements, acting in accordance with an agreed prior approval process.

If a practice is already in receipt of formal support from the ICB and requests PLT, the first step will be a discussion to ensure the practice is able to meet the terms of the scheme. Approval to participate in PLT may be made on a trial basis, with an agreed review point.

4.2 Applicable local standards

The Provider is required to assure the Commissioner of performance against the below:

- The Provider is CQC registered with no conditions.
- That all CQC quality outcomes and registration requirements are met and maintained.
- Be fully compliant with all requirements of their Primary Medical Services contract.
- Provider reports and manages incidents via local incident reporting processes in line with local Provider policy. The Provider is to report Serious Incidents (SIs), complaints and patient feedback relating to this service to NCL ICB Quality Team via nclICB.quality@nhs.net. SIs must be reported within 24 hours following identification.
- Have a named safeguarding lead (who can also be the Clinical Lead).

5. Applicable Quality Requirements

5.1 Applicable Quality Requirements

- The Provider operates a complaints procedure in line with current guidelines. All complaints should be monitored, audited and appropriate action taken as required.
- The ICB must be informed of any complaint made in relation to the service provided.
- The Provider has a contingency plan for failure of or breakdown in the service as part of its overall Business Continuity plans.

6. Location of Provider Premises

The Provider's delivery points should be from practice sites where GMS/PMS/APMS services are delivered.

7. Payment schedule

This service is commissioned from the provider between 1 April 2026 and 31 March 2028.

The Provider will be reimbursed as per the following rate:

- a one-off admin fee for joining the scheme of £100, per practice (main site)
- an engagement payment of £300 per PLT session, per main practice site
- an engagement payment of £100 per PLT session, per branch practice site

Payments are made on return of the PLT Feedback Form (Appendix D).

Payments will be processed monthly.

8. Monitoring

The PLT Feedback Form (Appendix D) is to be completed and submitted following a PCN/Practice PLT session as per schedule outlined in section 8 – *Payment Schedule*.

9. Termination and Suspension arrangements

Payments under the scheme will be suspended if at any time the Provider is unable to deliver services in line with the service specification or fail to meet contractor eligibility criteria. Before any suspension, the Provider and Boroughs directorate, NCL ICB, will meet to discuss the reason for the suspension to identify any possible resolution. If the matter is not resolved, the ICB will issue a suspension notice to the Provider within seven days. The ICB decision is final.

Appendices
A. NCL ICB Protected Learning Time Policy and Application Process 2026/28
B. NCL ICB Protected Learning Time Application Form
C. Suggested List of Topics
D. PLT Feedback form

The North Central London (NCL) Protected Learning Time (PLT) Locally Commissioned Scheme – Policy and Application Process

The PLT Policy

Core principles of the PLT Locally Commissioned Scheme (LCS)

These principles are to ensure the required levels of services are retained to meet the reasonable needs of patients:

1. Protected Learning Time (PLT) is a fixed amount of time for learning and development activities for practice and PCN staff.
2. General Practice requires prior approval to implement PLT from the Primary Care Team.
3. Practices must be open during all core contracted hours before applying for approval to implement both practice- and PCN-level PLT.
4. Practices should not close for a practice- or PCN-level PLT event.
5. The practice is required to put in place cover arrangements to ensure the practice remains open to patients and the public during practice- and PCN-level PLT sessions
6. As a prerequisite to PLT, the practice will have provided assurance of this via an approval process in accordance with the PLT policy.
7. Contract Variation for the PLT LCS will be issued to practices.
8. Following approval from the Primary Care Team, the practice and PCN will have PLT sessions for their practice staff, organised during pre-agreed times of the year.
9. The number of PLT events requested per year will be capped, per practice, at
 - a maximum of four practice-level sessions and a maximum of two PCN-level sessions
10. Any practice unable to meet the expectations outlined on the application form will not be approved for PLT. An essential requirement is that a practice remains open.
 - During core hours i.e. between 8.00am and 6.30pm without any gaps
 - Practice doors are open including for walk-in access as per the GP Patient Charter
 - Practice telephone lines are open
 - Patients have the ability to collect order/collect prescriptions in person if necessary
 - Patients have the ability to book/cancel pre-booked appointments by phone or in person if necessary
 - Patients can receive telephone advice from the Duty Doctor (where clinically necessary)
 - Patients can attend for face-to-face urgent appointments
 - Patients can request and obtain a home visit (where clinically necessary)
 - All staff providing cover have access to medical records
 - Online consultation tools are switched on for non-urgent appointment requests, medication queries and admin requests.
11. Where a practice is being supported by Primary Care regarding its Access Recovery Plan, or is already on the Contracting Case Log, a discussion will take place between the Primary Care Team and that practice to ensure the practice is able to meet the terms of this policy. Approval may be made on an agreed shorter period of time and reviewed before agreeing any further sessions e.g. for one quarter, with review afterwards.

12. All participating practices in PCN-level PLT must ensure their practice remains open and the requirements of this policy are met .
13. PCNs must choose from the Core Recommended topics (see appendix) for both sessions. Practices must choose one Core Recommended Topic and are able to choose topics of their choice for their remaining PLT events. Practices and PCNs are to organise their own PLT sessions. PCNs are to give details in the application form of the topics that will be covered.
14. Please note, PLT is not to be used for clinical supervision. PCN level PLT sessions should not be used to fund PCN participation which is funded through the PCN DES Practice Participation fund and any other PCN funding. To ensure productive discussion of strategic ICB topics, practices may consider sending key staff to PCN PLT sessions. PCN PLT sessions should take place in the first half of the year (by the end of quarter 2).
15. Practices are to share the schedule of PLT dates with their patients, PCN and local partners.
16. Upon completion of the PLT session, practices are to submit a Feedback Form (see appendix) on overall learning and outcomes from PLT sessions to the NCL Primary Care Team. For PCN level PLT, a practice may nominate a practice to submit the form on their behalf. On an annual basis, the practice team will be asked to complete a survey to evaluate their experience with PLT.
17. If for any reason the date(s) of any planned PLT sessions need to change, please advise the Primary Care Team of the new dates.

Contractual requirements and expectations of practices and PCNs having PLT

The following set of contractual requirements and expectations are to ensure practices adhere to core contractual requirements for remaining open during practice- and PCN-level PLT and that they act in accordance with an agreed set of prerequisite conditions.

1. Practices are to remain open during practice- and PCN-level PLT and provide details of cover arrangements
2. Cover arrangements may be through
 - existing staff from own practice (may include locum cover)
 - 'buddy' arrangements with another practice
 - sub-contracting arrangements
3. For further guidance on sub-contracting arrangements, practices are to discuss these with the Primary Care Commissioning & Contracting team.
4. Practices who wish to subcontract cover arrangements will need to have this approved as part of their application, by the Primary Care Team.
5. Practices with branch sites will need to seek additional clarification from the Primary Care Commissioning & Contracting team, prior to making an application.
6. Practices who are unable to provide 'core hours' service provision and the reasonable needs to patients and the public, will not be approved for practice- or PCN-level PLT.
7. As a minimum, patients should be able to access essential services throughout core hours by telephone and attend the practice's premises during core hours to collect prescriptions or access urgent medical attention. Patients should be able to book or cancel an appointment.

8. GP practices are required to keep their online consultation tools open for non-urgent appointment requests, medication queries and admin requests during core hours (8:00 am to 6:30 pm).
9. Where urgent medical attention is required, the Contractor should ensure arrangements are in-place that are appropriate to meet the reasonable needs of patients. i.e. a Duty Doctor on site to see patients.
10. Section C of the application form requires the practice to confirm it will meet the contractual requirements of remaining open.
11. The practice should ensure it has communicated with patients and the public on the team being on PLT and informed its Primary Care Network and local partners. As a minimum the practice is expected to:
 - place PLT comms on its website
 - posters in the practice and
 - engage with its Patient and Participation Group including sharing comms and monitoring feedback
 - Publish a schedule of PLT events should be published on the practice's website
12. Ensure any enhanced Directed Enhanced Service access appointments are unaffected by PLT²
13. Failing to adhere to the contractual conditions of a practice remaining open during practice- or PCN-level PLT or undertaking practice- or PCN-level PLT without prior approval from NHS NCL ICB London may result in contractual action being taken. In the event it is identified that a practice has 'closed' for practice- or PCN-level PLT, the individual practice circumstances will be reviewed and a supporting process followed, which includes an initial discussion with the Primary Care Contracting part of the Team, which may result in informal or formal action being taken. A referral may be made to the Primary Care Committee by exception, or in cases of repeated issues.

The application and approval process

The application and approval process are outlined below;

Application and Feedback Process

A: The practice should:

1. Sign up the PLT LCS via the LCS Contract Variation
2. Make an annual application for
 - Up to four practice-level PLT sessions and up to two PCN-level PLT sessions
3. Ensure a multi-event application, for a series of events, are equally spread, over the financial year, e.g. every two months. Commencing from (1st April 2026).
4. Plan sessions, for up to four hours.
5. Complete the ICB application form (see Appendix)

² Noting for most Primary Care Networks these appointments take place outside of core hours

6. Submit the Application Form –to the Primary Care Team (nclpcb.nclprimarycare@nhs.net) in line with the information provided on the covering email
7. Complete the feedback form following each PLT session and annual evaluation survey

Approval Process

B: The Primary Care team will:

1. Issue an LCS Contract Variation for practices to sign up to the PLT LCS.
2. consider and approve the annual practice applications.
3. review and approve the practice's cover arrangements to guarantee that the practice can fulfil the contractual requirements of remaining open during practice-level and PCN-level PLT.
4. Inform practices of the outcome of the approval process prior to the planned events.

Application Form

2026/27 Practice and PCN Protected Learning Time

This form is to confirm your practice's application to participate in the Protected Learning Time Scheme. Please review the document and complete all sections. Once completed and returned, the ICB will confirm the outcome of your application. Approved applications will then be issued with a contract variation for the PLT LCS. Payments will be made to your practice on receipt of the feedback form(s). For more detailed information on the scheme please review the PLT Policy. Please sign this form and return to nclcb.nclprimarycare@nhs.net.

For 2026/27, practices can apply for up to TWO PCN-level PLT sessions and up to FOUR Practice-level PLT sessions:

Practice and Provisional PLT Dates

Practice Name		
Branch site(s) (where applicable)		
Practice Code (s)		
Borough		
PCN		
PCN PLT Session Date	Time	Topic
1		
2		

Practice PLT Session Date	Time
1	
2	
3	
4	

B: Practice Cover arrangements

What cover arrangements has the practice put in place?	
Existing staff from own practice	<input type="checkbox"/>
'Buddy' arrangements with another practice	<input type="checkbox"/>
Sub-contracting arrangements	<input type="checkbox"/>

For existing staff or buddy cover arrangements:

Please confirm that a duty doctor will be available on site during each PLT session	
Yes	<input type="checkbox"/>
'No	<input type="checkbox"/>

Please give details of PRACTICE routine clinics and the number of appointments which will be stood down for the PLT session.	
PCN 1	
PCN 2	
PRACTICE 1	
PRACTICE 2	
PRACTICE 3	
PRACTICE 4	

For subcontracting cover arrangements:

If the practice has sub-contracting cover arrangements in place, has the sub-contracting agreement been completed?

Yes (Please attach a copy)	<input type="checkbox"/>
No	<input type="checkbox"/>

Name of provider providing cover	
Duration of their cover	
Please describe the model being provided to your patients during PLT	

C: Contractual conditions of practice remaining open during the PLT session

During core hours i.e. between 8.00am and 6.30pm without any gaps	
Practice doors are open for walk in patients	<input type="checkbox"/>
Practice telephone lines are open	<input type="checkbox"/>
Patients have the ability to collect order/collect prescriptions in person if necessary	<input type="checkbox"/>
Patients have the ability to book/cancel pre-booked appointments by phone or in person if necessary	<input type="checkbox"/>
Patients can receive telephone advice from the Duty Doctor (where clinically necessary)	<input type="checkbox"/>
Patients can attend face to face for urgent appointments where clinically appropriate	<input type="checkbox"/>
Patients can request and obtain a home visit (where clinically necessary)	<input type="checkbox"/>
All staff providing cover have access to medical records	<input type="checkbox"/>
Online consultation tools are switched on for non-urgent appointment requests, medication queries and admin requests during core hours (8:00 am to 6:30 pm)	<input type="checkbox"/>

D: Communication with patients and the public

Please describe how patients will be informed	
Schedule of PLT on the website	<input type="checkbox"/>
Phone message updated during PLT sessions	<input type="checkbox"/>
Schedule of PLT on a poster in practices premises	<input type="checkbox"/>
Comms & Engagement with Patient & Participation Group	<input type="checkbox"/>
Other- please provide further details	

E. Conditions of Funding

Confirmation	
Please check this box to confirm that you agree to the conditions of the funding and agree to deliver your chosen PLT session as outlined above.	<input type="checkbox"/>

SIGNED BY

Print Name:	
-------------	--

Signature:	
Role:	
Date:	

For completion by the NCL ICB Primary Care

Practice Application Status	
Approved	<input type="checkbox"/>
Not Approved	<input type="checkbox"/>
If 'Not Approved' checked above, please give reason	

PCN Protected Learning Time Suggested List of Topics
PCNs must use their PLT sessions to cover one of the following topics

PLT Topic	Potential areas of discussion
<p><i>Core recommended topic 1</i> Priorities within Integrated Care Board (ICB) and System (ICS)</p>	<ul style="list-style-type: none"> • Start Well, Live Well, Age Well Programmes • Public Health and Prevention Improvement • Health Inequalities data • Interface with partners such community pharmacy and acute trusts • Hot Topics such as Planned Care • Improving continuity of care • Winter Access Planning • Delivering Proactive Care • Neighbourhood Development • 10 year plan, implications for general practice, and the development of new contracting models and their impact
<p><i>Core recommended topic 2</i> Practice review of, and response to, outcomes data for system priority outcomes</p>	<ul style="list-style-type: none"> • Population Health data • Particular outcome / condition / pathway for a commissioned service e.g. Cancer, Annual Health Checks for patients with learning disabilities, Long Term Conditions LCS. • Changes to an operating model to improve outcomes achieved and / or pathway – e.g. call / recall approach, ways of working with specialist clinician. • Tackling health inequalities and improving outcomes • Dashboards

NB- PCNs must choose from the Core Recommended topics above for each session.

Please note, PLT is not to be used for clinical supervision.

Practice Protected Learning Time Suggested List of Topics
Practices can choose from the following topics

PLT Topic	Potential areas of discussion
<p>Core recommended topic 1 Priorities within Integrated Care Board (ICB) and System (ICS)</p>	<ul style="list-style-type: none"> • Start Well, Live Well, Age Well Programmes • Public Health and Prevention Improvement • Health Inequalities data • Interface with partners such community pharmacy and acute trusts • Hot Topics such as Planned Care • Improving continuity of care • Winter Access Planning • Delivering Proactive Care • Neighbourhood Development • 10 year plan, implications for general practice, and the development of new contracting models and their impact
<p>Core recommended topic 2 Practice review of, and response to, outcomes data for system priority outcomes</p>	<ul style="list-style-type: none"> • Population Health data • Particular outcome / condition / pathway for a commissioned service e.g. Cancer, Annual Health Checks for patients with learning disabilities, Long Term Conditions LCS. • Changes to an operating model to improve outcomes achieved and / or pathway – e.g. call / recall approach, ways of working with specialist clinician. • Tackling health inequalities and improving outcomes • Dashboards
<p>Core recommended topic 3 Patient and Community engagement</p>	<ul style="list-style-type: none"> • Engagement with patients, PPG, Healthwatch and VSCE partners • VCSE partners local offers, co-production and partnership working • Tackling health inequalities • Reflection on Patient Survey results • Holistic Care and Social Prescribing • Lifestyle Medicine
Wellbeing Support for Individuals and Teams	<ul style="list-style-type: none"> • Reducing the impact pressure on wellbeing of practice staff, • Support for staff to create an environment where wellbeing is a priority. • Identifying the risk of burnout and where can staff reach out to in order to get help. • Acknowledging and addressing conflict within teams to enable us to work together effectively • Conflict/ relationship management
Equality, Diversity & Inclusion	<ul style="list-style-type: none"> • EDI- Diversity Matters
Planning and Requirements for CQC Inspection Post- CQC discussions	<ul style="list-style-type: none"> • CQC inspection format prior to inspections. • Processes for CQC inspections. • Reflection on recent CQC inspections and any changes to implement as a result.
Change Management	<ul style="list-style-type: none"> • The rationale for a specific change • The teams role in implementation • How success will be measured • Staff engagement in evaluating a change that has been implemented • Agreeing any further change necessary, how this will be implemented, and how success will be measured.
Incident Reporting	<ul style="list-style-type: none"> • Up to date incident reporting processes • Learning from recent incidents
Patient Safety	<ul style="list-style-type: none"> • MDT approach to Safeguarding • Domestic Violence & Abuse awareness, patient support and referrals
Leadership & Development	<ul style="list-style-type: none"> • Team growth and development of knowledge, skills and capabilities • Opportunities that are available for staff • Team development of ways of working within the practice • Careers within general practice

Environmentally Sustainable General Practice	<ul style="list-style-type: none"> • Opportunity for practices to implement greener practices within their practice e.g. developing implementation plan.
Primary Care MDT working	<ul style="list-style-type: none"> • MDT models of working
Digital Skills	<ul style="list-style-type: none"> • Digital tools in use in the practice and how to utilise them • What success looks like for patients and the practice, and how it will be measured

NB- Practices must choose one Core Recommended Topics and are able to choose topics of their choice for their remaining PLT events from the above list.

Please note, PLT is not to be used for clinical supervision.

For further information and resources please see the NCL GP Website Protected Learning Time page.

[NCL GP PLT webpage](#)

NCL Training Hub offers support for the workforce in North Central London through a number of programmes. Please see the links for information about how we support staff across NCL.

Here is the link [NCL Training Hub](#)

The NCL ICB General Practice Website provides healthcare professionals working in primary care across NCL with the essential, up-to-date information they need to carry out their role.

Here is the link [Home - NCL ICB General Practice Website](#)

Please register to the website if you want to receive up-to-date information about news and events [Register - NCL ICB General Practice Website](#)

NCL ICB Protected Learning Time Locally Commissioned Scheme Feedback Form



North Central London
Integrated Care Board

This form will need to be returned to the NCL ICB Primary Care team detailing the learning and outcomes for each PCN- and Practice- level PLT session that has taken place. Please return this form to nclpcb.nclprimarycare@nhs.net after each PLT session. Payments are processed on return of this form.

Practice Name		Practice Code	
Contact details			
If PCN PLT session, please provide PCN details			

PLT Session Date	Topic	Brief summary of overall learning and outcomes
		<ul style="list-style-type: none"> ○ <i>Focus of meeting</i> ○ <i>Points discussed</i> ○ <i>Areas of learning</i> ○ <i>Any demonstrated improvements</i>
Summary of overall outcomes (tick all that apply)		<ul style="list-style-type: none"> ▪ PCN/Practice staff had time during PLT to learn and develop <input type="checkbox"/> ▪ PCN/Practice time had time during PLT to consider improvements to services and patient care <input type="checkbox"/> ▪ Improved staff understanding of topic <input type="checkbox"/> ▪ Better understanding of ICB/ICS priorities <input type="checkbox"/> ▪ Improved staff cohesion/ engagement/ wellbeing <input type="checkbox"/> ▪ Supporting workforce retention <input type="checkbox"/> ▪ PCN/Practice agreed practical changes to be implemented within specific area of working (e.g. with S.M.A.R.T. action plan) <input type="checkbox"/> ▪ PCN/Practice developed ways of working <input type="checkbox"/> ▪ Other (please specify) <input type="checkbox"/> <p>Other:</p>
Total number of attendees:		
Which staff roles attended the PLT session?		GPs <input type="checkbox"/> Nursing (including NA, TNA, HCA, ANP) <input type="checkbox"/> Managers (non-clinical) <input type="checkbox"/> Receptionists and administrators <input type="checkbox"/> Care Coordinators <input type="checkbox"/>

	Clinical Pharmacists (including PTs) <input type="checkbox"/> Other (Please specify) <input type="checkbox"/>
Where applicable, has the PCN/ practice identified additional learning needs from these sessions?	YES/NO (delete as appropriate) Please comment:
Have PCN/ practice staff had time during PLT to consider improvements to services and patient care?	YES/NO (delete as appropriate) Please comment:
Would you recommend your PLT topic to other PCNs/practices? If yes, please provide details of the speaker/ resources used.	YES/NO (delete as appropriate) Please comment:
Any other comments or suggestions?	

*example of defined outcomes e.g. changes management topic- practical changes that the practice can make agreed, an implementation plan developed collectively, agreement of how the change will be evaluated, all staff understanding the rationale for a specific change, their role in implementation, and how success will be measured / all staff engaged in evaluating a change that has been implemented and agreeing any further change necessary, how this will be implemented, and how success will be measured.

**North Central London ICB
Primary Care Committee Meeting
Tuesday 10 March 2026**

Report Title	Primary Care Committee Risk Register	Date of report	4 February 2026	Agenda Item	3.1
Lead Director / Manager	Sarah McIlwaine - Director of Primary Care	Email / Tel		sarah.mcilwaine@nhs.net	
Board Member Sponsor	Sarah McDonnell-Davies, Chief Transformation Officer				
Report Author	Kate McFadden-Lewis, Governance and Risk Lead	Email / Tel		katemcfadden-lewis@nhs.net	
Name of Authorising Finance Lead	Not applicable	Summary of Financial Implications This report assists the ICB in managing its most significant financial risks within the remit of the Committee.			
Name of Authorising Estates Lead	Not applicable	Summary of Estates Implications This report assists the ICB in managing its most significant estates risks within the remit of the Committee.			
Report Summary	<p>This report provides an overview of material risks falling within the remit of the Primary Care Committee ('Committee') of North Central London Integrated Care Board ('ICB').</p> <p><u>System Risk Management</u> The risks are being presented as falling into one of three categories which are:</p> <ul style="list-style-type: none"> • ICB only risks; • ICB risks generated from risks or issues in other organisations; • System risks that need to be owned and managed by the system. <p><u>The Committee Risk Register</u> There are no risks formally on the Committee's register. The threshold for escalation to the Committee is a risk score of 12 or higher. Since the last meeting of the Committee 1 risk has closed. 5 risks are below the Committee threshold, however, are reported for oversight and scrutiny.</p> <p>Key Highlights:</p> <p><u>System Risk – below Committee threshold but included for oversight</u></p> <p>PERF33: Failure to address Primary and Secondary Care interface challenges (Threat). Current Risk Rating: 9 (unchanged).</p>				

The long standing interface challenges pose a crucial risk to end-to-end patient pathways. This is also exacerbated by NCL's geographical complexity, increasing referral demand, winter pressures and workload issues arising from inappropriate task transfer between care settings.

To address risks attached to this domain, an interface improvement programme has been established with series of actions identified. This reflects a collaborative approach through primary and secondary care leadership representation and links to regional and national drivers. The programme governance agreed four key priority workstreams (GP Liaison service access, Referral Interface Group, Same Day Emergency Care and development of a bespoke Interface Dashboard). All priorities are making progress, but no new objectives have been established for 2025/26. The main aim is to complete the work on the previously identified priorities

Getting It Right First Time ('GIRFT') recommendations on Improving primary and secondary care interface have now been released. The trusts have been asked to assess against these indicators as well as continue with third assessment, similar to trust self assessment as in the first two assessments in 2024, with some additions (including expanding to community and specialist and mental health trust) and further details on some indicators. This was completed and submitted to NHS England on 15 September 2025.

Claire Fuller (National Clinical Director of Primary Care) has visited NCL ICB on three occasions over the last year as part of the Primary Care Network ('PCN') test site programme. Each visit has had a focus in interface challenges and learning has been captured and shared across the PCN test sites.

Royal Free Hospital ('RFH') trust has adverse outcomes and scored the worst for inappropriate task transfer. There are also ongoing concerns regarding lack of engagement from the RFH hospital group. The interface improvement funding received from NHS England (£40k) is dependent on the PCN navigator role to be funded by a trust and discussions with RFL and University College London Hospital ('UCLH') are in progress (further ahead with UCLH than with RFH).

ICB risks generated from risks or issues in other organisations – below Committee threshold but included for oversight

PERF15: *Failure to address variation in Primary Care Quality and Performance across NCL (Threat).*

Current Risk Rating: 8 (unchanged)

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 is underway to transform the ICB's approach to General Practice quality and performance, including a revised set of data products that are used consistently across our work with practices and a clear approach for how this data is used to drive our supportive work with practices.

The GP Patient Survey and Health Insights data is showing signs of improvement. The results show a closing of the gap between the best and worst performing practices. We have now embedded our data driven approach targeting support to outlier practices.

Delivery of at-scale services to improve quality, including clinical outcomes, is underway, including the second year of the NCL-wide long-term conditions locally

commissioned service. Progress with long-term conditions locally commissioned service ('LTC LCS'). is also narrowing variation between practices. This work will be underpinned by our NCL GP ambitions which will set the direction for our future ICB work plan once complete (currently on pause as the implications of the ICB transition work and merger are worked through).

This risk also links to PERF 22 (Failure to actively plan and support development of the General Practice estate) with variation in the quality of general practice estate contributing to variation in quality and performance. The ICB draft ambitions for general practice aim to increase consistency in patient experience of, and the quality of, general practice in North Central London while enabling practices to tailor their model for their registered population.

Variation will remain due to the parameters of the national contract model.

PERF22: *Failure to actively plan and support development of the General Practice estate (Threat).*

Current Risk Rating: 9 (unchanged).

Ongoing supply chain issues and availability of materials continue to impact labour supply and material pricing. However, construction price increases appear to be levelling off.

The labour supply and material pricing issues have resulted in pressure on the ICB 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. This has been captured within a more robust project financial model

While the ICB 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 is a medium-term issue and will need monitoring and management.

The ICB is analysing and planning the estates need and what steps would need to be taken to meet this. The ICB is linking with NHS London to influence the regional and national estates policy. The ICB Infrastructure Plan (issued July 2024) articulates the ask and options. Delivery of projects is now the key pressure. The change in the capital regime from 2026 onwards, and the lack of the ICB being able to allocate capital to Local Care, will materially impact delivery of the plan from April 2026 onwards. The NCL capital plan for primary care and neighbourhood was updated in September 2025 and submitted in December. Prioritisation to take place, led by the Neighbourhood Health team, in January 2026

Further work is required to update a Local Care Strategy, incorporating Neighbourhood care. An updated 1, 4 and 10 year pipeline has been developed and updated as part of the London summary, including the revenue implications of the Left Shift. Next steps are to ensure that this is widely socialised, and this will be taken to the Primary Care Committee ('PCC') when there is more certainty on the new structure, noting that this date may depend upon the ICB change programme. PCC is asked to note implications of risk PERF15 (Failure to address variation in Primary Care Quality and Performance across NCL) on estates risks.

PERF28: *Increased and undifferentiated demand, and variation in general practice access models (Threat).*

Current Risk Rating: 6 (unchanged).

Access to Primary Care remains a key challenge. Demand increased significantly during the COVID-19 pandemic and continues to increase, exacerbating access challenges. This is under regular discussion at the London Primary Care Board with NCL input.

Delivery of at-scale services to improve quality, including clinical outcomes continues, with the second year of the long-term conditions locally commissioned service ('LTC LCS') now helping to reduce variation between practices.

The ICB has developed and implemented a system capacity and access plan (May 2023-March 2025), in response to the Primary Care Access Recovery Plan and a number of initiatives are now taking effect. Additionally, Primary Care Networks ('PCNs') have delivered Capacity and Access Improvement Plans, and we are starting to see the impact on access models and positive patient perception of access across NCL practices.

A new contract for change support to practices began in October 2025, which is due to end in March 2027. 90 Support Level Framework meetings with practices have taken place with more booked and underway and all PCNs bar 1 have undertaken a Support Level Framework conversation. In addition, the development of neighbourhoods and increasing use of risk stratification will support with managing undifferentiated demand but this will take time.

Further work is required to address access to Primary Care, including:

- a stratified approach to responding to demand, so that different levels of need are met in the most effective way
- improving patient experience
- ease of access (including digital inclusion / exclusion)
- contributing factors including interface, workforce and patient needs and expectations

On average practices have provided a 15 to 30% increase in appointments compared to before COVID-19. This outstrips population growth and is indicative of practices meeting increased demand. With such a significant rise in activity in general practice, work is also needed on understanding the nature of the increased demand and how this is best met. This will be overseen by the Primary Care Committee. The ICB is participating in a national pilot to evidence and quantify the gap between resource and need in general practice, which will help inform future policy, and may have the opportunity to focus on identification of need in GP.

In addition, our data driven approach to tackle unwarranted variation is now embedded.

The annual GP patient survey results have been published, and we have seen a 1% to 4% increase across the key access questions in the survey showing signs of improvement to patient access. The results show a closing of the gap between the best and worst performing practices. However, the survey also shows continued variation in access models.

PERF31: *Failure to manage the impact of increased costs to the ICB, programme delay, rental revenue pressure on Integrated Care estate projects, as well as additional risks (including financial/accounting) (Threat).*

Current Risk Rating: 9 (unchanged).

	<p>Ongoing supply chain issues and availability of materials continue to impact labour supply and material pricing. However, construction price increases appear to be levelling off.</p> <p>The labour supply and material pricing issues have resulted in pressure on the ICB 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. This has been captured within a more robust project financial model</p> <p>While the ICB 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 is a medium-term issue and will need monitoring and management.</p> <p>The ICB is analysing and planning the estates need and what steps would need to be taken to meet this. The ICB is linking with NHS London to influence the regional and national estates policy. The ICB Infrastructure Plan (issued in July 2024) articulated the ask and options. Delivery of projects now the key pressure, aligned to new government priorities, with a particular focus on Integrated Hubs.</p> <p>Further work is underway with place and primary care teams to describe and to shape our investment pipeline. An updated 3, 5 and 10 year pipeline has been developed and updated as part of London summary, including the revenue implications, which needs to be widely socialised and this will be taken to the Primary Care Committee ('PCC') when there is more certainty on the new structure, noting that this date may depend upon the ICB change programme. The NHS 10 year plan will also impact estates contribution the Neighbourhood Care agenda. NCL is contributing to this national agenda. PCC is asked to note implications of risk PERF15 (Failure to address variation in Primary Care Quality and Performance across NCL) on estates risks.</p> <p><u>Closed risk</u> Since the last meeting the following risk has closed:</p> <p>PERF32: Failure to procure clinical waste collections services for operationalisation on 1 April 2025 (Threat).</p> <p>The contract has been signed and formally executed with the ICB seal. Service has commenced and mobilisation process and termination notices have been serviced to the three incumbent providers who are actively involved in the transitioning arrangements. Clinical Waste services are now in place for both GP practices & community pharmacies and lack of service provision is no longer a risk.</p> <p>A new risk will be raised relating to the ongoing legal challenge however this is a financial risk and does not impact services.</p>
Recommendation	<p>The Committee is asked to:</p> <ul style="list-style-type: none"> • NOTE the report and provide feedback on the risks; • IDENTIFY any strategic gaps within the Committee's remit and propose any strategic risks or areas to include as part of the review.
Identified Risks and Risk Management Actions	<p>The risk register will be a standing item for each meeting of the Committee.</p>

Conflicts of Interest	Conflicts of interest are managed robustly and in accordance with the ICB's conflict of interest policy.
Resource Implications	This report supports the ICB in making effective and efficient use of its resources.
Engagement	This report is presented to each Committee meeting. The Committee includes a clinician and Non-Executive Members.
Equality Impact Analysis	This report was written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	The Committee Risk Register is presented at each Committee meeting.
Next Steps	The next steps are as follows: <ul style="list-style-type: none"> • To continue to manage risks in a robust way; • To continue the development of the ICB's approach to system risk management.
Appendices	Appendices are: <ol style="list-style-type: none"> 1. Primary Care Committee Risk Register; 2. The Committee Risk Overview Report; and 3. Risk scoring key.

ID	Risk Owner	Risk Category	Risk Description	Overall Status	Priority	Impact	Controls in place	Evidence of Controls	Overall Status of Controls in place	Controls Needed	Actions	Action Deadline	Update on Actions	Rating	Update for Committee	Date of Last Update	Notes
System Risk – below Committee threshold but included for oversight																	
PERF33	Sarah McDonnell - Chief Transformation Officer	Healthcare	Failure to address Primary and Secondary Care interface challenges (Threat)	AVERAGE	3	3	<p>C1. Four main trusts Clinical interface groups with joint chairing across primary and secondary care.</p> <p>C2. Agreed short term priorities for interface working.</p> <p>C3. Consensus document published in Jan 2024.</p> <p>C4. PCN test site - interface identified as priority.</p> <p>C5. Interface dashboard development.</p>	<p>C1. Four working COGs (monthly meetings).</p> <p>C2. Programme governance and four priority workstreams.</p> <p>C3. Consensus document.</p> <p>C4. PCN test site improvement plans.</p> <p>C5. Monthly report on dashboard.</p>	70% chance of successfully controlling the risk	<p>CH1. Agree Prioritisation of interface challenges - set medium and long term priorities.</p> <p>CH2. Accountability of CMO, COO trusts.</p> <p>CH3. Embedding of national interface recommendations (published in July).</p> <p>CH4. Standardisation of GP liaison role and quality alerts to be developed.</p> <p>CH5. Interface dashboard reporting.</p> <p>CH6. Interchangeable roles for GP Liaison across pathway.</p> <p>CH7. Implementation of the learning from the March 2023 Claire Fuller visit.</p> <p>CH8. Overall referral policy update.</p> <p>CH9. Re-positing of NCL wide IISG April 2026.</p> <p>CH10. Self assessment of NCL ICB against national interface framework.</p>	<p>A1. To ensure interface priorities delivered with alignment to NHSE operational guidance.</p> <p>A2. Specialty specific outcomes (Cardiology).</p> <p>A3. Embedding of national interface recommendations (published in July).</p> <p>A4. Education sessions for GPs on interpreting Holograms and the local management pathway (which aligns with the LCLP guidance) have been reviewed following discussion at the last meeting. A first draft of an AF pathway is due to be discussed at the next meeting.</p> <p>A5. A draft NCL wide endocrinology request form (to replace individual provider forms) is also in development.</p> <p>A6. Formal comments sent to Richard Cole and Jo Savage regarding updates on interface priorities 2024/25 and ongoing challenges.</p> <p>A7. As well as signposting GPRF and other self assessment. Current gaps identified in accountability involving RSI.</p> <p>A8. Overall referrals forward endorsed at EMU with additional assurance provided. Initial meeting with community providers in September to be followed by further meetings with GPs to discuss challenges to implementation. This has been included in commissioning intentions for 2026/27. Due to limited capacity the focus will be on the 3 acute providers only initially and discussions with the LCLH Alliance around handover. The onward referrals policy which will replace the CQC referral policy has been updated. As the implementation of the updated policy sits with providers, they have been asked to ensure effective and regular internal comms and an update to GPs will be sent out in March 2026.</p> <p>A9. Following further work with providers, the standard GP liaison pathway has been streamlined to bring it in line with governance processes and make it easier to operationalise. The GP Feedback & Alert form on EMU has been tested by GPs with positive feedback although some challenge around the need for it to be submitted by a GP or on behalf of a GP. Both this and the internal escalation pathway for feedback, alerts and patient safety events have been endorsed by the Referral Interface group as well as the GP Liaison and Trust Risk & Patient Safety teams.</p> <p>A10. The EMU team for submitting feedback and alerts is now finalised. Work on the build for the automation of internal escalation pathways in each provider is well underway and testing is in progress. A live pilot using PCOs and LMS is due to commence in February and final roll out across NCL is planned for March.</p> <p>A11. A current plan is being developed (initial assessment meeting with all NCL providers in progress).</p> <p>A12. The third CFTB will to the ICB look place on 28 Oct 2025, with a change of focus away from interface and looking at neighbourhoods and integration. Progress of trials in improving interface was called independently RPH with noted improvement in LCUH and Whittington. NCLT has an interface group with LMC but not with ICB presence. Initial discussion on the back of GPRF assessment with tertiary providers.</p> <p>A13. On hold pending outcome of NHS changes.</p> <p>A14. The third Self Assessment was completed by all acute trusts in conjunction with GP colleagues and first self assessment completed by the community and mental health trusts. These have been submitted to NHSE. Trusts were also asked to complete a GPRF self-assessment which was similar to (but not the same as) the self-assessments</p>	3	3	<p>The long standing interface challenges pose a crucial risk to end-to-end patient pathways. This is also exacerbated by NCL's geographical complexity, increasing referral demand, winter pressures and workload issues arising from inappropriate task transfer between care settings.</p> <p>The address risks attached to this domain, an interface improvement programme has been established with series of actions identified. This reflects a collaborative approach through primary and secondary care leadership representation and links to regional and national drivers. The programme governance agreed four key priority workstreams (GP Liaison service access, Referral Interface Group, Same Day Emergency Care and development of a bespoke Interface Dashboard). All priorities are making progress, but no new objectives have been established for 2026/26. The main aim is to complete the work on the previously identified priorities.</p> <p>Getting a Right First Time (GRFT) recommendations on improving primary and secondary care interface have now been released. The trusts have been asked to assess against these objectives as well as continue with their assessment, similar to trust self assessment as in the first two assessments in 2024, with some additions including expanding to community and specialist (mental health trust) and mental health trust details on some indicators. This was completed and submitted to NHSE England on 15 September 2025.</p> <p>Claire Fuller (National Clinical Director of Primary Care) has visited NCL ICB on three occasions over the last year as part of the Primary Care Network (PCN) test site programme. Each visit has had a focus in interface challenges and learning has been captured and shared across the PCN test sites.</p> <p>Royal Free Hospital (RFH) trust has adverse outcomes and scored the worst for inappropriate task transfer. There are also ongoing concerns regarding lack of engagement from the RFH hospital group. The interface improvement funding received from NHS England (SAK) is dependent on the PCN navigators role to be funded by a trust and discussions with RPH and University College London Hospital (UCLH) are in progress (rather shared with UCLH than with RFH).</p>	02/02/2026	CHM	
ICB risks generated from risks or issues in other organisations – below Committee threshold but included for oversight																	
PERF15	Sarah McDonnell - Chief Transformation Officer	Healthcare	Failure to address variation in Primary Care Quality and Performance (Threat)	AVERAGE	3	3	<p>C1. ICB Primary Care Committee (PCC) oversight of quality and performance data across all Primary Care Organisations (PCOs) and GP practices.</p> <p>C2. Robust processes in primary care contracts team for identifying practices that require additional monitoring and support on quality and performance (including case log, hotspots meetings and improvement plans).</p> <p>C3. Data-driven approach to primary care which combines data on quality and performance with insight from across ICB target to support practices where most needed, including change management support commissioned from external providers for this purpose.</p> <p>C4. Consistent approach to commissioning services to improve quality in General Practice including practice resilience funding, long-term conditions locally commissioned service (LTC LCS).</p> <p>C5. Data-driven approach to managing long term conditions for quality of care for the future GP. Change support in place, supporting ongoing cycle of evaluation and refinement of data driven approach.</p>	<p>C1. Primary Care Committee papers.</p> <p>C2. Primary Care Contract Papers.</p> <p>C3. ICB papers, service specifications, action notes from Collaborative Practice insight meetings.</p> <p>C4. People Strategy new approach.</p> <p>C5. LTC LCS mobilised.</p> <p>C6. National funding policy including System Development Funding.</p> <p>C7. Fellowship programme delivered by NCL Training Hub, updates provided to external providers.</p> <p>C8. Commissioning of the Flexible Staff Pool has not been extended but provider has confirmed they will continue to deliver the Flexible Staff Pool during 2025/26.</p> <p>C9. Contract with NCL Training Hub for 2025/26 signed.</p> <p>C10. Training hub programme.</p> <p>C11. Primary Care Workforce Dashboard with new for 2024/25 RAG rating analysis on practice/PCN submissions together with practice comms to Practices and PCNs flagging their status.</p> <p>C12. Confirmation of System Development Funding in 2025/26, due to national changes in SDF im-fencing arrangements, to support delivery of GP Retention and Training Hub Development.</p> <p>C13. Programme of work reflected in contract for 2025/26.</p> <p>C14. Contract in place.</p>	70% chance of successfully controlling the risk	<p>CH1. Further development of quality and performance report. Data driven approach embedded.</p> <p>CH2. Staff in place, annual PCN workstream submission to NHSE. Training Hub supporting ARRS role development and responding to concerns around the role of and support to Physician Associates and supervision of Multi-professional teams.</p> <p>CH3. People Strategy new approach.</p> <p>CH4. LTC LCS mobilised.</p> <p>CH5. National funding policy including System Development Funding.</p> <p>CH6. Fellowship programme delivered by NCL Training Hub, updates provided to external providers.</p> <p>CH7. Commissioning of the Flexible Staff Pool has not been extended but provider has confirmed they will continue to deliver the Flexible Staff Pool during 2025/26.</p> <p>CH8. Contract with NCL Training Hub for 2025/26 signed.</p> <p>CH9. Training hub programme.</p> <p>CH10. Primary Care Workforce Dashboard with new for 2024/25 RAG rating analysis on practice/PCN submissions together with practice comms to Practices and PCNs flagging their status.</p> <p>CH11. Confirmation of System Development Funding in 2025/26, due to national changes in SDF im-fencing arrangements, to support delivery of GP Retention and Training Hub Development.</p> <p>CH12. Programme of work reflected in contract for 2025/26.</p> <p>CH13. Contract in place.</p>	<p>A1. Regular updates to Committee on progress with revised G&P data. Data driven approach embedded.</p> <p>A2. Incorporating feedback from engagement with stakeholders into next iteration of Ambitions for practice review. NH Ambitions now on pause due to ICB cost reduction programme.</p>	<p>A1. G&P report has been revised. Complete and strengthen controls in place (C1) New updates to the G&P power BI dashboard are suspended pending the ICB structure. The national dashboard data is now strong, and stable month on month. The proposed approach to utilising the national data, supplemented with local data and insight, has been implemented. It is now built, with caveats, into the regular G&P report to PCC.</p> <p>A2. Final draft in preparation - paused internal sign off process temporarily until further information available about future ICB structure which will inform the approach to sign-off - ambitions now on pause due to ICB cost reduction programme.</p>	3	3	<p>This risk highlights the ongoing need to reduce unexplained variation in quality and performance across general practices. The risk is complex and requires multi-faceted actions to mitigate it. Work is underway to transform the ICB approach to General Practice quality and performance, including a revised set of data products that are used consistently across our work with practices and a clear approach for how this data is used to drive our supportive work with practices.</p> <p>Delivery of acute services to improve quality, including clinical outcomes, is underway, including the second year of the NCL-wide long-term conditions locally commissioned service. Progress with long-term conditions locally commissioned service (LTC LCS) is, also narrowing variation between practices. This work will be underpinned by our NCL GP Ambitions which will set the direction for our future ICB work plan once complete (currently on pause as the implications of the ICB transition work and merger are worked through).</p> <p>This risk also links to PERF 22 (Failure to actively plan and support development of the General Practice estate) with variation in the quality of general practice estate contributing to variation in quality and performance. The ICB draft Ambitions for general practice aim to increase consistency in patient experience of, and the quality of, general practice in North Central London while enabling practices to tailor their model for their registered population.</p> <p>Workplan will remain due to the parameters of the national contract model.</p>	02/02/2026	CHM
PERF18	Sarah McDonnell - Chief Transformation Officer	Healthcare	Failure to effectively develop the primary care workforce (Threat)	AVERAGE	3	3	<p>C1. Establishment of primary care networks. Primary Care Networks recruiting new roles through national Additional Roles Reimbursement Scheme (ARRS) programme.</p> <p>C2. Close work with NCL Training Hub to maximise impact of available funding for workforce development, recruitment and retention.</p> <p>C3. Ongoing ICB support of PCNs in relation to ARRS role development and recruitment.</p> <p>C4. NCL-wide People Strategy.</p> <p>C5. Consistent approach to managing long term conditions in primary care via an LMS - users full range of primary care workforce and creates space for additional roles to deliver proactive care.</p> <p>C6. Measures to support GP training, recruitment and retention to help deliver 6300 more doctors in primary care. This includes 60% increase in GP training places in London over the last 5 years.</p> <p>C7. Expansion and promotion of Clinical Placements in NCL to attract, support and embed more new entrants to the practice workforce.</p> <p>C8. Primary Care Flexible Staff Pool and an offer to strengthen links between workers and GPs and GPNs working to work flexibly in GP and continuing through 25/26 with existing funding reserves.</p> <p>C9. Mentoring scheme first developed under the GP and GPNs Fellowship and Mentoring scheme to be expanded out to wider workforce.</p> <p>C10. 8 new programmes of workforce development and transformation commissioned for 2025/26 delivered by the NCL Training Hub and supporting the plans of the NCL People Strategy.</p> <p>C11. A Primary Care Wellbeing Lead is in place.</p> <p>C12. Development of Borough-based workforce analysis updated every two months for 2025/26 and proactive work underway to improve workforce analysis and delivery of commissioned support to develop specialist approaches delivery continuing during 2025/26.</p> <p>C13. Training Hub 2025/26 contract signed and issued. Review of contract management approach underway.</p>	<p>C1. Committee papers.</p> <p>C2. Programme papers, ICB papers and System Development Funding (SDF) programme.</p> <p>C3. Staff in place, annual PCN workstream submission to NHSE.</p> <p>C4. People Strategy new approach.</p> <p>C5. LTC LCS mobilised.</p> <p>C6. National funding policy including System Development Funding.</p> <p>C7. Fellowship programme delivered by NCL Training Hub, updates provided to external providers.</p> <p>C8. Commissioning of the Flexible Staff Pool has not been extended but provider has confirmed they will continue to deliver the Flexible Staff Pool during 2025/26.</p> <p>C9. Contract with NCL Training Hub for 2025/26 signed.</p> <p>C10. Training hub programme.</p> <p>C11. Primary Care Workforce Dashboard with new for 2024/25 RAG rating analysis on practice/PCN submissions together with practice comms to Practices and PCNs flagging their status.</p> <p>C12. Confirmation of System Development Funding in 2025/26, due to national changes in SDF im-fencing arrangements, to support delivery of GP Retention and Training Hub Development.</p> <p>C13. Programme of work reflected in contract for 2025/26.</p> <p>C14. Contract in place.</p>	70% chance of successfully controlling the risk	<p>CH1. Development of robust support and supervision standards for ARRS and Direct Patient Care roles (non GP and GPNs).</p>	<p>A1. Confirmation of final steps in approach in 2025/27.</p>	<p>A1. Plan agreed with Training Hub - to be reflected in 2026/27 contracting approach once confirmed.</p>	3	3	<p>This risk highlights the importance of Primary Care workforce development, and the ongoing challenges with recruitment and retention.</p> <p>A range of national and local schemes are in place to mitigate the risk. These include the national Primary Care Network (PCN) additional roles reimbursement scheme (ARRS) which has enabled PCNs to access national funding to recruit into a range of 20 different roles. PCNs continue to recruit to these roles and are supported by Training Hubs with induction and professional development. There is an expectation that ICBs and systems will explore different ways of supporting PCNs to recruit. In 2024/25 we focused to spend 60% of available ARRS funding but exceed this at an actual spend of 80%. For Newly Qualified GPs ARRS funding was increased to spend 70% and after reallocation we had spent 60%, noting this was the first year of GP ARRS which were introduced mid year without confirmation that the role would continue. For both areas of funding we have demonstrated significant success in PCN recruitment to ARRS roles and the ability to effectively utilise national funding to develop the local multi-disciplinary workforce teams. NCL has the highest ARRS FTE per million patient population in London, as identified in a recent Regional ARRS Stocktake.</p> <p>The focus of work with the Training Hub on supervision is integrated throughout the work that the ARRS roles can be supported to operate within the wider multi-disciplinary team in general practice. This will in turn inform approaches to supervision considered by neighbourhood teams as they develop over time.</p> <p>System Development Funding (SDF) is funding 9 programmes of workforce development and transformation, delivered by the NCL Training Hub and supporting the plans of the People Strategy with a strong focus on the multi-professional workforce and industry of offers to non-traditional roles. Delivery continues into 2025/26 and SDF 2025/26 funding for 8 new workstreams confirmed and contracts signed and issued in October 2025 with mobilisation now underway.</p>	02/02/2026	CHM
PERF22	Sarah McDonnell - Chief Transformation Officer	Healthcare	Failure to actively plan and support development of the General Practice estate (Threat)	WEAK	3	3	<p>C1. Primary Care Commissioners and Estate teams in situ, with negotiation experience, and ensure buy in of all partners of process and timetable. Focus on ensuring both sufficient contingency and non-recurrent revenue to manage risk, including accounting risk (CDELURS 16).</p> <p>C2. Robust governance of Rent Budgets, the value addition plan and contingency budgets, to identify potential budgets (including external funding) to increase contingency.</p> <p>C3. Primary Care Committee (PCC) established to manage Primary Care strategy and commissioning.</p> <p>C4. Primary Care capital bids are now part of the overall ICS capital allocation prioritisation on the prioritised investment pipeline. Unlikely to continue beyond April 2025. Capex being discussed.</p> <p>C5. Primary Care Deep Dive analysis undertaken to review rent position for each practice and the long-term need for improvements or replacement of premises.</p>	<p>C1. Employment contracts, Structure charts, previous negotiated investment agreements, agreed delivery toolkits between all partners.</p> <p>C2. Budgets, financial reports, SFA. Agreed process to resolve major risks to the estate over Financial Years 22/24-26/27.</p> <p>C3. PCC Terms of Reference.</p> <p>C4. Finance templates, funding pipelines, oversight by Local Care Infrastructure Delivery Board (LCIDB) and Finance Committee sign-offs.</p> <p>C5. Support critical negotiations with Landlords and Developers.</p> <p>C6. Sign-off by CFO and Finance Committee.</p> <p>C7. PC Deep Dive presented initial findings to PCC Feb 2024, updated to PCC.</p> <p>C8. Primary Care capital bids are now part of the overall ICS capital allocation prioritisation on the prioritised investment pipeline. Unlikely to continue beyond April 2025. Capex being discussed.</p> <p>C9. Primary Care Deep Dive analysis undertaken to review rent position for each practice and the long-term need for improvements or replacement of premises.</p>	60% chance of successfully controlling the risk	<p>CH1. Monitoring of increased costs, currently c. 20%, and impact on Rent and Contingency Budgets.</p> <p>CH2. Prioritisation of Primary Care development schemes and identify those practices most at risk / nearing critical milestones with NCL, listed to allow.</p> <p>CH3. Support critical negotiations with Landlords and Developers.</p> <p>CH4. Regular reviews held with Landlords & Developers over NCL.</p> <p>CH5. Support critical negotiations with Landlords and Developers.</p> <p>CH6. Periodic review of proposed schemes affordability to identify additional capital/revenue required, with updates to PCC.</p> <p>CH7. Primary Care Deep Dive supports prioritisation of investment, including further consistency in spend re new build and refurb projects.</p> <p>CH8. Ongoing focus on how we optimise the use of national LIG & LMF funding.</p>	<p>A1. Pipeline of potential work via primary and community care estates groups and buy in by finance, primary care, contracting and estate in these priorities.</p> <p>A2. Ongoing exploration of ability to increase flexibility of use in NHS.</p> <p>A3. Regular reviews held with Landlords & Developers over NCL.</p> <p>A4. Complete - PCC being updated on review on periodic basis. February review of Deep Dive at PCC. Set -</p> <p>A5. Discussions take place on high risk schemes as they emerge.</p> <p>A6. Discussion at LCIDB in April (subcommittee to SADC) took place. Information being updated over the summer. To inform a SADC decision on Autumn. Formal linkage to Primary Care Ambitions. Being brought back to LCIDB in May 2025. Being taken back to later in year when more certainty on new structure. No Local Care allocation risk for Local Care Delivery. Will maintain NCL needs to focus on relatively limited amounts of national capital being allocated to Local Care (64m national capital secured 2025/26 versus the 16m ICB capital).</p> <p>A7. Ongoing discussions with London as to how we optimise the use of national LIG & LMF funding.</p>	3	3	<p>Ongoing supply chain issues and availability of materials continue to impact labour supply and material pricing. However, construction price increases appear to be levelling off.</p> <p>The labour supply and material pricing issues have resulted in pressure on the ICB to increase capital investment in building programmes, or to fund them indirectly through increased rents. This will pressure on both contingency and rent budgets. This has been captured within a more robust project financial model.</p> <p>While the ICB 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 is a medium-term issue and will need monitoring and management.</p> <p>The ICB is analysing and planning the estates need and what steps would need to be taken to meet this. The ICB is linking with NHS London to influence the regional and national estates policy. The ICB Infrastructure Plan (2024) articulates the risk and options. Delivery of projects is now the key pressure. The change in the capital regime from 2026 onwards, and the lack of the ICB being able to allocate capital to Local Care, will materially impact delivery of the plan from April 2026 onwards. The NCL capital estate policy, the ICB Infrastructure Plan (2024) and the ICB being able to allocate capital to Local Care, will materially impact delivery of the plan from April 2026 onwards. The NCL capital estate policy, the ICB Infrastructure Plan (2024) and the ICB being able to allocate capital to Local Care, will materially impact delivery of the plan from April 2026 onwards.</p> <p>Further work is required to update a Local Care Strategy, incorporating Neighbourhood care. An updated 1.4 and 10 year update is being developed and updated as part of the London summary, including the revenue implications of the Left Shift. Next steps are to ensure that this is widely socialised, and this will be taken to the Primary Care Governance PCC in 2026. The ICB is participating in a national pilot to evidence and quantify the ICB change programme. PCC is asked to note implications of risk PERF 15 (Failure to address variation in Primary Care Quality and Performance across NCL) on estates risks.</p>	02/02/2026	CHM	
PERF28	Sarah McDonnell - Chief Transformation Officer	Healthcare	Increased and undifferentiated demand, and variation in general practice access models (Threat)	STRONG	3	2	<p>C1. ICB Primary Care, Analytics, Digital and Comms teams developing insights into access in general practice.</p> <p>C2. Primary Care Operational Group meetings with stakeholders including Local Medical Committees (LMC) to maintain alignment on pressures and support any escalations.</p> <p>C3. ICB programme to deliver the requirements of the primary care access recovery programme and support all practices to transition to a standard 'Modern General Practice' operating model. Commissioned change management programme to provide hands-on support to practices.</p> <p>C4. Communication campaign launched for local residents to ensure the services offered by and approach to accessing general practice and wider primary care is clear.</p> <p>C5. Engagement of key stakeholders including staff, NHSE, LMC, CIRS System Executive briefed on the challenges and supporting local solutions.</p> <p>C6. Annual primary care writer plans which include additional resources to support access over Q4.</p> <p>C7. Support to General Practice staff - recruitment, retention, wellbeing, zero tolerance of abuse.</p> <p>C8. Successful delivery and evaluation of the local programme of work to respond to the national Access Recovery Plan for General Practice, including access of the commissioned change management programme.</p> <p>C9. Risk stratification approach for PCNs (in line with the Capacity and Access, Resilience Plan guidance for 2025/26) agreed and communicated to PCNs as being met by use of the LTC LCS risk stratification approach.</p>	<p>C1. Data and insights including G&P report for PCC.</p> <p>C2. Reports, meeting notes, minutes.</p> <p>C3. Reports, meeting notes, minutes, EMT, PCC and Board papers.</p> <p>C4. Reports to PCC and Board, copies of survey of practices regarding progress, evaluation reports from change support providers.</p> <p>C5. Reports to PCC and Board, copies of survey of practices regarding progress, evaluation reports from change support providers.</p> <p>C6. Communications to PCNs.</p>	80%+ chance or higher of successfully controlling the risk	<p>CH1. General Practice Ambitions in place which articulate the vision for managing increased demand.</p> <p>CH2. Sustained programme to address challenges at the interface with other services (see PERF 33).</p>	<p>A1. General Practice Ambitions to be finalised.</p> <p>A2. Continue to progress the interface work programme (see PERF 33).</p>	<p>A1. Currently on pause due to the model ICB work.</p> <p>A2. Interface work programme in progress with specialty clinical groups established, and a single route pathway drafted (see PERF 33).</p>	3	2	<p>Access to Primary Care remains a key challenge. Demand increased significantly during the COVID-19 pandemic and continues to increase, exacerbating access challenges. This is under regular discussion at the London Primary Care Board with NCL input.</p> <p>Delivery of acute services to improve quality, including clinical outcomes continues, with the second year of the long-term conditions locally commissioned service (LTC LCS) now helping to reduce variation between practices.</p> <p>The ICB has developed and implemented a system capacity and access plan (May 2023/March 2025), in response to the Primary Care Access Recovery Plan and a number of initiatives are now taking effect. Additionally, Primary Care Networks (PCNs) have delivered Capacity and Access Improvement Plans, and we are starting to see the impact of access models on patient perception of access across NCL practices.</p> <p>A new contract for change support to practices began in October 2024, which is due to end in March 2027. 90 Support Level Framework meetings with practices have taken place with more booked and underway and all PCNs bar 1 have undertaken a Support Level Framework consultation. In addition, the development of neighbourhoods and increasing use of risk stratification will support managing unexplained demand that will take time.</p> <p>Further work is required to address access to Primary Care, including:</p> <ul style="list-style-type: none"> a stratified approach to responding to demand, so that different levels of need are met in the most effective way; improving patient experience; use of access (including digital inclusion / exclusion) and; contributing factors including interface, workforce and patient needs and expectations. <p>Our average practices have provided a 15 to 30% increase in appointments compared to before COVID-19. This outstrips population growth and is indicative of practices meeting increased demand. With such a significant rise in activity in general practice, this also needs to be considered in understanding the nature of the increased demand and how this is best met. This will be overseen by the Primary Care Committee. The ICB is participating in a national pilot to evidence and quantify the ICB change programme. The NHS 10 year plan will also impact estates contribution which will help inform future policy, and may have the opportunity to focus on identification of need in GP.</p> <p>In addition, our data driven approach to tackle unexplained variation is now embedded.</p> <p>The annual GP patient survey results have been published, and we have seen a 1% to 4% increase across the key access questions in the survey showing signs of improvement to patient access. The results show a closing of the gap between the best and worst performing practices. However, the survey also shows some continued variation in access models.</p>	02/02/2026	CHM
PERF31	Sarah McDonnell - Chief Transformation Officer	Healthcare	Failure to manage the impact of increased costs to the ICB, programme delay, revenue pressure on integrated Care estate (Threat), as well as additional risks (including financial accounting) (Threat)	WEAK	3	3	<p>C1. Primary Care Commissioners and Estate teams in situ, with negotiation experience, and ensure buy in of all partners of process and timetable. Focus on ensuring both sufficient contingency and non-recurrent revenue to manage risk, including accounting risk (CDELURS 16).</p> <p>C2. Robust governance of Rent Budgets, the value addition plan and contingency budgets, to identify potential budgets (including external funding) to increase contingency.</p> <p>C3. Primary Care Committee (PCC) established to manage Primary Care strategy and commissioning.</p> <p>C4. Primary Care capital bids are now part of the overall ICS capital allocation prioritisation on the prioritised investment pipeline.</p> <p>C5. Primary Care Deep Dive analysis undertaken to review rent position for each practice and the long-term need for improvements or replacement of premises.</p> <p>C6. Local care infrastructure delivery board (LCIDB) in place to oversee capital spend - working through governance including PCC as part of new structure.</p>	<p>C1. Employment contracts, Structure charts, previous negotiated investment agreements, agreed delivery toolkits between all partners.</p> <p>C2. Budgets, financial reports, SFA. Agreed process to resolve major risks to the estate over Financial Years 22/24-26/27.</p> <p>C3. PCC Terms of Reference.</p> <p>C4. Finance templates, funding pipelines, oversight by Local Care Infrastructure Delivery Board (LCIDB) and Finance Committee sign-offs.</p> <p>C5. Support critical negotiations with Landlords and Developers.</p> <p>C6. Sign-off by CFO and Finance Committee.</p> <p>C7. PC Deep Dive presented initial findings to PCC Feb 2024, next steps and implications being worked up.</p> <p>C8. Local care infrastructure delivery board (LCIDB) in place to oversee capital spend - working through governance including PCC as part of new structure.</p>	60% chance of successfully controlling the risk	<p>CH1. Monitoring of increased costs, currently c. 20%, and impact on Rent and Contingency Budgets.</p> <p>CH2. Prioritisation of Primary Care development schemes and identify those practices most at risk / nearing critical milestones with NCL, listed to allow.</p> <p>CH3. Support critical negotiations with Landlords and Developers.</p> <p>CH4. Regular reviews held with Landlords & Developers over NCL.</p> <p>CH5. Periodic review of proposed schemes affordability to identify additional capital/revenue required, with updates to PCC.</p> <p>CH6. Primary Care Deep Dive supports prioritisation of investment, including further consistency in spend re new build and refurb projects, especially for Integrated Hubs. Further work underway to describe impact of loss of P&A allocation to Local Care underwritten. Other options to be explored, including holding for regional capital + NCLWML split.</p>	<p>A1. Pipeline of potential work via primary and community care estates groups and buy in by finance, primary care, contracting and estate in these priorities.</p> <p>A2. Ongoing exploration of ability to increase flexibility of use in NHS.</p> <p>A3. Regular reviews held with Landlords & Developers over NCL.</p> <p>A4. Complete - PCC being updated on review on periodic basis. February review of Deep Dive at PCC.</p> <p>A5. Discussions take place on high risk schemes as they emerge.</p> <p>A6. Discussion at LCIDB in April (subcommittee to SADC) took place. Information being updated over the summer. To inform a SADC decision on Autumn. Formal linkage to Primary Care Ambitions. Being brought back to LCIDB in May 2025. Being taken back to later in year when more certainty on new structure. No Local Care allocation risk for Local Care Delivery. Will maintain NCL needs to focus on relatively limited amounts of national capital being allocated to Local Care (64m national capital secured 2025/26 versus the 16m ICB capital).</p> <p>A7. Ongoing discussions with London as to how we optimise the use of national LIG & LMF funding.</p>	3	3	<p>Ongoing supply chain issues and availability of materials continue to impact labour supply and material pricing. However, construction price increases appear to be levelling off.</p> <p>The labour supply and material pricing issues have resulted in pressure on the ICB to increase capital investment in building programmes, or to fund them indirectly through increased rents. This will pressure on both contingency and rent budgets. This has been captured within a more robust project financial model.</p> <p>While the ICB 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 is a medium-term issue and will need monitoring and management.</p> <p>The ICB is analysing and planning the estates need and what steps would need to be taken to meet this. The ICB is linking with NHS London to influence the regional and national estates policy. The ICB Infrastructure Plan (2024) articulates the risk and options. Delivery of projects now the key pressure, signed to new government priorities, with a particular focus on Integrated Hubs.</p> <p>Further work is underway with place and primary care teams to describe and to shape our investment pipeline. An updated 3.3 and 10 year pipeline has been developed and updated as part of the London summary, including the revenue implications, which will be widely socialised and this will be taken to the Primary Care Committee (PCC) when there is more certainty on the new structure, noting that this date may depend upon the ICB change programme. The NHS 10 year plan will also impact estates contribution the Neighbourhood Care agenda. NCL is contributing to the national agenda. PCC is asked to note implications of risk PERF 15 (Failure to address variation in Primary Care Quality and Performance across NCL) on estates risks.</p>	02/02/2026	CHM	

North Central London ICB PCC Risk Overview Report					2025 - 2026				Movement From Last Report	Target Risk Score
					Current Risk Score					
Risk ID	Risk Title	Risk Owner	Risk description	AUG	OCT	JAN	FEB			
System Risk – below Committee threshold but included for oversight										
PERF33	Failure to address Primary and Secondary Care interface challenges (Threat).	Sarah McDonnell-Davies - Chief Transformation Officer	<p>CAUSE: If the ICS fails to ensure a seamless journey for patients moving between Primary and Secondary Care,</p> <p>EFFECT: There is a risk that there is an inappropriate workload transfer between primary and secondary care, and mental health services, and a loss of productivity and efficiency; there is a risk that there are inappropriate referrals and rejection and patients will not receive the right care at the right place and time and experience increased waiting times.</p> <p>IMPACT: this may negatively impact on clinical quality and safety of services and negative patient experience and outcomes. This may also have a negative impact on workforce morale and retention and a negative financial impact on the system.</p>	9	9	9	9	→	6	
ICB risks generated from risks or issues in other organisations – below Committee threshold but included for oversight										
PERF15	Failure to address variation in Primary Care Quality and Performance across NCL (Threat).	Sarah McDonnell-Davies - Chief Transformation Officer	<p>CAUSE: If the ICB fails to address variation in quality and performance in General Practice due to different operating models, list sizes and population demographics, arising from the nature of the GP contract,</p> <p>EFFECT: There is a risk that practices across NCL will offer differential patient experience, access to services, management of long term conditions or achievement of health outcomes for NCL residents.</p> <p>IMPACT: This may result in persistent inequities in the quality of care our residents receive and either create or exacerbate existing health inequalities.</p>	12	12	8	8	→	4	
PERF22	Failure to actively plan and support development of the General Practice estate (Threat).	Sarah McDonnell-Davies - Chief Transformation Officer	<p>CAUSE: If the ICB does not manage the need for increased capital investment or increased rent/service charge funding to develop the General Practice estate, due to increased construction costs, delivery delays, and increased market rents ('CMR') requiring the approval of the District Valuer,</p> <p>EFFECT: There is a risk that Primary Care development schemes will either be cancelled, delayed or scaled down. There is a risk that when GPs retire accommodation is potentially lost new accommodation is unaffordable. Additional capital and/or revenue will need to be found for existing schemes already under contract and to deliver sustainable primary care.</p> <p>IMPACT: This may result in the ICB being unable to deliver improvements to Primary Care services and negative patient experience. This may result in an inability to provide/re-provide sufficient Primary Care accommodation where needed. This may also result in an inability to invest to improve patient care and support existing services as well as to improve (digital and) estates infrastructure in line with the needs of the NCL population, and to deliver modern and safe care.</p>	9	9	9	9	→	9	
PERF28	Increased and undifferentiated demand, and variation in general practice access models (Threat).	Sarah McDonnell-Davies - Chief Transformation Officer	<p>CAUSE: If the ICB fails to support a targeted approach to managing general practice demand, and to address patient and stakeholder concerns around timely and appropriate access to general practice,</p> <p>EFFECT: There is a risk of inability to appropriately prioritise clinical need, exacerbating patient perception that they cannot see a GP and so either do not present to services when they need to, or do not present to the right place at the right time. There is a risk to the reputation of provision and commissioning and to the ICB ability to deliver a population-based approach. There is a risk to NHS staff of negativity and abuse.</p> <p>IMPACT: This may result in delays to patients accessing care or pressures elsewhere in the system. There may be a negative impact on the workforce and providers.</p>	9	9	6	6	→	6	
PERF31	Failure to manage the impact of increased costs to the ICB, programme delay, rental revenue pressure on Integrated Care estate projects, as well as additional risks (including financial/accounting) (Threat).	Sarah McDonnell-Davies - Chief Transformation Officer	<p>CAUSE: If the ICB does not manage the need for increased capital investment or increased rent/service charge funding to develop the Integrated community estate, due to increased construction costs, delivery delays, and increased market rents ('CMR') requiring the approval of the District Valuer,</p> <p>EFFECT: There is a risk that Integrated Care development schemes will either be cancelled, delayed or scaled down. Additional capital and/or additional revenue will need to be found for existing schemes already under contract to deliver sustainable integrated care to meet NCL's Population Health Improvement ambition.</p> <p>IMPACT: This may result in the ICB being unable to deliver improvements to Integrated community services and negative patient experience. This may also result in an inability to invest to improve and integrate patient care and support existing services, as well as to improve (digital and) estates infrastructure in line with the needs of the NCL population, and to deliver modern and safe care.</p>	9	9	9	9	→	9	

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
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North Central London
Integrated Care Board

**North Central London ICB
Primary Care Committee Meeting
10 March 2026**

Report Title	2025/26 Month 10 NCL ICB Delegated Primary Care Finance Report	Date of report	23 February 2026	Agenda Item	4.1
Lead Director / Manager	Sarah Rothenberg	Email / Tel		sarahrothenberg@nhs.net	
Board Member Sponsor	Sarah McDonnell-Davies, Chief Transformation Officer				
Report Author	Nita Naran, Head of Finance (Primary Care) NCL ICB	Email / Tel		nita.naran@nhs.net	
Name of Authorising Finance Lead	Sarah Rothenberg, Deputy Director of Finance Business Partnering (Primary Care) NCL ICB	Summary of Financial Implications To present to the Committee the 2025/26 Delegated Primary Care Month 10 (M10) financial performance. The report also includes the Enhanced Services 2025/26 M10 financial performance for the Non- Delegated Primary Care.			
Name of Authorising Estates Lead	Not applicable.	Summary of Estates Implications Not applicable.			
Report Summary	<p>This report presents the financial outturn for Delegated Primary Care for North Central London Integrated Care Board (NCL ICB) for the period April 2025 to January 2026 (Months 1-10).</p> <p>As at M10, year to date spend was £304.5m which is a breakeven position.</p> <p>Forecast outturn for the full year is breakeven with a forecast spend of £366.3m.</p> <p>Expected funding streams to be received later in the financial year are weight management £0.3m and Q4 Advice and Guidance £0.9m.</p> <p>Allocations for Q3 Advice and Guidance and the final allocation for PCN Test Sites have now been received.</p>				
Recommendation	The Committee is requested to NOTE the 2025/26 financial position as at Month 10 (January 2026).				
Identified Risks and Risk	There is increasingly limited flexibility within the Delegated Primary Care budget to cover unbudgeted costs and further cost constraints within the wider ICB due to national NHS changes.				

Management Actions	<p>These include costs that sit outside core contract payments for example revenue costs linked to premises, estate development costs linked to practice moves or developments, legal costs, costs to support caretaking and procurement activity and other costs associated with the effective running of primary medical services.</p> <p>The budget and risks are regularly reviewed in detail by the Executive, Director of Finance, Director of Estates and others.</p> <p>The Committee will need to exercise caution to avoid overspends and ensure any financial decisions are given appropriate scrutiny.</p> <p>The Committee should flag any further information that would support it to undertake this function effectively.</p> <p>Due to organisational, governance, and system changes arising from the merger with the NWL ICB, there is a risk that primary care finance functions experience disruption during transition, leading to reduced service continuity, delays in decision-making and delays in provider payment and support.</p>
Conflicts of Interest	<p>This report was written in accordance with the ICB's Conflicts of Interest Policy.</p>
Resource Implications	<p>Significant staff capacity to manage complex budgets. Risk of overspend at ICB level impacting ICS financial position and duty to balance.</p>
Engagement (Including LMC if required)	<p>Not applicable.</p>
Equality Impact Analysis	<p>Not applicable.</p>
Report History and Key Decisions	<p>Regular report for noting by the Committee.</p>
Next Steps	<p>Review Primary Care financial reporting requirements in light of merging ICBs and new governance structure.</p> <p>Estate costs - Consider where primary care leads and/or the committee may need to prioritise investment and use of resources across WNL ICB. Continue active monitoring and review of risks arising from a declining estate, lease terms ending and build costs rising, increases in list sizes.</p> <p>Identify ways to optimise resources by working across delegated and non-delegated budgets e.g. in the commissioning of enhanced services (as in the case of the LTC LCS which commenced in October 2023).</p>
Appendices	<p>Month 10 Primary Care Delegated Commissioning Finance Report.</p>

Month 10: January 2026 Primary Care Delegated Commissioning Finance Report

PCC Mar 2026

Executive Summary

This pack presents the 2025/26 Delegated Primary Care budget and financial position across North Central London (NCL) Integrated Care Board (ICB).

- As at Month 10 2025/26, the NCL Delegated Primary Care budget, delivered a breakeven position.
- The report also presents the position for each of the five areas within NCL (Barnet, Camden, Enfield, Haringey and Islington). However, the Committee and ICB Board of Members are required to ensure commitments are met and the budget achieves overall balance across NCL.

Finance Tables

- This report presents the month end position as at Month 10 (January 2026) against confirmed budgets of £366m (slide 3).
- The delegated primary care budget by borough follows, including and excluding premises (slides 4-5).
- This is followed by ARRS staffing and expenditure information (slide 6).
- Appendices 1-5 (slides 7 -11) cover expenditure by locality, further ARRS data, DES expenditure and Non-Delegated Enhanced Services.

2025/26 Month 10 Primary Care Delegated Commissioning Finance Position

Service	Weighted List Size as at 1st Jan 26	YTD Budget £000's	YTD Actual £000's	YTD Variance Fav/(Adv) £000's	Annual Budget £000's	Forecast Outturn £000's	Forecast Variance Fav/(Adv) £000's
PMS	837,621	102,457	102,356	102	122,880	122,880	0
GMS	825,646	117,582	114,897	2,685	141,135	139,332	1,803
APMS	78,356	16,244	19,030	(2,787)	19,484	21,287	(1,803)
Other Medical Services	0	68,194	68,194	0	82,782	82,782	0
Total Primary Care Medical Services	1,741,622	304,477	304,477	0	366,282	366,282	0

The NCL Delegated Commissioning closing position is breakeven at Month 10. The key points to note are:

- The YTD and forecast variances within the 3 PMS, GMS and APMS contracts relate to changes in practice contracts in year.
- The forecast is breakeven and there is an assumption built into the position that the following allocations will transfer from NHSE in Months 11 and 12 25/26:
 - Weight Management (£0.3m) for M1-12
 - Advice and Guidance (£0.9m) relating to M10-12
- Other Medical Services above includes the costs of PCN DES payments shown in Appendix 4, CQC & Indemnity, PCSE Letters, Sterile Products and Infection, Prevention and Control advice.
- Allocations for Q3 Advice and Guidance and the final allocation for PCN Test Sites have been received since month 8.

2025/26 Delegated Primary Care Budget



North Central London
Integrated Care Board

Description	Barnet £'000	Camden £'000	Enfield £'000	Haringey £'000	Islington £'000	NCL Total £'000
PMS						
PMS Additional and Essential Services	18,134	21,086	33,892	23,177	4,552	100,841
PMS Enhanced Services	283	279	566	324	41	1,494
PMS Quality and Outcomes Framework (QOF)	1,563	1,488	2,804	1,605	203	7,663
PMS Premises Payment	1,754	3,409	3,481	2,114	106	10,865
PMS Other Administered Funds (Maternity etc)	439	522	246	404	0	1,611
PMS Personally Administered Drugs	85	84	158	77	4	407
Total PMS	22,258	26,868	41,148	27,700	4,907	122,880
GMS						
GMS Global Sum & MPIG	35,024	21,019	8,115	17,189	31,630	112,977
GMS Enhanced Services	520	583	131	251	669	2,154
GMS Quality and Outcomes Framework (QOF)	2,891	1,304	686	1,149	2,161	8,191
GMS Premises Payment	3,956	2,907	814	2,728	4,612	15,017
GMS Other Administered Funds (Maternity etc)	485	203	49	91	588	1,416
GMS Personally Administered Drugs	134	60	30	39	71	333
Total GMS	43,009	26,076	9,826	21,446	39,730	140,088
APMS						
APMS Essential and Additional Services	623	4,300	2,522	4,537	3,465	15,447
APMS Enhanced Services	6	33	30	58	32	160
APMS Quality and Outcomes Framework (QOF)	34	189	183	311	181	898
APMS Premises Payment	73	620	281	751	942	2,668
APMS Other Administered Funds (Maternity etc)	0	0	0	0	278	278
APMS Personally Administered Drugs	0	7	7	12	8	34
Total APMS	736	5,149	3,024	5,669	4,906	19,484
Other Medical Services						
PCN	20,143	16,850	15,152	14,849	13,951	80,945
CQC & Idemnity	340	254	262	298	220	1,374
Total Other Medical Services	20,483	17,104	15,414	15,146	14,172	82,319
Total Primary Care Medical Services	86,486	75,197	69,412	69,962	63,715	364,771
Jan Weighted List Size	412,307	348,809	332,573	331,638	316,295	1,741,622
Cost per PWP by Locality	209.76	215.58	208.71	210.96	201.44	209.44

The table summarises the 2025/26 Delegated Primary Care locality budget for NCL ICB.

The table shows a breakdown of the 2025/26 rebased budget across the 5 localities and calculates a £ per weighted patient (£PWP) cost based on the 1st January 2026 GP list sizes.

The £PWP ranges from the lowest in Islington of £201.44 to the highest in Camden of £215.58 for 2025/26. Islington has just 2 PMS practices which is significantly fewer than Haringey, Enfield and the other localities and partially accounts for this variation. Estates costs cause other notable variation across the 5 localities.

Note 1:

The sum of NCL non-borough budget (£1.51m), and this borough-based total equals the annual NCL budget on slide 3.

2025/26 Delegated Primary Care Budget excluding Premises expenditure



North Central London
Integrated Care Board

Description	Barnet £'000	Camden £'000	Enfield £'000	Haringey £'000	Islington £'000	NCL Total £'000
PMS						
PMS Additional and Essential Services	18,134	21,086	33,892	23,177	4,552	100,841
PMS Enhanced Services	283	279	566	324	41	1,494
PMS Quality and Outcomes Framework (QOF)	1,563	1,488	2,804	1,605	203	7,663
PMS Other Administered Funds (Maternity etc)	439	522	246	404	0	1,611
PMS Personally Administered Drugs	85	84	158	77	4	407
Total PMS	20,504	23,458	37,667	25,586	4,801	112,016
GMS						
GMS Global Sum & MPIG	35,024	21,019	8,115	17,189	31,630	112,977
GMS Enhanced Services	520	583	131	251	669	2,154
GMS Quality and Outcomes Framework (QOF)	2,891	1,304	686	1,149	2,161	8,191
GMS Other Administered Funds (Maternity etc)	485	203	49	91	588	1,416
GMS Personally Administered Drugs	134	60	30	39	71	333
Total GMS	39,054	23,169	9,011	18,719	35,119	125,071
APMS						
APMS Essential and Additional Services	623	4,300	2,522	4,537	3,465	15,447
APMS Enhanced Services	6	33	30	58	32	160
APMS Quality and Outcomes Framework (QOF)	34	189	183	311	181	898
APMS Other Administered Funds (Maternity etc)	0	0	0	0	278	278
APMS Personally Administered Drugs	0	7	7	12	8	34
Total APMS	663	4,529	2,743	4,917	3,964	16,816
Other Medical Services						
PCN	20,143	16,850	15,152	14,849	13,951	80,945
CQC & Idemnity	340	254	262	298	220	1,374
Total Other Medical Services	20,483	17,104	15,414	15,146	14,172	82,319
Total Primary Care Medical Services	80,705	68,260	64,835	64,368	58,055	336,222
Jan Weighted List Size	412,307	348,809	332,573	331,638	316,295	1,741,622
Cost per PWP by Locality	195.74	195.69	194.95	194.09	183.55	193.05

This table shows a breakdown of the 2025/26 NCL ICB Delegated Primary Care rebased budget across the 5 localities and calculates a £s per weighted patient (£PWP) cost based on the 1st January 2026 GP list sizes excluding premises expenditure.

The £PWP ranges from the lowest in Islington of £183.55 to the highest in Barnet of £195.74 for 2025/26. Islington has just 2 PMS practices which is significantly fewer than Haringey, Enfield and the other localities and causes this variation.

2025/26 M1-10 ARRS WTE and Expenditure



North Central London
Integrated Care Board

Role	Average M1-M10 WTE	M10 WTE	YTD Reimbursement £	Reimbursement Accrual £	YTD Total Expenditure £
Advanced Dietician Practitioner	0.50	-	25,643		25,643
Advanced Nurse Practitioner	7.45	7.73	401,221	53,882	455,102
Advanced Paramedic Practitioner	5.13	5.51	238,261	52,264	290,526
Advanced Pharmacist Practitioner	23.56	15.37	1,195,188	121,556	1,316,744
Advanced Physiotherapist Practitioner	2.12	1.67	111,286	10,762	122,048
Apprentice Physician Associate	0.20	1.00	4,316	4,316	8,632
Care Coordinator	191.22	190.70	4,649,367	673,149	5,322,516
Clinical Pharmacist	237.53	240.61	10,750,865	1,822,083	12,572,948
Dietician	2.18	2.63	104,904	14,518	119,421
Digital and Transformation Lead	23.96	22.51	1,075,665	149,974	1,225,638
Enhanced Practice Nurse	5.29	4.38	200,343	29,493	229,835
Experienced General Practice Nurse	0.95	2.12	31,745	8,617	40,363
First Contact Physiotherapist	29.57	27.79	1,411,100	220,168	1,631,268
General Practice Assistant	83.04	83.18	2,047,599	260,586	2,308,185
GP (ARRS)	47.46	49.95	2,869,841	460,560	3,330,401
Health and Wellbeing Coach	17.70	18.56	468,091	66,392	534,482
Healthcare Support Worker	1.18	1.80	19,040	3,083	22,123
Mental Health Practitioner Band 7	5.31	5.00	131,270	14,035	145,305
Mental Health Practitioner Band 8a	3.96	3.96	108,372	12,290	120,662
New to General Practice Nurse	2.40	3.00	57,609	15,529	73,138
Nursing associate	5.09	6.11	138,101	16,907	155,008
Occupational therapist	0.40	0.40	21,462	2,385	23,847
Paramedic	9.58	8.29	410,875	61,709	472,584
Pharmacy Technician	23.15	23.30	705,785	91,361	797,146
Physician Associate	93.14	85.82	3,812,000	517,009	4,329,009
Social Prescribing Link Worker	73.14	69.38	2,107,429	265,102	2,372,531
Student Nursing Associate	7.20	6.00	167,643	20,195	187,838
Trainee nursing associate	1.30	-	35,351		35,351
Total ARRS	903.69	886.76	33,300,372	4,967,923	38,268,295

- The table summarises the 2025/26 Additional Roles Reimbursement Scheme (ARRS) average M1-10 Working Time Equivalent (WTE), M10 WTE and total YTD expenditure from the 1st April 2025 to the 31st January 2026.
- The full ARRS allocation this financial year is within the baseline funding therefore no drawdown exercise is required.
- Appendix 2 & 3 shows the WTE/Headcount per role by PCN.

Appendix 1 - 2025/26 M10 Expenditure by Locality



North Central London
Integrated Care Board

		TD Actual	YTD Variance Fav/(Adv)	Annual Budget	Forecast Outturn	Forecast Variance Fav/(Adv)
		£000's	£000's	£000's	£000's	£000's
Barnet CCG						
PMS	18,559	20,000	(1,441)	22,258	22,258	0
GMS	35,859	35,128	731	43,009	43,009	0
APMS	614	837	(223)	736	736	0
Other Medical Services	17,269	16,805	465	20,483	20,483	0
Total Primary Care Medical Services	72,301	72,770	(468)	86,486	86,486	0

		TD Actual	YTD Variance Fav/(Adv)	Annual Budget	Forecast Outturn	Forecast Variance Fav/(Adv)
		£000's	£000's	£000's	£000's	£000's
Enfield CCG						
PMS	34,309	33,769	539	41,148	41,148	0
GMS	8,192	8,007	186	9,826	9,826	0
APMS	2,521	2,855	(334)	3,024	3,024	0
Other Medical Services	12,418	12,502	(85)	15,414	15,414	0
Total Primary Care Medical Services	57,440	57,133	307	69,412	69,412	0

		TD Actual	YTD Variance Fav/(Adv)	Annual Budget	Forecast Outturn	Forecast Variance Fav/(Adv)
		£000's	£000's	£000's	£000's	£000's
Camden CCG						
PMS	22,401	22,273	129	26,868	26,868	0
GMS	21,742	21,484	258	26,076	26,076	0
APMS	4,292	4,284	9	5,149	5,149	0
Other Medical Services	14,140	14,576	(436)	17,104	17,104	0
Total Primary Care Medical Services	62,575	62,616	(41)	75,197	75,197	0

		TD Actual	YTD Variance Fav/(Adv)	Annual Budget	Forecast Outturn	Forecast Variance Fav/(Adv)
		£000's	£000's	£000's	£000's	£000's
Haringey CCG						
PMS	23,096	22,467	630	27,700	27,700	0
GMS	17,881	17,390	491	21,446	21,446	0
APMS	4,726	5,308	(582)	5,669	5,669	0
Other Medical Services	12,357	12,516	(159)	15,146	15,146	0
Total Primary Care Medical Services	58,061	57,681	379	69,962	69,962	0

		TD Actual	YTD Variance Fav/(Adv)	Annual Budget	Forecast Outturn	Forecast Variance Fav/(Adv)
		£000's	£000's	£000's	£000's	£000's
Islington CCG						
PMS	4,092	3,846	245	4,907	4,907	0
GMS	33,127	31,792	1,335	39,730	39,730	0
APMS	4,090	5,685	(1,595)	4,906	4,906	0
Other Medical Services	11,624	11,442	182	14,172	14,172	0
Total Primary Care Medical Services	52,933	52,765	167	63,715	63,715	0

Appendix 2 - 2025/26 ARRS WTE per role per PCN as at M10



North Central London
Integrated Care Board

PCN	Advanced Nurse Practitioner	Advanced Paramedic Practitioner	Advanced Pharmacist Practitioner	Advanced Physiotherapist Practitioner	Apprentice Physician Associate	Care Coordinator	Clinical Pharmacist	Dietician	Digital and Transformation Lead	Enhanced Practice Nurse	Experienced General Practice Nurse	First Contact Physiotherapist	General Practice Assistant	GP (ARRS)	Health and Wellbeing Coach	Healthcare Support Worker	Mental Health Practitioner Band 7	Mental Health Practitioner Band 8a	New to General Practice Nurse	Nursing associate	Occupational therapist	Paramedic	Pharmacy Technician	Physician Associate	Social Prescribing Link Worker	Student Nursing Associate	Grand Total
BARNET 1D PCN						5.33	4.47		0.63			0.45	1.96	0.94													18.01
BARNET 1W PCN			2.59			3.48	2.80	0.60	1.00			1.00	1.00	2.53	0.80			1.00					2.43		1.81		20.12
BARNET 2 PCN						37.76	5.71		1.00			3.43		0.72			2.00						6.36			1.00	57.98
BARNET 3 PCN						12.09	8.11	0.13	1.00			3.00	1.00	0.89	1.40			1.00					3.00		5.00	1.00	37.62
BARNET 4 PCN			1.00			9.00	2.43		1.00			1.03	4.00	0.22	3.80								0.98		1.47		25.93
BARNET 5 PCN	0.75					3.51	8.60	1.00	1.00	0.40		2.00		1.00		0.80		1.00							1.50		21.55
BARNET 6 PCN			1.00			2.22	10.16		1.05			2.31	0.80	1.66										1.80	1.91		22.91
BARNET 7 PCN						1.87	3.00		1.43			1.00		0.72									1.00		1.44		11.45
CENTRAL 1 ISLINGTON PCN						2.00	7.71		1.00					0.66											2.21	3.00	16.59
CENTRAL 2 ISLINGTON PCN						1.45	12.48		0.50	0.21			0.60												3.00		18.24
CENTRAL CAMDEN PCN		1.00				5.00	8.95		1.00			1.00			0.80								2.00	9.71	1.80		31.25
CENTRAL HAMPSTEAD PCN			2.13			1.00	1.53		1.00	1.60			2.00	2.00								1.00		5.20	0.67		18.14
EDMONTON PCN						2.00	4.00		1.00					0.32	1.00									6.00	1.00	1.00	16.32
ENFIELD CARE NETWORK PCN	0.80					2.60	15.75		1.00				11.07	3.45	4.58		1.00			1.00			0.45	0.60			42.29
ENFIELD SOUTH WEST PCN						4.00	11.00		1.00					0.80									1.00				18.80
ENFIELD UNITY PCN		3.51	1.00			17.03	23.71	0.80	1.00			2.00	3.92	0.67	2.60								1.43	15.36	2.93		75.96
HARINGEY - EAST CENTRAL PCN	2.56					3.73	10.05					1.00		1.42	2.77									7.31	2.81		31.66
HARINGEY - N15/SOUTH EAST PCN						7.20	5.39			0.80			3.95	0.80									2.00	2.76	1.00		23.90
HARINGEY - NORTH CENTRAL PCN						12.37	7.54		0.50			1.99		1.20	0.80								1.23		1.70		27.32
HARINGEY - NORTH EAST PCN					1.00	7.19	6.07					2.00	7.40	3.41					2.00				1.00	2.00	1.47		33.54
HARINGEY - NORTH WEST PCN	1.00					4.83	10.47						2.00	2.45											2.00	1.00	23.75
HARINGEY - SOUTH WEST PCN						2.12	8.10				0.45	1.00	4.32	0.44						0.40				0.32	1.40	1.00	19.54
HARINGEY - WELBOURNE PCN	0.80					10.80	6.79		1.00			0.21	4.43	1.25									2.80	1.83	1.80		32.70
KENTISH TOWN CENTRAL PCN						3.31	5.80				0.67		3.73	3.80					1.00	0.80				2.89	4.00		26.00
KENTISH TOWN SOUTH PCN		1.00				3.40	7.20		1.00				2.00	0.32											1.00		15.92
NORTH 1 ISLINGTON PCN	0.57			1.00		9.51	3.64	0.10	1.60			0.50	1.00	2.51					0.96		0.91	0.40	0.64	0.40	4.00		22.49
NORTH 2 ISLINGTON PCN	0.25		7.65	0.67		2.00	4.00						4.53	3.28		1.00			1.00				1.67	7.00	2.00		43.30
NORTH CAMDEN PCN	1.00					1.00	3.43		0.80	0.69			2.08	2.41							1.00			10.36	2.00		24.85
SOUTH CAMDEN PCN						1.00	3.43		0.80	0.69			13.22	2.04											1.00		22.18
SOUTH ISLINGTON PCN						3.51	12.61		1.00	0.07		3.87		1.70								2.33	2.00		4.00		31.08
WEST AND CENTRAL PCN						2.71	3.00		1.00				4.82	1.60									1.00	3.00	1.00	1.00	19.12
WEST CAMDEN PCN						2.72	1.87			0.60			2.36	1.76							1.00				5.07	2.00	17.37
WEST ENFIELD COLLABORATIVE PCN						3.99	6.25							3.00									1.64	3.00	1.00		18.88
Grand Total	7.73	5.51	15.37	1.67	1.00	190.70	240.61	2.63	22.51	4.38	2.12	27.79	83.18	49.95	18.56	1.80	5.00	3.96	3.00	6.11	0.40	8.29	23.30	85.82	69.38	6.00	886.76

Appendix 3 - 2025/26 ARRS Headcount per role per PCN as at M10



North Central London
Integrated Care Board

PCN	Advanced Nurse Practitioner	Advanced Paramedic Practitioner	Advanced Pharmacist Practitioner	Advanced Physiotherapist Practitioner	Apprentice Physician Associate	Care Coordinator	Clinical Pharmacist	Dietician	Digital and Transformation Lead	Enhanced Practice Nurse	Experienced General Practice Nurse	First Contact Physiotherapist	General Practice Assistant	GP (ARRS)	Health and Wellbeing Coach	Healthcare Support Worker	Mental Health Practitioner Band 7	Mental Health Practitioner Band 8a	New to General Practice Nurse	Nursing associate	Occupational therapist	Paramedic	Pharmacy Technician	Physician Associate	Social Prescribing Link Worker	Student Nursing Associate	Grand Total	
BARNET 1D PCN						15.00	6.00		2.00			2.00	3.00	3.00													37.00	
BARNET 1W PCN			4.00			4.00	3.00	1.00	1.00			1.00	1.00	4.00	1.00			1.00									25.00	
BARNET 2 PCN						45.00	9.00		1.00			4.00		2.00			2.00										71.00	
BARNET 3 PCN						13.00	10.00	1.00	1.00			3.00	1.00	2.00	2.00			1.00					3.00		7.00	1.00	43.00	
BARNET 4 PCN			1.00			9.00	3.00		1.00			2.00	5.00	1.00	5.00			1.00					1.00				32.00	
BARNET 5 PCN	1.00					7.00	13.00	1.00	1.00	1.00		2.00		2.00		1.00											32.00	
BARNET 6 PCN			1.00			6.00	12.00		1.00			3.00	1.00	2.00											2.00		31.00	
BARNET 7 PCN						2.00	3.00		3.00			1.00	1.00	1.00													14.00	
CENTRAL 1 ISLINGTON PCN						2.00	9.00		1.00					2.00										1.00			20.00	
CENTRAL 2 ISLINGTON PCN						4.00	13.00		1.00	1.00			1.00														24.00	
CENTRAL CAMDEN PCN			1.00			5.00	11.00		1.00			1.00			1.00								2.00		11.00	2.00	35.00	
CENTRAL HAMPSTEAD PCN				2.00		1.00	2.00		1.00	2.00			2.00	2.00								1.00			5.00	1.00	19.00	
EDMONTON PCN						2.00	4.00		1.00					1.00	1.00												17.00	
ENFIELD CARE NETWORK PCN	1.00					3.00	19.00		1.00				14.00	5.00	5.00			1.00			1.00		1.00				52.00	
ENFIELD SOUTH WEST PCN						4.00	11.00		1.00					1.00									1.00				19.00	
ENFIELD UNITY PCN			5.00	1.00		23.00	26.00	1.00	1.00			2.00	5.00	1.00	3.00								2.00	18.00	4.00		92.00	
HARINGEY - EAST CENTRAL PCN	4.00					4.00	15.00					1.00		5.00	3.00												44.00	
HARINGEY - N15/SOUTH EAST PCN						8.00	10.00			1.00			6.00	1.00													34.00	
HARINGEY - NORTH CENTRAL PCN						16.00	10.00		1.00			3.00		5.00	1.00							3.00		2.00	4.00	2.00	41.00	
HARINGEY - NORTH EAST PCN					1.00	8.00	9.00					2.00	7.00	10.00						2.00				1.00	2.00	2.00	44.00	
HARINGEY - NORTH WEST PCN	1.00					6.00	13.00						2.00	3.00												2.00	28.00	
HARINGEY - SOUTH WEST PCN						3.00	15.00				1.00	1.00	6.00	1.00							1.00				1.00	2.00	32.00	
HARINGEY - WELBOURNE PCN	1.00					13.00	10.00		1.00			1.00	5.00	2.00									4.00	3.00	3.00		43.00	
KENTISH TOWN CENTRAL PCN						5.00	6.00				1.00		4.00	4.00					1.00						3.00	5.00	30.00	
KENTISH TOWN SOUTH PCN			1.00			4.00	8.00		1.00				2.00	1.00												1.00	18.00	
NORTH 1 ISLINGTON PCN	1.00			2.00			8.00		2.00			1.00	1.00	4.00				1.00		1.00		1.00				4.00	28.00	
NORTH 2 ISLINGTON PCN	1.00		10.00	1.00		13.00	4.00	1.00			1.00		5.00	4.00			1.00				1.00		2.00	7.00	2.00		53.00	
NORTH CAMDEN PCN	1.00					2.00	4.00						3.00	4.00													28.00	
SOUTH CAMDEN PCN						1.00	5.00		1.00	1.00			15.00	5.00							1.00					11.00	29.00	
SOUTH ISLINGTON PCN						6.00	14.00		1.00	1.00		6.00		7.00								6.00		2.00		4.00	47.00	
WEST AND CENTRAL PCN						3.00	3.00		1.00				8.00	2.00									1.00		3.00	1.00	1.00	23.00
WEST CAMDEN PCN						3.00	2.00			1.00			3.00	3.00							1.00					5.00	2.00	20.00
WEST ENFIELD COLLABORATIVE PCN						5.00	7.00							3.00									2.00				1.00	21.00
Grand Total	11.00	7.00	19.00	3.00	1.00	245.00	297.00	5.00	27.00	8.00	3.00	36.00	101.00	93.00	22.00	2.00	5.00	4.00	3.00	7.00	1.00	15.00	27.00	96.00	82.00	6.00	1,126.00	

Appendix 4 – 2025/26 DES expenditure as at M10



North Central London
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PCN DES Services	YTD Budget	YTD Actual	YTD Variance Fav/(Adv)	Annual Budget	Forecast Outturn	Forecast Variance Fav/(Adv)
	£000's	£000's	£000's	£000's	£000's	£000's
Assisted Roles Reimbursement Scheme	38,268	38,268	0	46,868	46,868	0
Capacity and Access Incentive	2,086	2,086	0	2,503	2,503	0
Capacity and Access Support	4,866	4,866	0	5,840	5,840	0
Care Home Premium	610	610	0	732	732	0
Support Payment - Clinical Director & Leadership and Management	2,272	2,272	0	2,727	2,727	0
Enhanced Access	12,929	12,929	0	15,515	15,515	0
Investment and Impact Fund Achievement	312	312	0	375	375	0
Network Participation Payment	2,553	2,553	0	3,065	3,065	0
Test Site Additional Capacity	2,801	2,801	0	3,361	3,361	0
Total PCN DES Services	66,697	66,697	0	80,985	80,985	0

GP DES Services	YTD Budget	YTD Actual	YTD Variance Fav/(Adv)	Annual Budget	Forecast Outturn	Forecast Variance Fav/(Adv)
	£000's	£000's	£000's	£000's	£000's	£000's
Learning Disability	1,272	1,272	0	1,527	1,527	0
Minor Surgery	593	593	0	712	712	0
Violent Patients	246	246	0	295	295	0
Advice & Guidance	1,102	1,102	0	1,274	1,274	0
Total GP DES Services	3,212	3,212	0	3,807	3,807	0

Appendix 5 - 2025/26 Non-Delegated Locally Enhanced Services as at M10



Non Delegated Enhanced Services	YTD Budget	YTD Actual	YTD Variance Fav/(Adv)
	£000's	£000's	£000's
Locally Commissioned Services	14,204	14,204	0
Total Non Delegated Enhanced Services	14,204	14,204	0

Annual Budget	Forecast Outturn	Forecast Variance Fav/(Adv)
£000's	£000's	£000's
17,045	17,045	0
17,045	17,045	0



North Central London
Integrated Care Board

**North Central London ICB
Primary Care Committee Meeting
10 March 2026**

Report Title	General Practice Quality and Performance Report	Date of report	19 February 2026	Agenda Item	4.2
Lead Director / Manager	Becky Kingsnorth, Assistant Director for Primary Care Strategy and Change	Email / Tel		rebeccakingsnorth@nhs.net	
Board Member Sponsor	Sarah McDonnell-Davies, Chief Transformation Officer				
Report Author	Tamzin Jamieson, Head of Primary Care Strategy & Change	Email / Tel		tamzin.jamieson1@nhs.net	
Name of Authorising Finance Lead	Not applicable	Summary of Financial Implications Not applicable.			
Name of Authorising Estates Lead	Not applicable	Summary of Estates Implications Not applicable.			
Report Summary	<p>The Quality and Performance Report supports the work of the Primary Care Committee by providing data and insight into quality, activity and capacity in General Practice across North Central London.</p> <p>In this report, in addition to regular information on appointments, contact activity and CQC, we review Online Consultation data to understand the volume of contact between patients and practices and how this has increased over time and with the introduction of contractual requirements (as of 1st October 2025). When looking at appointment data we explore Face to Face appointment data alongside other modes of contacting a practice.</p> <p>The data shows further improvement in the latest results from the ONS Health Insights Survey and Friends and Family Test.</p> <p>Information is provided on the change support service provided by Islington GP Federation over 18 months to September 2025. We describe the new GP Change Support service which started in October 2025 in NCL.</p>				
Recommendation	<p>The PCC is asked to:</p> <ul style="list-style-type: none">• COMMENT on the data presented in this report.• NOTE the support provided to general practice through the ICB commissioned GP change support services – past and present.				

Identified Risks and Risk Management Actions	<p>Timeliness and quality of data is known to be variable in some of the national datasets which form the basis of this report. Coding and recording approaches also vary between practices.</p> <p>This risk been mitigated to a degree by work practices were incentivised to undertake two years ago to improve the quality of the GPAD appointments dataset, and ICB internal work to improve data quality in the NWRS workforce dataset. However we know that variation in approach to recording activity persists.</p> <p>Overall, the value of using this data to demonstrate the quality and volume of work General Practice delivers outweighs the risk of making judgements based on poor quality data. Where outliers or areas of variation are identified in the dataset the ICB's first course of action would be exploratory with the practice to understand why, following up formally as necessary.</p>
Conflicts of Interest	<p>Not applicable.</p>
Resource Implications	<p>Not applicable.</p>
Engagement	<p>Following the Collaborative Practice Insights meetings described in this report, the primary care team will engage with practices showing as outliers in national data sets to discuss the data and any support needs the practice may have.</p>
Equality Impact Analysis	<p>Not applicable.</p>
Report History and Key Decisions	<p>Not applicable.</p>
Next Steps	<p>Continuation of improvement and build of the Q&P dashboard</p>
Appendices	<p>Q&P Dashboard headline report</p>

General Practice Quality & Performance Report

Primary Care Committee, March 2026

Introduction

In this report, in addition to regular information on appointments, contact activity and CQC, we review Online Consultation data to understand the volume of contact between patients and practices and how this has increased over time and with the introduction of contractual requirements (as of 1st October 2025). When looking at appointment data we explore Face to Face appointment data alongside other modes of contacting a practice.

The data shows further improvement in the latest results from the ONS Health Insights Survey and Friends and Family Test.

Information is provided on the change support service provided by Islington GP Federation over 18 months to September 2025. We describe the new GP Change Support service which started in October 2025 in NCL.

The report includes:

- Standard quality and performance headlines which now includes online consultation data
- Patient perception of general practice – through the ONS Health Insights Survey and the Friends and Family Test Survey
- Update on the Data Driven Approach and Collaborative Practice Insight meetings
- Look back on the change support service (April 2024 to September 2025) to support practices in the implementation of Modern General Practice operating model and the new consolidated GP Change Support contract



Headlines

Q&P Headlines: Online Contacts

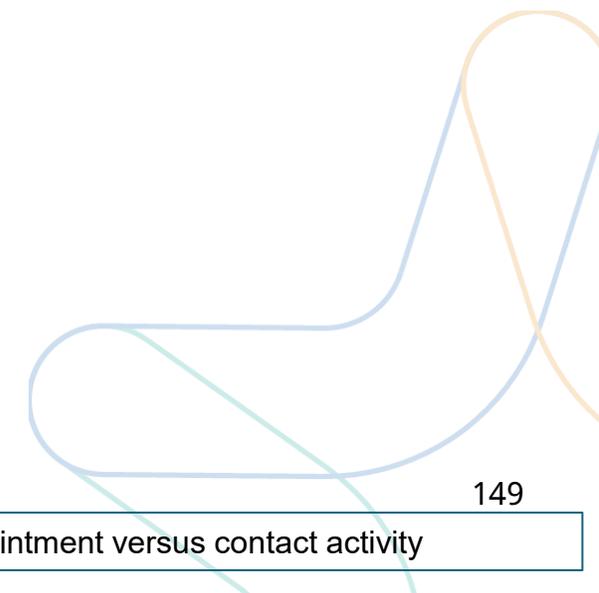
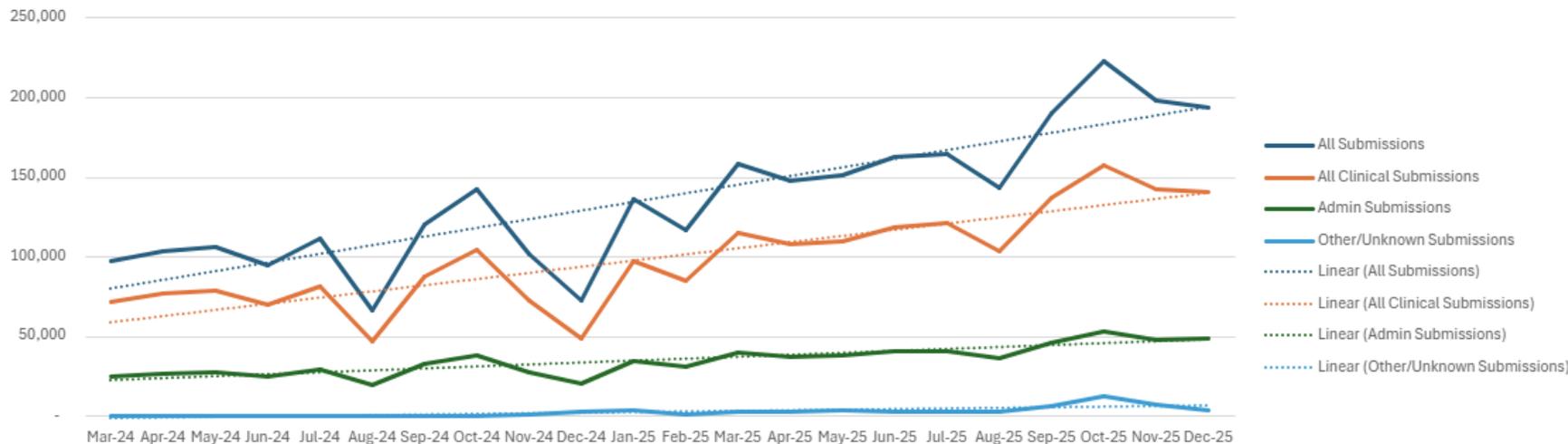
Data from suppliers of online consultation tools to general practice
Latest data: December 2025

Online Consultation submissions/ Online contacts in General Practice

From 1 October 2025, practices were required to comply with the new contractual requirement that Online consultations (OC) must be available throughout core hours (8:00am - 6:30pm, weekdays excl. holidays) with no caps or restrictions. Non-urgent appointment requests, medication queries, and admin requests should be accessible via OC tools.

- **In October 223,069 online consultation submissions were recorded**, which is the highest total number of online consultations made to date in a calendar month
- In the following two months this decreased and the total submissions were recorded as 194,051 in December 2025
- December numbers are still higher than in September (pre contractual requirements) with the majority of the increased submissions being recorded as Clinical submissions.

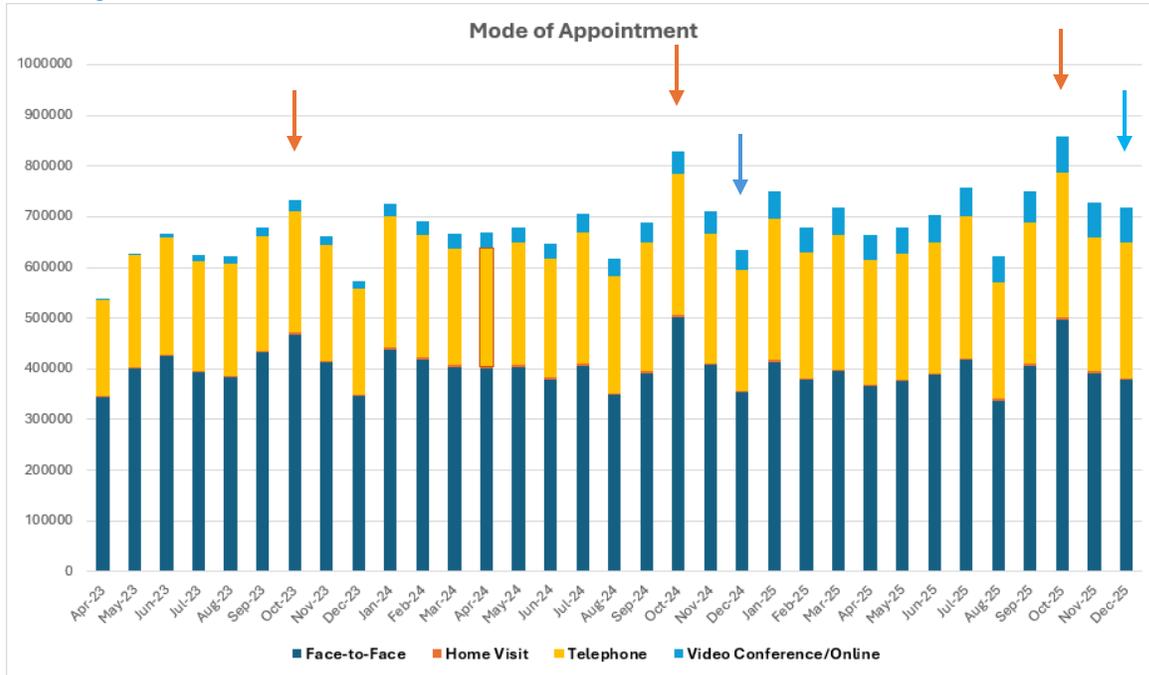
Online Consultations - NCL Mar 24-Dec 25



See appendix 3 for explanation of appointment versus contact activity

Q&P Headlines: Appointments By Mode NCL

Data from GPAD
Latest data: December 2025



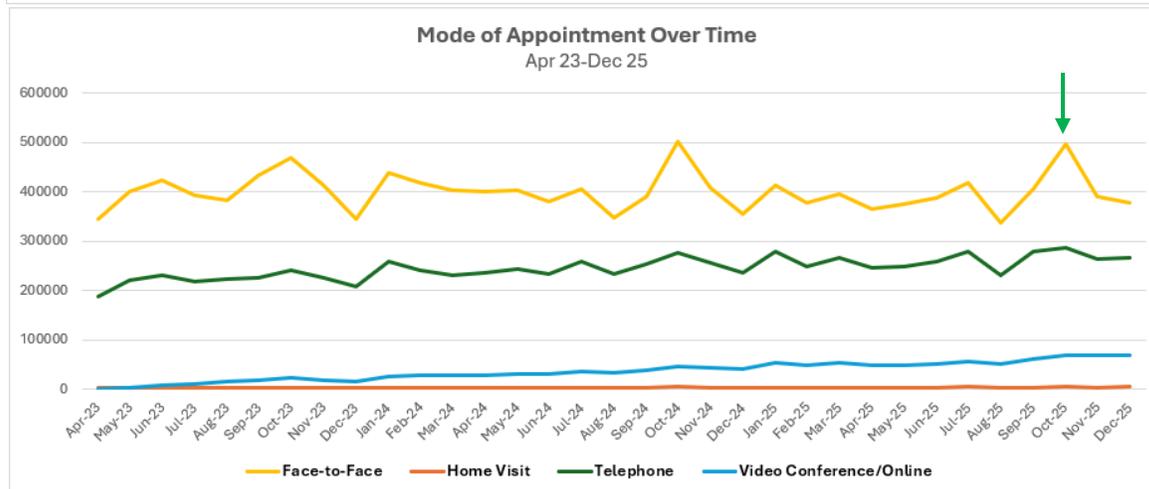
In this report we look at the latest data and look back at data from October - the month from which practices were required to comply with the new contractual requirement that Online consultations (OC) must be available throughout core hours

December 2025 Data (Latest data)

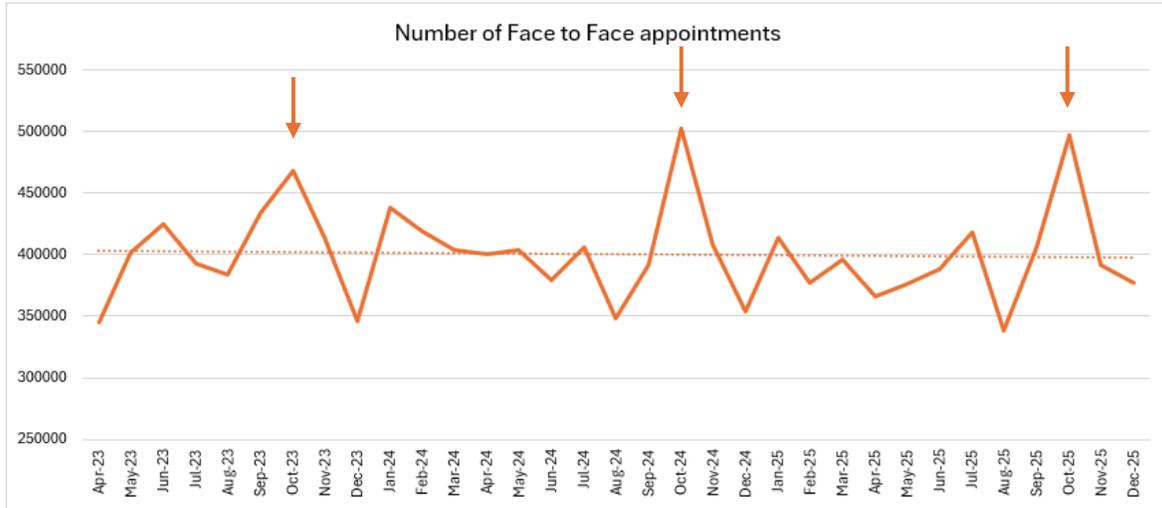
- GP practices in NCL delivered a total of 717,238 appointments in December 2025, 13% more than in December 2024 (blue arrows in Mode of Appointment graph).
- In NCL there was a 4% increase in all appointments over the calendar year (January to December 2025).

October 2025 Data

- October 2025 saw the greatest number of appointments in NCL to date in one calendar month at 857,699 appointments.
- The graph (red arrows: Mode of Appointment) shows appointment numbers are seasonal; for the past 3 years October has seen the highest number of appointments.
- October 2025 saw the additional impact of the new contractual requirement that practices offer online consultations during core hours; may have resulted in higher demand and the need for a greater number of appointments than previously.
- In October 2025 (green arrow: Mode of Appointment Over Time) the additional demand for appointments was supplied through face-to-face appointments, while the number of telephone appointments remains far more stable month on month.



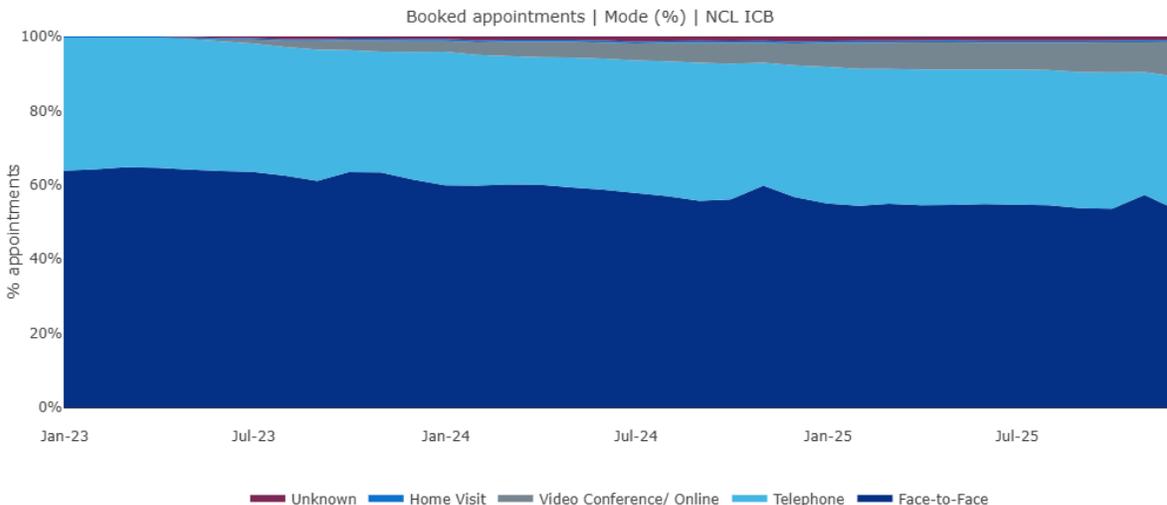
Q&P Headlines: Appointments Face to Face appointments



Number of Face to Face appointments

- In the 2024 calendar year NCL practices offered 4,855,602 Face to Face appointments and in the 2025 calendar year NCL practices offered 4,744,477 Face to Face appointments.
- The dotted trend line shows that face to face appointment numbers are very slowly decreasing. They decreased by 2% from 2024 to 2025.
- The peaks and troughs in face to face appointments are seasonal, as noted on the previous page.

Data from GPAD
Latest data: December 2025



Percentage of Face to Face appointments

- The percentage of Face to Face appointments has decreased more significantly than the percentage change in number of Face to Face appointments.
- Important to note: the decrease in percentage of Face to Face appointments is significantly related to the introduction of another mode of appointment – in the form of Video/ Online appointments.
- Graph to the left shows percentage of Face to Face appointments have declined in line with the percentage increase of Video/ Online appointments.

Graphs from the **London Primary Care Data Report** on NHS Futures (London Primary Care Transformation)
Latest data: November 2025

Q&P Headlines: Appointments

While there is a high level of public, press and political focus on the percentage of appointments that take place **face to face**, it is important to note that, as practices implement Modern General Practice access and the related approaches to triage, we would expect the percentage of contacts and appointments taking place via **telephone or online** to increase and for Face to Face to decrease.

From this data we can hypothesise that this may indicate the movement of NCL practices to a Modern General Practice operating model.

This data should be considered alongside patient satisfaction. NCL patient satisfaction with their GP practices - specifically regarding access – is, on average, improving (we are also working to address variation in this trend at practice level). See ONS HIS and Friends and Family Test surveys on pages 11 to 14.



Q&P Headlines: Contact Activity (Demand)

Why it is important that we measure Contact Activity

Historically we have measured patient demand (met demand) on general practice by the number of appointments provided to patients. This didn't include demand/ contacts from patients on the admin functions/staff or the demand on clinicians that doesn't result in an appointment.

Measuring online consultation activity partially fills this gap in our understanding of the number of contacts a practice manages on a regular basis. By monitoring this alongside other indicators we will be able to track the impact that has on patients, practices and the wider system.

Total Contacts/ Activity includes all appointments and online consultation submissions/ online contacts combined.

December 2025 (latest data):

Including the ~30,000 out of hours appts in PCN and borough hub services, NCL recorded approx 911,289 total patient contacts in Dec 2025.

- Online contacts: 194,051
- Appointments: 717,238
- Out of hours circa: 30,000
- Total contacts: 911,289

October 2025:

October 2025: 1,080,768 recorded contacts (incl. the ~30,000 out of hours appointments in PCN and borough hub services). This is the highest number of contacts made by patients with GP practices in NCL to date in any one calendar month.

- Online contacts: 223,069
- Appointments: 857,699
- Out of hours circa: 30,000
- Total contacts: 1,080,768

**In October 2025 there were over
1 million (combined) contacts
in NCL between patients and their GP**

Q&P Headlines: CQC

CQC ratings summary

- Two practices remain outstanding (O)
- Two practices are rated as inadequate (I)
- Seven practices are rated as requires improvement (RI)
- All other practices are rated good (G)

CQC inspections over the last 6 months:

There have been 11 CQC inspections in NCL in the last 6 months.
Of these:

- 8 practices remain unchanged – rated as Good
- 2 practices are now rated as Good (previous inspection rated them as Requires Improvement)
- 1 practice is now rated as Requires Improvement (previous inspection rated them as Good)

Practice name	Current Status	Date of inspection
The Edmonton Medical Practice	Good	30/01/2026
Wentworth Medical Practice	Good	27/01/2026
Chalfont Surgery	Good	05/01/2026
Penshurst Gardens Surgery	Good	20/11/2025
Pennine Drive Practice	Requires improvement	12/11/2025
White Lodge Medical Practice	Good	24/09/2025
Lichfield Grove Surgery	Good	09/09/2025
The Everglade Medical Practice	Good	19/08/2025
The Old Court House Surgery	Good	19/08/2025
The Bounces Road Surgery	Good	18/08/2025
Torrington Park Group Practice	Good	28/07/2025

Q&P Headlines: Workforce

Included as part of the separate workforce annual report



Patient Perception of General Practice

- Health Intelligence Survey (ONS HIS): Wave 18
- Friends and Family Survey: October data

Patient Perception of General Practice: Headlines

Health Intelligence Survey (ONS HIS)

- **Same-day contact success remains strong**, performing above the London average and closing the gap with national performance
- **Almost half of patients understood their next step as a face-to-face appointment**, in line with both London and England.
- **NCL has achieved the highest ‘good’ ratings in London** for patients’ overall experience of contacting their GP practice
- **We also have the lowest ‘poor’ ratings in London**, and lower than national averages
- When asked about the last 12 months, NCL patients were **the most likely in London to say their practice has improved** — and the least likely to say it has worsened

We include a new indicator used by London and national teams to track improvement: GPP-06a-2 Percentage who were successful or unsuccessful in making contact with their GP practice in the last 28 days

- This indicator looks at All Contact Methods and at each method of contact separately - In Person, Telephone, Other, Online, Online GP Website, Online NHS App (see appendix for these slides)
- Across All Contact methods in Wave 18 **NCL has achieved higher than London and England for patients who find contacting their practice ‘easy’ and the lowest number of patients that find contacting their practice ‘difficult’**
- The same applies for online contacts where **NCL has over 6% higher achievement for those who find it ‘easy’ to contact their practice online** – both through the website and using the NHS App.
- NCL achieves higher than London across all methods for patients finding it ‘easy’ to contact their practice.
- The only contact method where NCL has a lower achievement than England for ‘easy’ to contact your practice is ‘In Person’
- However – **there is a large degree of fluctuation over the last 4 waves. We will need to monitor this over time to determine true trends**

See Appendix 1 for detailed slides on ONS HIS data referred to above.

Friends and Family Test

- There is slow but steady improvement in responses to the F&F survey across NCL from March 2024 with positive responses rising and negative responses falling.
- NCL reached the 90% national average for patients who would positively recommend their practice to Friends and Family in August 2025, remained at 90% in September and received 91% positive responses in October.

Friends and Family Test

FFT gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using the simple question which asks “Overall, how was your experience of our service?” on a scale ranging from very good to very bad. GP practices have been required to make the opportunity to provide feedback through FFT available to their patients since 01/12/2014, and submit data to NHS England each month since the end of January 2015. Further information can be found on the FFT webpage: [NHS England » Friends and Family Test](#)

From April 2020, a new question about overall experience replaced the original FFT question about whether people would recommend the service they used to their friends and family. The replacement question invites feedback on the overall experience of using the service. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.

While the results are not statistically comparable against other organisations because of the various data collection methods, FFT provides a broad measure of patient experience that can be used alongside other data to inform service improvement and patient choice.

There is slow but steady improvement in responses to the F&F survey across NCL from March 2024 with positive responses rising and negative responses falling.

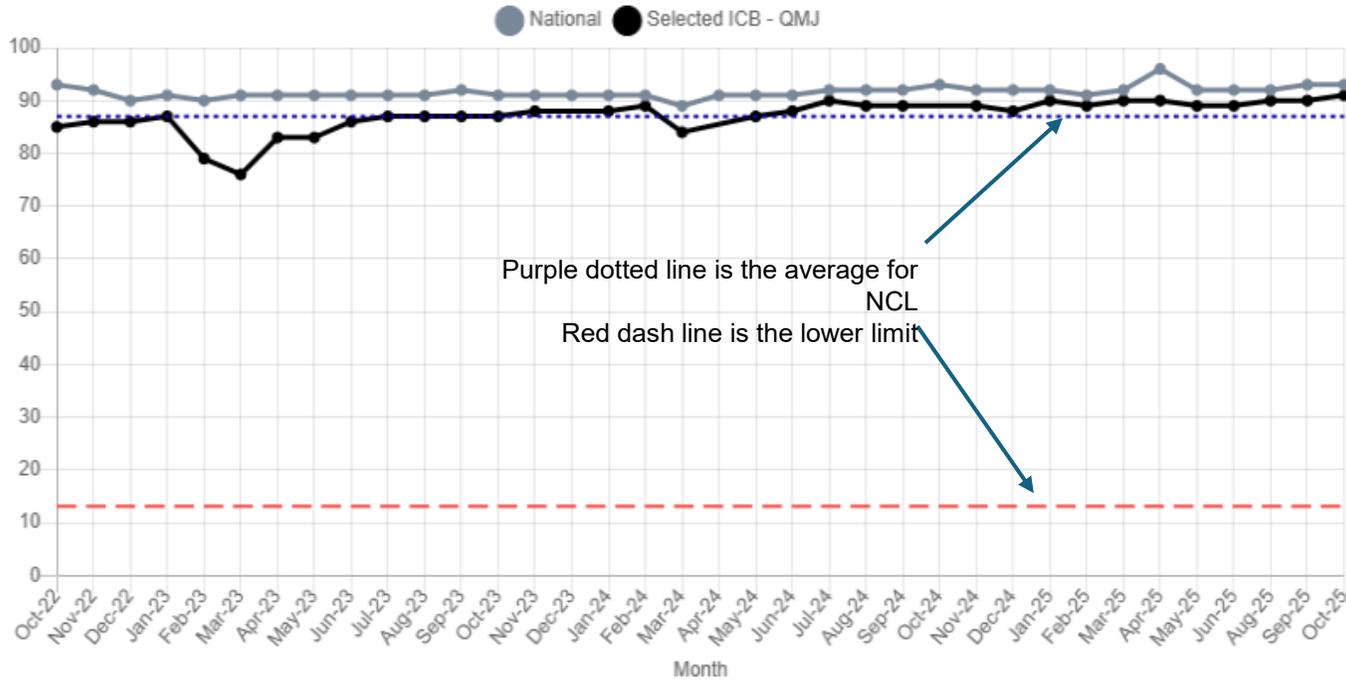
However, the survey data shows us there is a high degree of inconsistency, in the practice level data, in how practices share the survey with patients and how they gather the responses.

Modes include:

- Handwritten
- Telephone call
- Tablet/kiosk
- Smartphone app/ online
- SMS / text message

At NCL level the preferred mode of collection is Text Message. This differs greatly by practice, with practices who don't collect by text message receiving far fewer responses each month. At practice level the statistical quality of the data can be questionable where there are high numbers of unsubmitted (or not gathered) responses or low number of responses from patients.

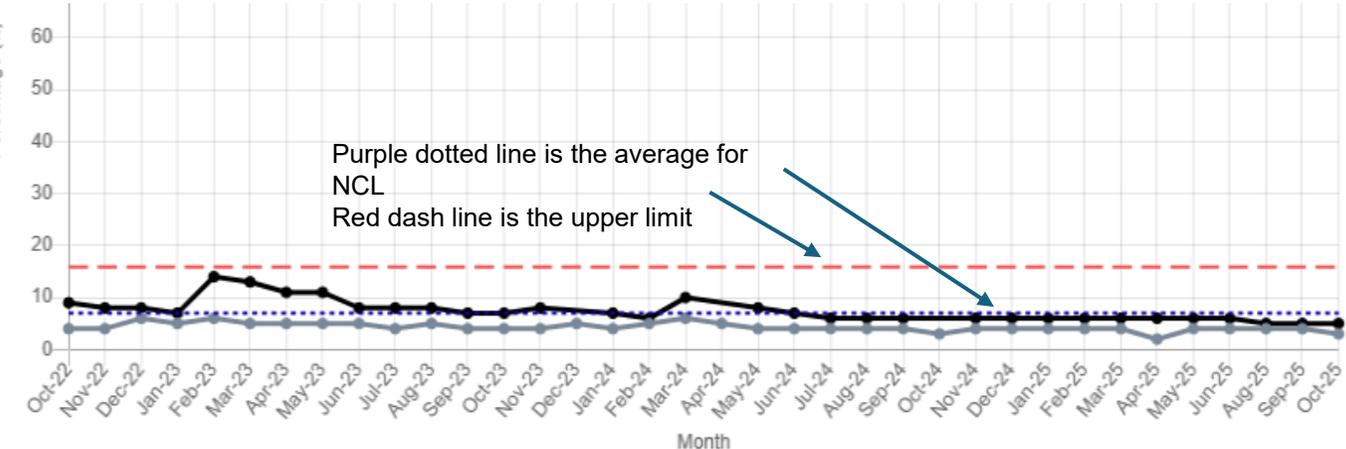
Friends and Family Test



Positive responses:

- Positive responses have been rising in NCL since March 2024.
- The ICB is 90% positive responses.
- NCL reached the 90% in August 2025.
- NCL remained at 90% in September 2025
- In October 2025 we received 91% positive responses.
- National positive responses in October 2025 was 93%

To Note:
The percentage change October 2022 to October 2025 is not significant. However it is a **steady, sustained improvement in both positive and negative responses which continue to improve month on month.**



Negative responses:

- Negative responses have dropped in NCL since March 2024.
- NCL negative responses have lowered to 5% since August 2025.
- National negative responses in October 2025 was 3%



Data Driven Approach

Data Driven Approach: Collaborative Practice Insights (CPI) update

CPI update:

NCL began using national data from the GP National Dashboard to identify NCL outlier practices with significant positive and negative variation in quarter 2 of 2025/26. The practices on the list have changed from month to month since August 2025, as the metrics used and the weightings have been tested nationally. Dashboard is now showing consistency, and we have faith in the data it provides, notwithstanding known data quality issues.

We have also tested and formalised how we use this data. To maintain sight of practices that make improvements and no longer appear on the significant variation list in a particular month, these practices remain on the list for discussion at CPI meetings. This enables us to offer support to practices showing early improvement to help strengthen their positive improvements. It also provides the opportunity to learn from the improvements practices have made which will help support other practices with similar issues.

CPI Meeting dates:

Borough for discussion	Next CPI Meeting Date
Enfield	13/11/2025
Barnet	11/12/2025
Islington	08/01/2026
Haringey	12/02/2026 (postponed to March)
Camden	12/03/2025 (postponed to April)

Significant negative variation:

- The list has stabilised with 32 practices on the significant negative variation list for November 2025 to January 2026. In January only one practice was added to the significant negative variation list and one practice moved off the list.
- As the table to the right shows, we now have 50 practices on the 'long list' for significant negative variation. 32 of these practices currently show significant negative variation (January 2026).

Borough	Negative variation January 2026	Negative variation list from Sept 2025 to January 2026	Positive variation January 2026
Barnet	10	17	7
Camden	5	9	11
Enfield	6	9	1
Haringey	6	9	5
Islington	5	6	3
Total	32	50	27

Month	Significant negative variation	Significant positive variation
Aug-25	33	
Sep-25		
Oct-25	34	13
Nov-25	32	18
Dec-25	32	18
Jan-26	32	27

Significant positive variation:

- In January there was a large jump in the number of practices showing significant positive variation from 18 to 27 practices.
- When looking at what elements had improved to move them onto the significant positive variation list, we found that improvements had been made in the Access domain.
- 24 of the 28 practices show a dominant positive variation in Access.



Change Support to support implementation of Modern General Practice

April 2024 to September 2025

GP Change Support service: Supporting the implementation of Modern General Practice

Background for the service

The Delivery Plan for Recovering Primary Care Access (Primary Care Access Recovery Plan / PCARP), was introduced by NHS England in the 2023/24 planning guidance and published in May 2023. The plan contained a significant number of requirements of individual GP Practices including the need to make the transition to the Modern General Practice operating model by March 2025. The access recovery plan was published in the context of a renewed focus nationally on improving patient satisfaction with General Practice as measured through the national GP Patient Survey. There was an expectation that the achievement of the deliverables in the access recovery plan would also deliver an improvement in patient experience.

The overarching goal of the GP change support contract commissioned by NCL ICB from Islington GP Federation (IGPF) was to work in collaboration with NCL ICB, together with other system partners to support the GP Practices in North Central London to:

- Successfully make the transition to the Modern General Practice operating model as described in the access recovery plan by March 2025
- Improve patient experience of accessing General Practice as measured by the questions in the national GP Patient Survey

This was achieved by working with individual GP Practices across NCL to provide hands-on change management expertise and capacity, supporting practices to make changes to their operating models and ways of working to deliver sustainable improvements for patients.

The contract ran for 18 months, from April 2024 to September 2025, with the initial 12 month contract being extended by 6 months.

- 97 practices were originally identified as needing support. Of these:
 - 9 declined the offer of support
 - 15 did not engage
- Other practices were identified as the work progressed and some practices reached out to the IGPF team for help and were included in the support offered by IGPF.

GP Change Support service: Supporting the implementation of Modern General Practice

There were three modes of delivery:

- **One to One change support:** supporting the practice to make operational change based on their individual practice need – starting with a discussion about their current access model and practice challenges.
41 practices took up this offer
- **Peer Support:** bringing together small groups of practices that had similar goals and providing them with a forum to work through their individual projects. There were two topics: websites and total triage. After the initial peer group, follow-ups and virtual drop-in sessions were offered to all attendees.
- **Working in Partnership** - after the initial assessment the specific change support offer could also include a ‘warm handover’ to:
 - Digital First run Digital Change Facilitator programme
 - Universal offer from NCL Training Hub – leading on workforce and training, the goal of the universal offer was to create a comprehensive support package that aligned with the core themes of PCARP and was accessible to every practice across NCL. Careful work went into agreeing the handover process to maintain a practice’s initial engagement.

In addition to this, complementary resources were designed as part of the Training Hub universal offer and by Healthwatch.

On-the-Ground Support

64 practice visits (by Change Managers and Digital Change Facilitators)

Borough	Number of practices
Barnet	23
Camden	5
Islington	11
Haringey	11
Enfield	14
Total	64

Peer Group Sessions Delivered Over 18 Months

Session Type	Number of Sessions	Number of individual attendees
Total Triage	7	50
Change Management	3	27
Website Improvement	2	2
Demand & Capacity	4	23
Patient Participation Groups (PPG)	2	31
GP Triage Townhall Event	1	22
DTL Network	6	31
Total	25	186

GP Change Support service: Measuring success

GP Patient Survey results:

We will look at the specific practices who received support through the change management programme, in the August 2026 GP Patient Survey results. The 2025 survey results only give early findings, having been collected in Jan/Feb 2025 and therefore mid-programme.

Feedback on the change support service from general practice:

From the DTL network (Digital Transformation Lead)

'Thank you very much for organising these sessions for NCL DTLs. They were very interesting topics and always informative. Always good to share our work/knowledge with colleagues too. Would be great if these program could be a yearly re-occurrence.'

The GP Townhall event (open forum to share information, encourage discussion and broaden engagement)

'Thank you John and colleagues - great town hall... do reach out for more conversation and solutioning this... education and collaboration may be helpful to manage workload...'

'Thanks guys. Really interesting to hear that on the whole we are all on a similar page and all trying out best to balance the patient demands'

When asked their takeaway from the Change Management session

'Every new changes brings on resistance. You need the support of your whole team both clinical and admin staff to support that change. Must always consider the human factor whenever you decide a change is needed'

From our total triage group

'There was good background info, good points for consideration and helped with understanding of how to mitigate certain contract requirements'

New local change management support to General Practice

From 1st October, local change management support for practices, covering digital transformation, Modern General Practice access models & implementation of the long term conditions locally commissioned service, moved to a consolidated delegated offer, having previously been delivered by different partners in NCL.

Following open procurement this is being delivered by Haringey GP Federation in partnership with all NCL GP Federations and Qualitas Consortium, a national provider of practice level support. The new service builds on and consolidates change support previously provided separately to support implementation of Modern General Practice Access, implementation of the Long term Conditions LCS, and implementation of digital transformation.

Local clinical and non-clinical support teams will be made available in each Borough alongside subject matter expertise at an NCL and national level (via Qualitas). The offer has been expanded to include access support to vulnerable population groups who may experience digital exclusion.

In parallel, NCL Training Hub continues to provide LTC specific clinical training alongside personalised care and support planning training as part of the wider training offer to all of General Practice.

This new service compliments the existing National offers, Support Level Framework conversations and PCN Capacity and Access Support and Improvement Plans as outlined [General Practice Access Support - NCL ICB General Practice Website](#).

New local change management support to General Practice

Practices in scope for support:

The **initial focus** of the change support offer is a subset of practices where the change team have identified need by taking a data driven approach.

- Support will be tailored to each practice and includes practical change management, quality improvement expertise and opportunities for peer learning
- Initially, support will focus on practices that need the most help in these areas, alongside a universal offer available to all practices
- Support will be delivered through a single, joined up offer, building on the valuable work previously delivered by a range of partners across NCL - many of whom continue to be involved in the new programme
- Access support will also consider vulnerable patient groups who may be digitally excluded

The service will iterate and consider other data over time - the team will evolve this process over the duration of the support offer to consider other data sets that might be helpful

- 15-20% of capacity will be open to **any practice who request support**



Conclusion

Conclusion

In this report, alongside regular headline reporting, we include a new headline to be monitored – the new contractual requirements that came into affect on 1st October.

The report provides a view of how mode of appointments in NCL general practice is changing and how contact activity (demand on general practice) is increasing. We also report on patients' perception of their practice and access to their practice is moving in a positive direction.

We focused on the previous and current GP change support service offers in NCL. Providing information on how practices have been supported to move to a modern general practice operating model and how this service has changed to pull together various support offers into one combined service.

The Committee is asked to:

- COMMENT on the data presented in this report
- NOTE the support provided to general practice through the ICB commissioned GP change support services – past and present

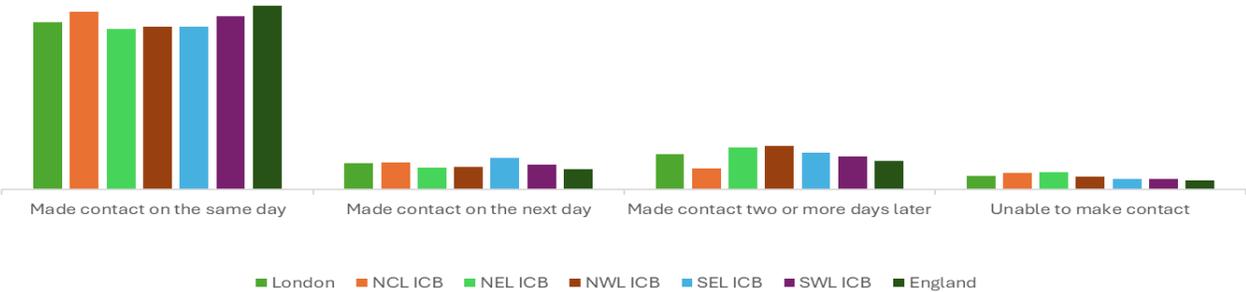


Appendix 1: ONS Health Insights Survey (HIS)

GPP-004a: Percentage who were successful or unsuccessful in making contact with their GP practice in the last 28 days

Wave 18 (11/11/25 – 03/12/25): NCL, London ICBs, Region, National

GPP-004a	London	NCL ICB	NEL ICB	NWL ICB	SEL ICB	SWL ICB	England
weighted results (% of responses)							
Made contact on the same day	69.2	73.4	66.2	67.2	67.3	71.6	75.9
Made contact on the next day	10.8	11.1	9.1	9.4	13.2	10.4	8.4
Made contact two or more days later	14.6	8.6	17.4	18.1	15.2	13.6	11.8
Unable to make contact	5.5	6.9	7.3	5.3	4.3	4.4	3.9

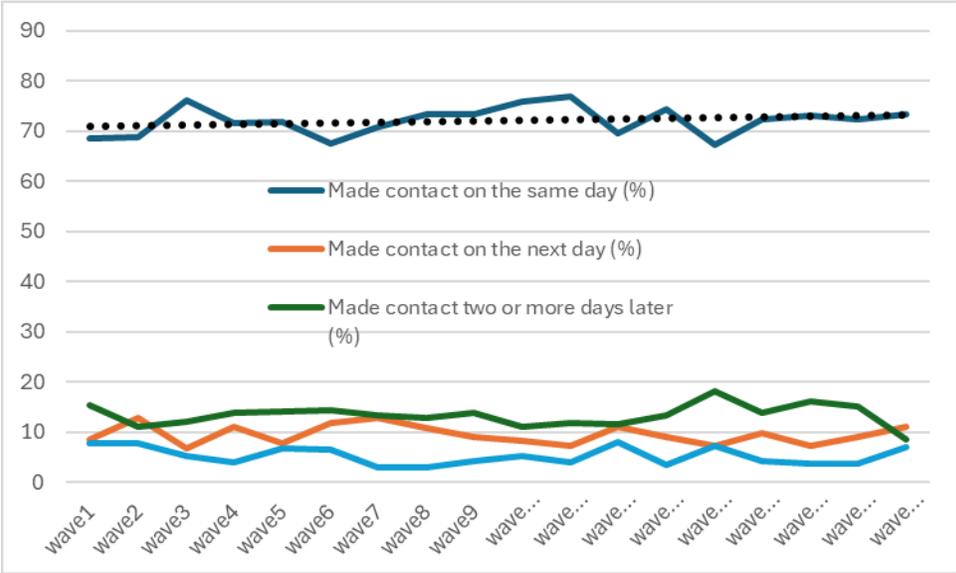


- In Wave 18 **NCL** continue to be **above the London average** for percentage of patients **successful at making contact with their GP practice on the same day**. We are now **2.5% below the England average** compared to 4.5% in wave 17.
- In Wave 18 **NCL** position has changed and is now **higher than both London and England average** for patients who were **unable to make contact with their practice**.

NCL Wave 18 - number of responses

Total	2,099
Q 4a	984

Wave 1 to 18: NCL



- There is some fluctuation wave on wave – however it can be seen from the trendline that those who have responded as ‘**made contact on the same day**’ has remained **stable**.

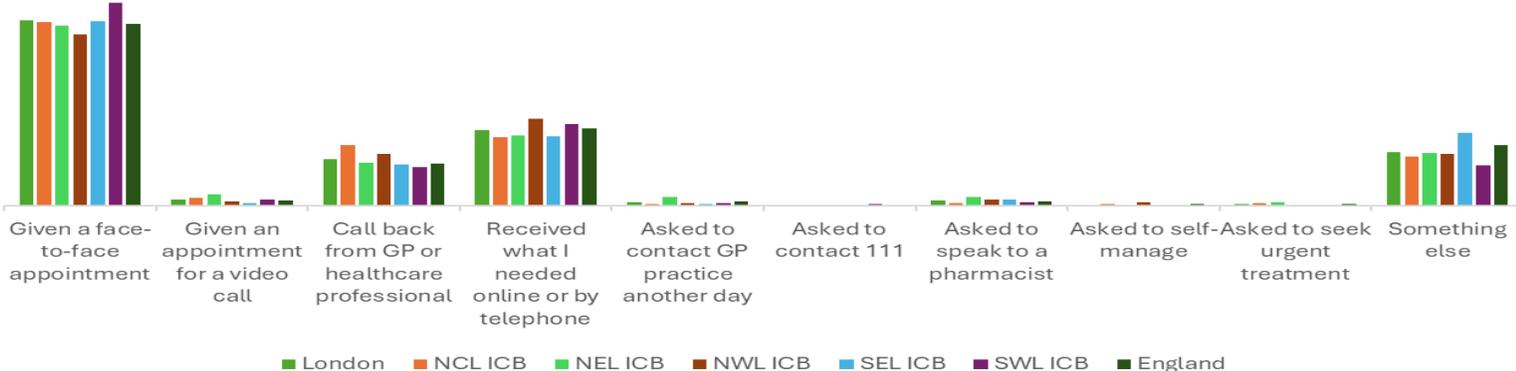
GPP-009-2: Thinking of the last time you made contact with your GP practice, what did you understand the next step would be? And What did your GP practice ask you to do?

NCL-Wave-18--number-of-responses

Total	2,099
Q.9-2	947

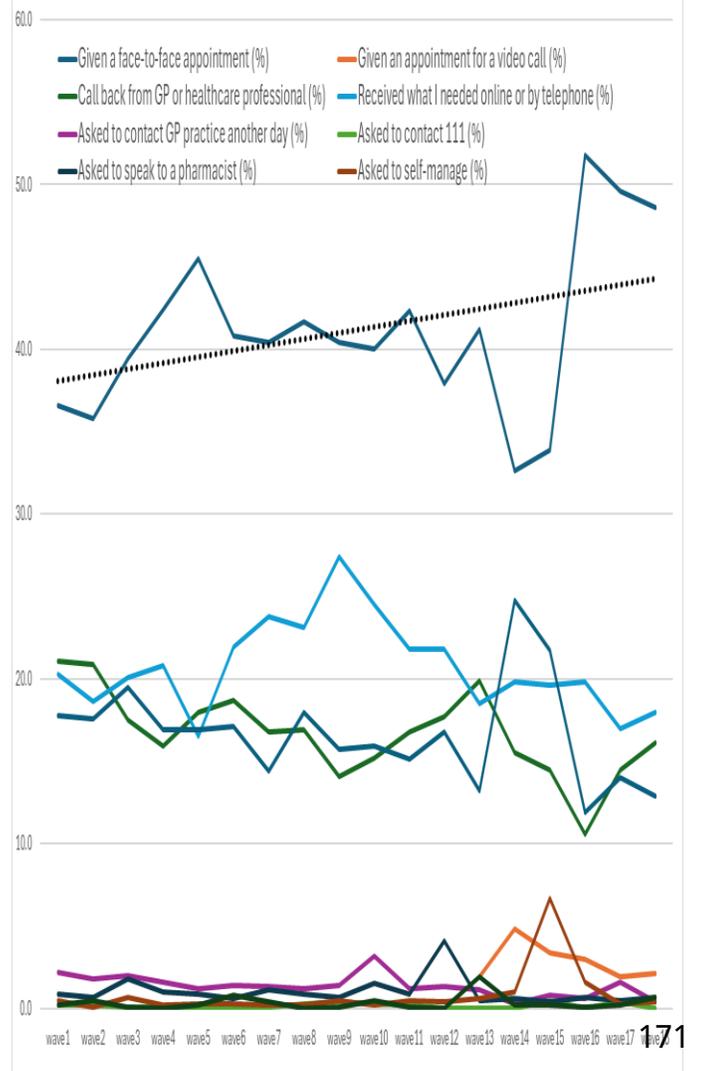
Wave 18 (11/11/25 – 03/12/25): NCL, London ICBs, Region, National

GPP-009-2	London	NCL ICB	NEL ICB	NWL ICB	SEL ICB	SWL ICB	England
weighted results (% of responses)							
Given a face-to-face appointment	49.0	48.6	47.6	45.2	48.8	53.7	48.0
Given an appointment for a video call	1.6	2.1	3.0	1.1	0.6	1.7	1.3
Call back from GP or healthcare professional	12.2	16.1	11.4	13.7	10.8	10.2	11.0
Received what I needed online or by telephone	19.9	18.0	18.6	23.0	18.3	21.5	20.3
Asked to contact GP practice another day	0.8	0.4	2.2	0.6	0.4	0.7	1.1
Asked to contact 111	0.1	0.0	0.1	0.2	0.0	0.4	0.3
Asked to speak to a pharmacist	1.3	0.7	2.2	1.5	1.6	0.9	1.2
Asked to self-manage	0.3	0.4	0.1	1.0	0.0	0.0	0.4
Asked to seek urgent treatment	0.4	0.7	0.8	0.1	0.2	0.1	0.4
Something else	14.2	12.9	14.0	13.6	19.2	10.7	16.0



- According to patients that responded to this question in NCL **48.6%** of patients understood their **next step to be 'given a face to face appointment'** remains **similar to both London (49%) and national averages (48%)** increasing from the previous wave. An overall increasing trend can be seen across time in the response for NCL as shown in the trendline on the graph.
- Percentage increase in patients 'asked to self manage' continues to be consistent with both London and national average. We will continue to monitor this in a bid to have greater understanding as to whether any trend analysis can be interpreted.

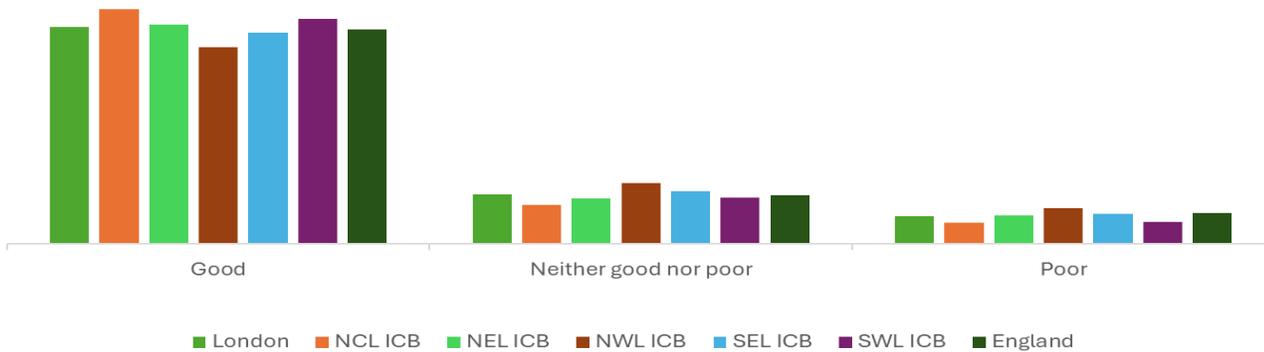
Wave 1 to 18: NCL



GPP-014a: Perception of overall experience of GP practice, for those who tried to contact their GP practice in the last 28 days

Wave 18 (11/11/25 – 03/12/25): NCL, London ICBs, Region, National

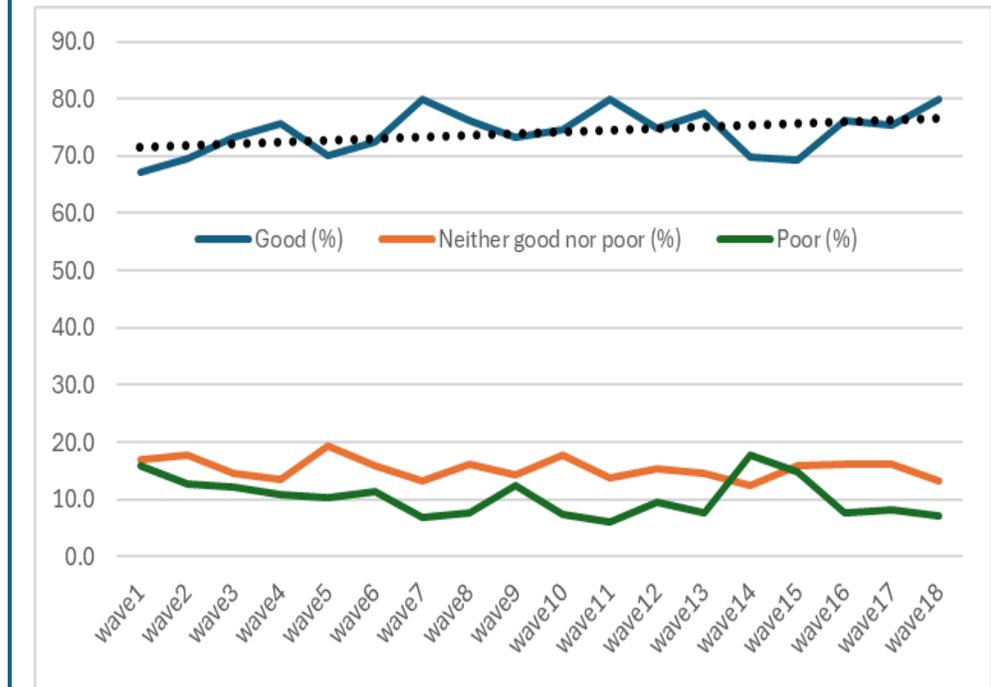
GPP-014a	London	NCL ICB	NEL ICB	NWL ICB	SEL ICB	SWL ICB	England
	weighted results (% of responses)						
Good	73.9	79.8	74.6	67.0	71.8	76.7	72.9
Neither good nor poor	16.8	13.2	15.6	20.8	18.0	15.9	16.6
Poor	9.3	7.1	9.8	12.2	10.2	7.4	10.5



- The percentage of patients that rated their perception of **overall experience of contacting** their GP practice as **'good'** is now the **highest in London** in wave 18 and is **higher than both London and national averages**.
- The percentage of patients that rated their perception of **overall experience of contacting** their GP practice as **'poor'** is again the **lowest in London** in Wave 18 and this is **lower than the national average**.

NCL-Wave-18--number-of-responses	
Total	2,099
Q-14a	984

Wave 1 to 18: NCL

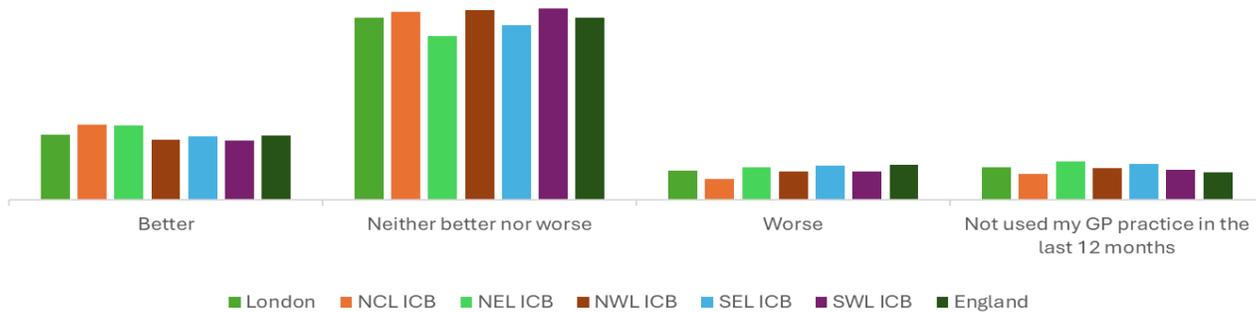


- When we look at the responses over time, we can see that there is a slow and stable trend of improvement continues for those patients rating their perception of **overall experience of contacting** their GP practice as **'good'** from Wave 1 to Wave 18.

GPP-0016-2: Over the last 12 months, how do you think the service provided by your GP practice has changed?

Wave 18 (11/11/25 – 03/12/25): NCL, London ICBs, Region, National

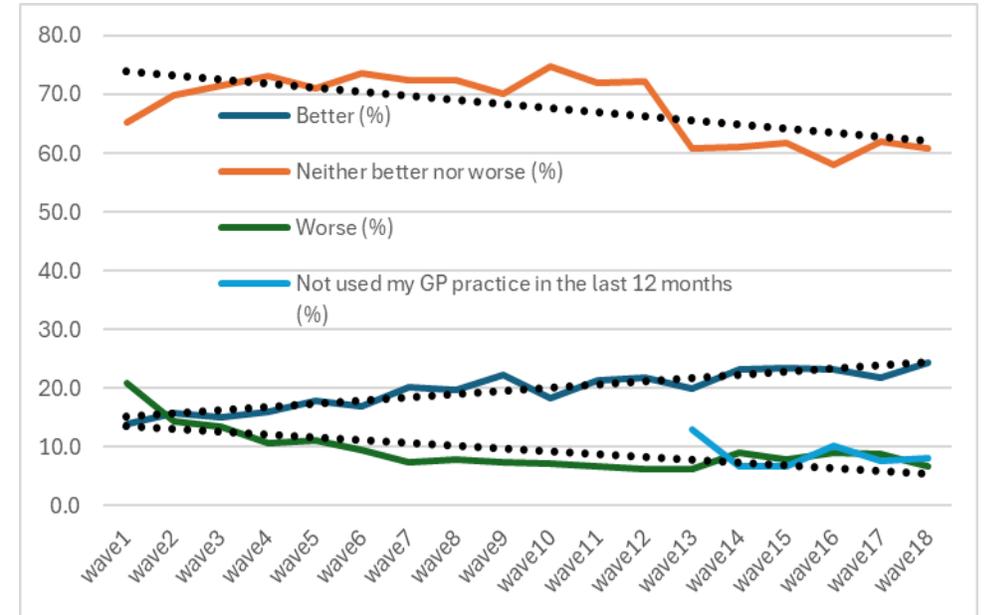
GPP-016-2	London	NCL ICB	NEL ICB	NWL ICB	SEL ICB	SWL ICB	England
weighted results (% of responses)							
Better	21.2	24.3	24.0	19.5	20.6	19.1	20.7
Neither better nor worse	58.9	60.8	53.0	61.4	56.6	62.1	59.0
Worse	9.5	6.7	10.6	9.1	11.1	9.1	11.3
Not used my GP practice in the last 12 months	10.5	8.2	12.4	10.1	11.7	9.7	9.0



- Responses from NCL patients rating their practice as **'better'** in response to the question **'Over the last 12 months, how do you think the service provided by your GP practice has changed?'** is the **highest in London** and continues to be **higher than both the national and London averages**
- Responses from NCL patients rating their practice as **'worse'** in response to the question **'Over the last 12 months, how do you think the service provided by your GP practice has changed?'** continues to **be lower than the national, London and all other London ICB averages**

NCL-Wave-18--number-of-responses	
Total	2,099
Q.16-2	2,099

Wave 1 to 18: NCL

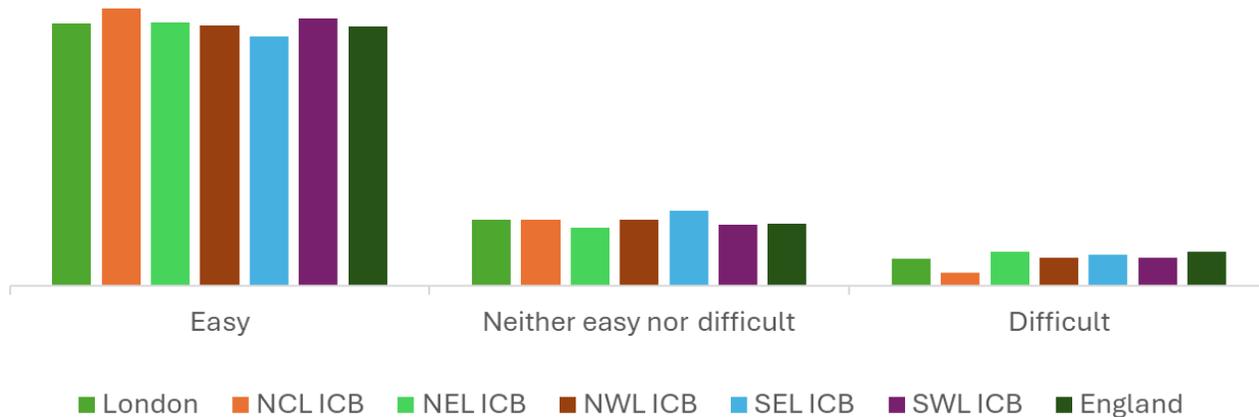


- There has been a **consistent reduction** in patients rating their practice as **'neither better nor worse'** than it was 12 months ago. This is directly related to the new question where patients chose to answer 'not used my GP in the last 12 months'.
- Patients rating their practice as **'worse'** than it was 12 months ago has seen an overall trend of a **slow and steady reduction**.
- The total patients selecting these options has **reduced** from **70.6%** in **wave 17** to **67.5%** in **wave 18**
- Patients rating the practice as **'better'** than it was 12 months ago continues a stable but **slow increase**.

GPP-06a-2: GPP-006-2a | How easy or difficult was it to make contact with your GP practice? (All contact methods)

Wave 18 (11/11/25 – 03/12/25): NCL, London ICBs, Region, National

GPP-006-2a	London	NCL ICB	NEL ICB	NWL ICB	SEL ICB	SWL ICB	England
	weighted results (% of responses)						
Easy	74.0	78.0	74.3	73.4	70.1	75.2	73.1
Neither easy nor difficult	18.5	18.5	16.3	18.7	21.2	17.2	17.4
Difficult	7.5	3.5	9.4	7.9	8.7	7.7	9.5

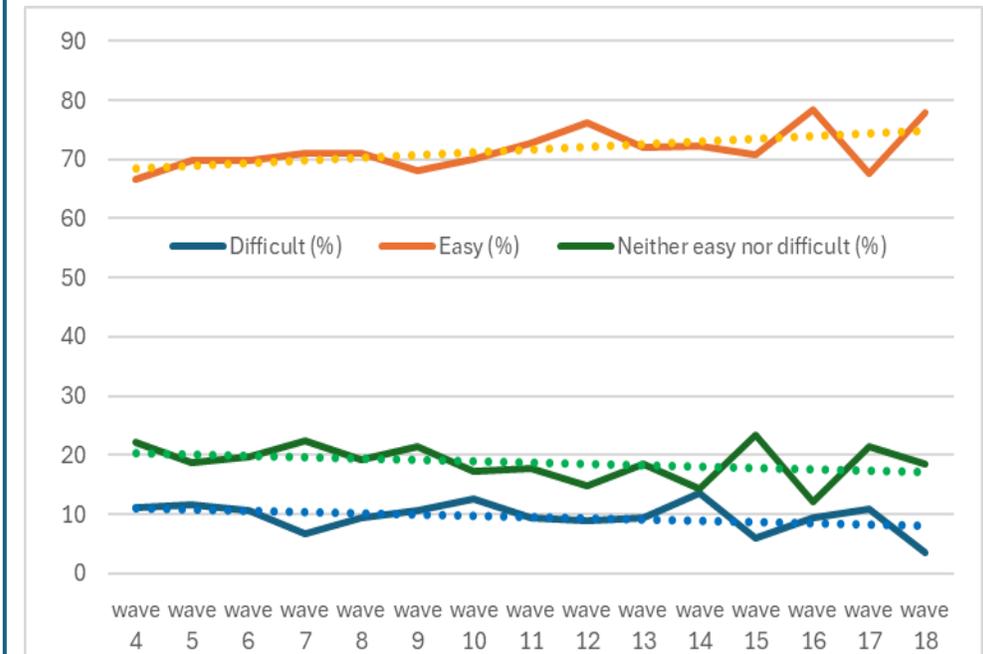


- The percentage of patients that had **'difficulty'** contacting their GP practice is now the **lowest in London** in wave 18 and is **lower than both London and national averages**.
- The percentage of patients that found contacting their GP practice **'easy'** is now the **highest in London** in Wave 18 and is also **higher than the national average**.

NCL-Wave-18--number-of-responses

Total	2,099
Q-6a-2-(All)	945

Wave 1 to 18: NCL



- When we look at the responses over time, we can see that from the trend lines for Wave 4 to Wave 18, **'Easy'** to make contact has shown a **slow steady increase** whereas **'Difficult'** and **'Neither easy nor difficult'** to make contact has shown a **very gradual decrease**.

GPP-06a-2: GPP-006-2a | How easy or difficult was it to make contact with your GP practice? (In Person)

Wave 18 (11/11/25 – 03/12/25): NCL, London ICBs, Region, National

GPP-006-2a	London	NCL ICB	NEL ICB	NWL ICB	SEL ICB	SWL ICB	England
weighted results (% of responses)							
Easy	74.8	75.1	75.7	69.7	77.6	76.1	76.2
Neither easy nor difficult	19.3	20.6	19.9	21.5	13.8	21.0	16.2
Difficult	5.9	4.3	4.4	8.8	8.6	3.0	7.6

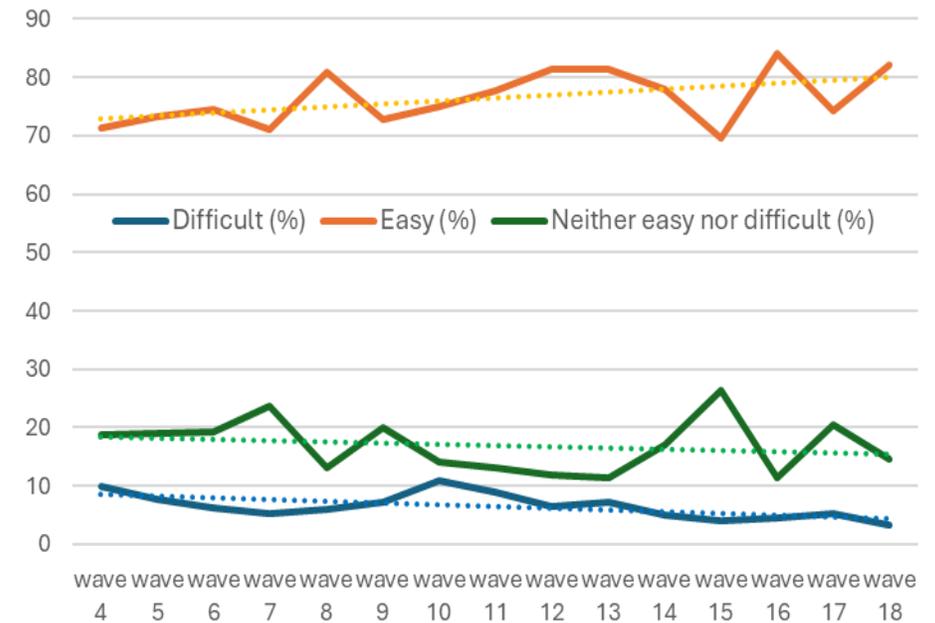


■ London ■ NCL ICB ■ NEL ICB ■ NWL ICB ■ SEL ICB ■ SWL ICB ■ England

- The percentage of patients that had **'difficulty'** contacting their GP practice in person is **amongst the lowest in London** in wave 18 and is **lower than both London and national averages**.
- The percentage of patients that found contacting their GP practice in person is **in line with both London and national averages**.

NCL-Wave-18--number-of-responses	
Total	2,099
Q-6a-2.(In-person)	143

Wave 1 to 18: NCL

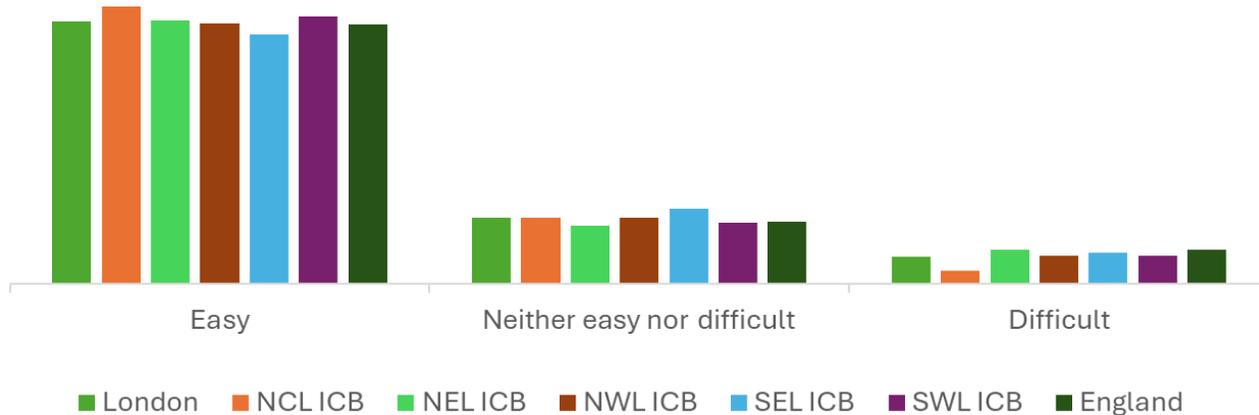


- When we look at the responses over time, we can see that from the trend lines for Wave 4 to Wave 18, **'Easy'** and **'Neither easy nor difficult'** to make contact has shown a **slow steady increase** whereas **'Difficult'** to make contact has shown a **very gradual decrease**.

GPP-06a-2: GPP-006-2a | How easy or difficult was it to make contact with your GP practice? (Telephone)

Wave 18 (11/11/25 – 03/12/25): NCL, London ICBs, Region, National

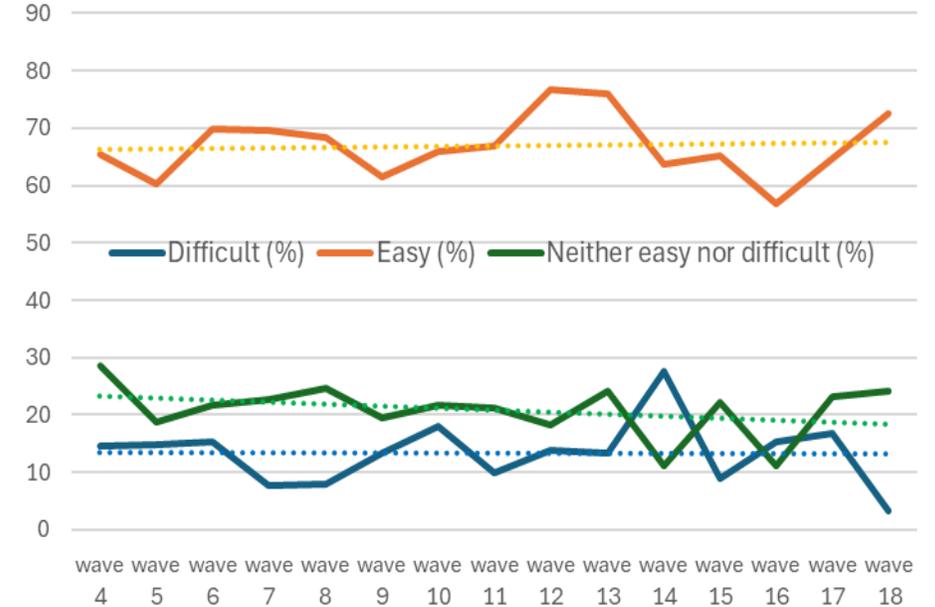
GPP-006-2a	London	NCL ICB	NEL ICB	NWL ICB	SEL ICB	SWL ICB	England
weighted results (% of responses)							
Easy	74.0	78.0	74.3	73.4	70.1	75.2	73.1
Neither easy nor difficult	18.5	18.5	16.3	18.7	21.2	17.2	17.4
Difficult	7.5	3.5	9.4	7.9	8.7	7.7	9.5



- The percentage of patients that had **'difficulty'** contacting their GP practice is now the **lowest in London** in wave 18 and is **lower than both London and national averages**.
- The percentage of patients that found contacting their GP practice **'easy'** is now the **highest in London** in Wave 18 and is also **higher than the national average**.

NCL-Wave-18--number-of-responses	
Total	2,099
Q-6a-2-(Telephone)	335

Wave 1 to 18: NCL

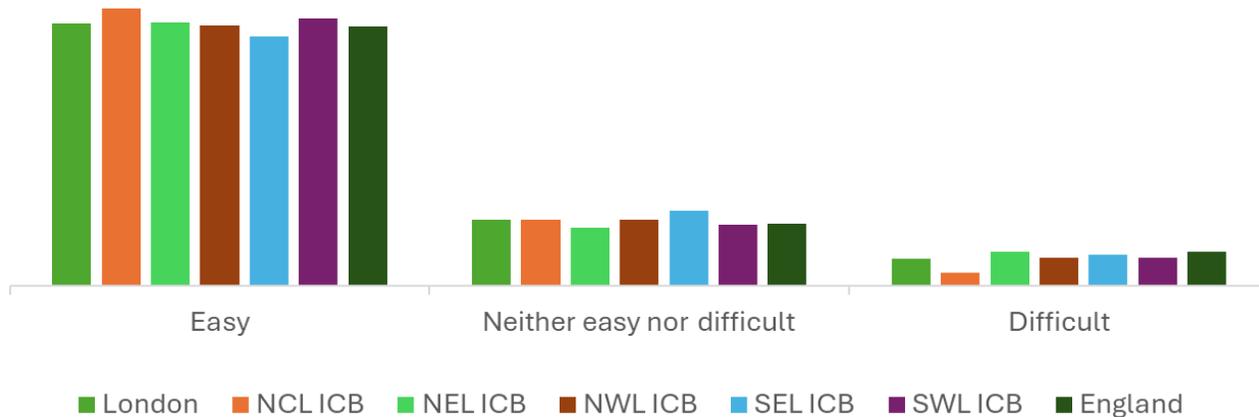


- When we look at the responses over time, we can see that from the trend lines for Wave 4 to Wave 18, **'Easy'** to make contact on telephone has shown a **slow steady increase** whereas **'Difficult'** and **'Neither easy nor difficult'** to make contact on telephone has shown a **very gradual decrease**.

GPP-06a-2: GPP-006-2a | How easy or difficult was it to make contact with your GP practice? (Other)

Wave 18 (11/11/25 – 03/12/25): NCL, London ICBs, Region, National

GPP-006-2a	London	NCL ICB	NEL ICB	NWL ICB	SEL ICB	SWL ICB	England
weighted results (% of responses)							
Easy	74.0	78.0	74.3	73.4	70.1	75.2	73.1
Neither easy nor difficult	18.5	18.5	16.3	18.7	21.2	17.2	17.4
Difficult	7.5	3.5	9.4	7.9	8.7	7.7	9.5

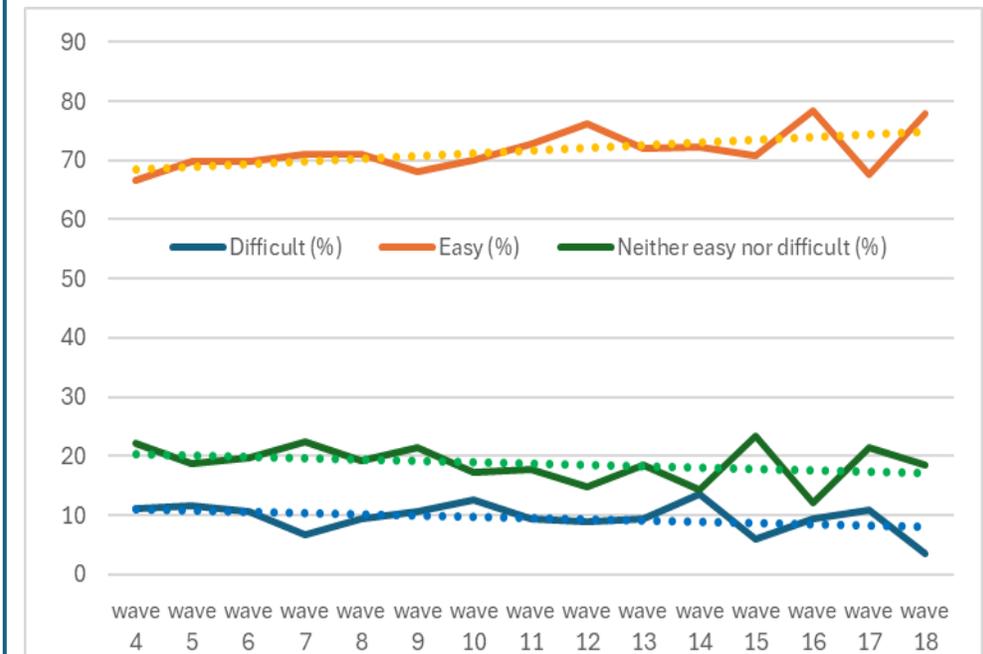


- The percentage of patients that had **'difficulty'** contacting their GP practice is now the **lowest in London** in wave 18 and is **lower than both London and national averages**.
- The percentage of patients that found contacting their GP practice **'easy'** is now the **highest in London** in Wave 18 and is also **higher than the national average**.

NCL-Wave-18--number-of-responses

Total	2,099
Q-6a-2-(Other)	28

Wave 1 to 18: NCL

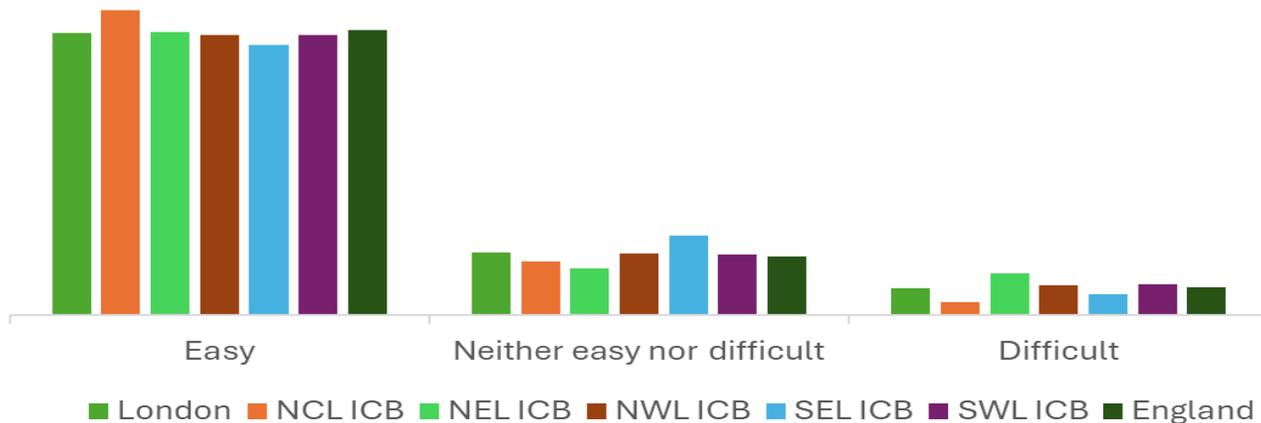


- When we look at the responses over time, we can see that from the trend lines for Wave 4 to Wave 18, **'Easy'** to make contact has shown a **slow steady increase** whereas **'Difficult'** and **'Neither easy nor difficult'** to make contact has shown a **very gradual decrease**.

GPP-06a-2: GPP-006-2a | How easy or difficult was it to make contact with your GP practice? (Online)

Wave 18 (11/11/25 – 03/12/25): NCL, London ICBs, Region, National

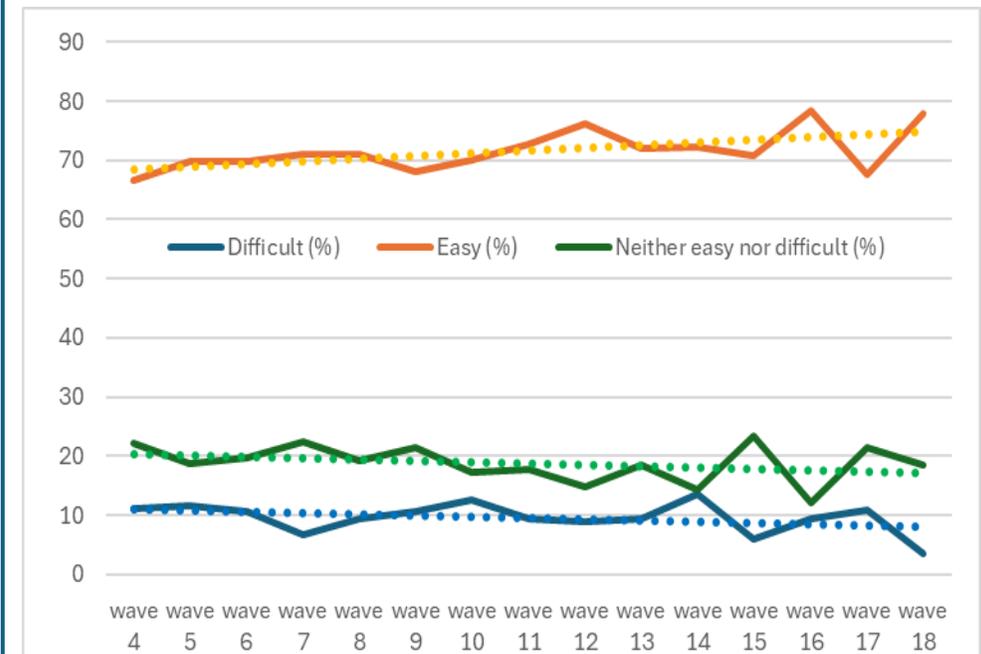
GPP-006-2a	London	NCL ICB	NEL ICB	NWL ICB	SEL ICB	SWL ICB	England
	weighted results (% of responses)						
Easy	76.1	82.2	76.4	75.6	72.9	75.5	76.8
Neither easy nor difficult	16.8	14.5	12.5	16.5	21.4	16.4	15.8
Difficult	7.1	3.3	11.2	7.9	5.6	8.2	7.4



- The percentage of patients that had '**difficulty**' contacting their GP practice online is now the **lowest in London** in wave 18 and is **lower than both London and national averages**.
- The percentage of patients that found contacting their GP practice online '**easy**' is now the **highest in London** in Wave 18 and is also **higher than the national average**.

NCL-Wave-18--number-of-responses	
Total	2,099
Q-6a-2-(Online)	439

Wave 1 to 18: NCL



- When we look at the responses over time, we can see that from the trend lines for Wave 4 to Wave 18, '**Easy**' to make contact online has shown a **slow steady increase** whereas '**Difficult**' and '**Neither easy nor difficult**' to make contact online has shown a **very gradual decrease**.

GPP-06a-2: GPP-006-2a | How easy or difficult was it to make contact with your GP practice? (Online – GP website)

Wave 18 (11/11/25 – 03/12/25): NCL, London ICBs, Region, National

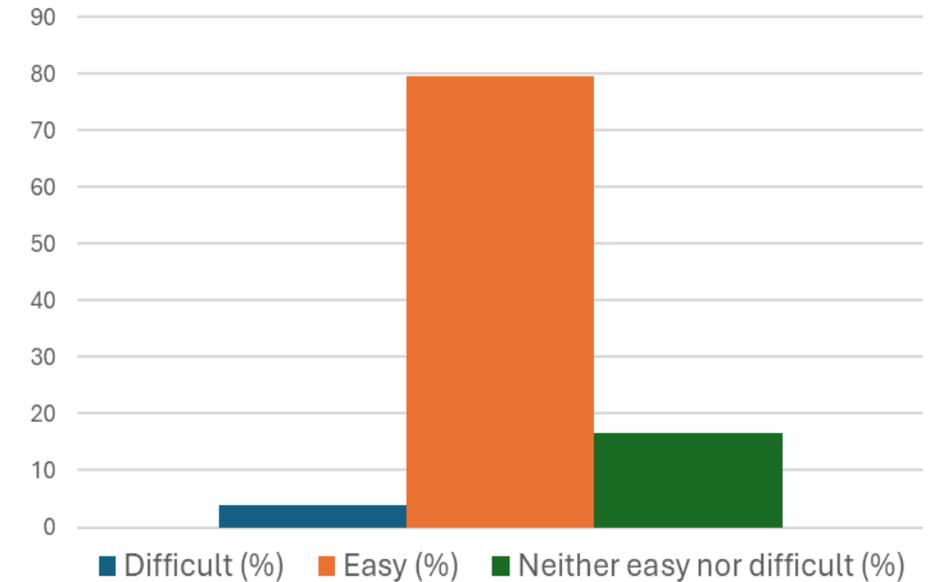
GPP-006-2a	London	NCL ICB	NEL ICB	NWL ICB	SEL ICB	SWL ICB	England
	weighted results (% of responses)						
Easy	73.4	79.5	71.6	75.5	71.3	70.5	73.6
Neither easy nor difficult	18.7	16.7	17.8	16.5	22.0	19.1	17.3
Difficult	7.8	3.9	10.6	8.0	6.7	10.5	9.1



- This is new sub-category for the option online which has now been further broken down to NHS App and GP Website The percentage of patients that had **'difficulty'** contacting their GP practice via their GP Website is the **lowest in London** in wave 18 and is **lower than both London and national averages**.
- The percentage of patients that found contacting their GP practice via the NHS App **'easy'** is the **highest in London** and also **higher than the London and national averages**.
- **These response are for Wave 18 only**

NCL-Wave-18--number-of-responses ^a	
Total ^a	2,099 ^a
Q-6a-2-(Online--GP-Website) ^a	286 ^a

Wave 1 to 18: NCL

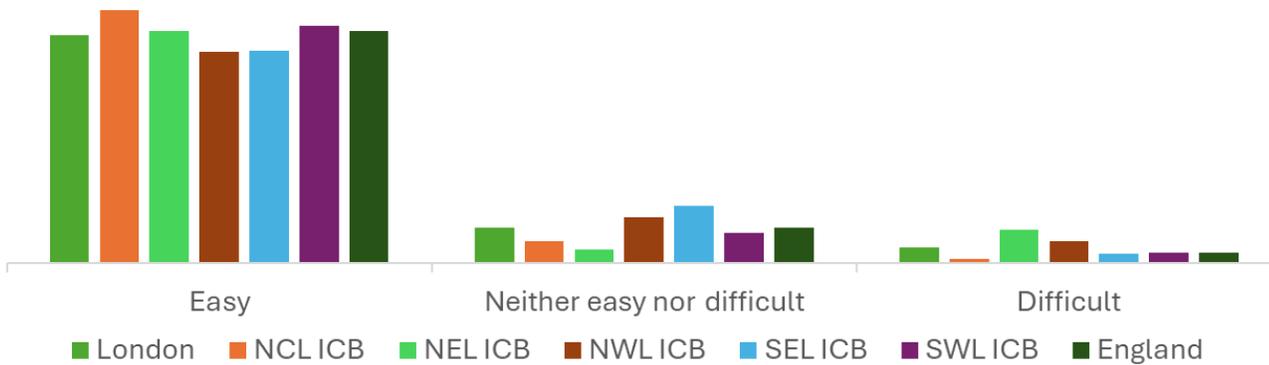


- As this is the first occasion for the NHS App response to be recorded as a separate response, no trends can be identified.
- However, wave 18 demonstrates that **only 3.9%** of those who responded found contacting via their GP Website **difficult**. 179

GPP-06a-2: GPP-006-2a | How easy or difficult was it to make contact with your GP practice? (Online – NHS App)

Wave 18 (11/11/25 – 03/12/25): NCL, London ICBs, Region, National

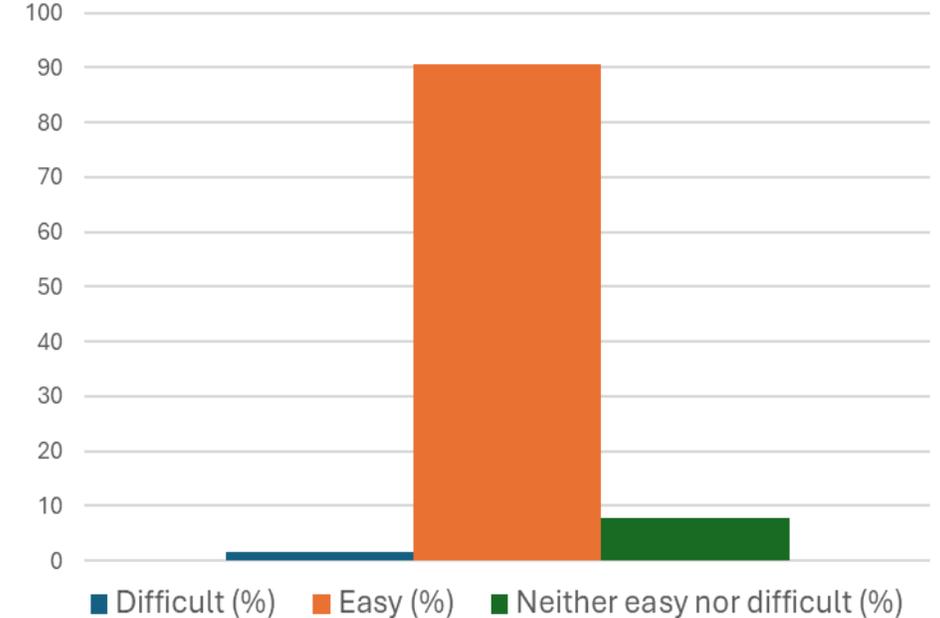
GPP-006-2a	London	NCL ICB	NEL ICB	NWL ICB	SEL ICB	SWL ICB	England
	weighted results (% of responses)						
Easy	81.6	90.5	83.3	75.8	76.0	85.1	83.3
Neither easy nor difficult	12.8	7.9	4.8	16.4	20.5	11.1	12.8
Difficult	5.6	1.6	11.9	7.8	3.6	3.8	3.9



- This is new sub-category for the option online which has now been further broken down to NHS App and GP Website The percentage of patients that had '**difficulty**' contacting their GP practice via the NHS App is the **lowest in London** in wave 18 and is **lower than both London and national averages**.
- The percentage of patients that found contacting their GP practice via the NHS App '**easy**' is the **highest in London** and also **higher than the London and national averages**.
- **These response are for Wave 18 only**

NCL-Wave-18--number-of-responses	
Total	2,099
Q-6a-2-(Online--NHS-App)	153

Wave 1 to 18: NCL



- As this is the first occasion for the NHS App response to be recorded as a separate response, no trends can be identified.
- However, wave 18 demonstrates that **only 1.6%** of those who responded found contacting via the NHS App **difficult**.

Health Insight Survey

The Health Insight Survey (HIS) is commissioned by NHS England and aims to understand participants' experience of their GP practice and other NHS services, including dental care and pharmacy services.

The ONS HIS data has been exported and manipulated to look at trends over time. Also comparing NCL responses to both London and England responses. It is important to note that from wave 13, covering the period 24/6/25 – 16/7/25 there were significant changes with introduction of new questions and removal/change of existing questions has taken place, including two of the access questions used in this report. In addition, Question 007 has been removed due to a low response rate, where no findings or trends are determinable.

Key Access questions in the ONS HIS:

- 004a: Percentage who were successful or unsuccessful in making contact with their GP practice in the last 28 days (illustrative of a move to modern general practice: optimising contact channels)
- **009-2: Thinking of the last time you made contact with your GP practice, what did you understand the next step would be? And What did your GP practice ask you to do?** (this is a development of the previous question)
- 014a: Perception of overall experience of GP practice, for those who tried to contact their GP practice in the last 28 days (illustrative of a move to modern general practice: Increased overall satisfaction with access to general practice)
- **016-2: Over the last 12 months, how do you think the service provided by your GP practice has changed?** (this is a development of the previous question)

New options for answers were also added to questions 009 & 016 in Wave 13.

- **009-2:** additional response option "Given an appointment for a video call"
- **016-2:** additional response option "Not used my GP in the last 12 months"

Wave	Data Collection Period
wave1	23/07/24 to 14/08/24
wave2	20/08/24 to 11/09/24
wave3	17/09/24 to 09/10/24
wave4	15/10/24 to 06/11/24
wave5	12/11/24 to 04/12/24
wave6	10/12/24 to 01/01/25
wave7	07/01/25 to 29/01/25
wave8	04/02/25 to 26/02/25
wave9	04/03/25 to 26/03/25
wave10	01/04/25 to 23/04/25
wave11	29/04/25 to 21/05/25
wave12	27/05/25 to 18/06/25
wave13	24/06/25 to 16/07/25
wave14	22/07/25 to 13/08/25
wave15	19/08/25 to 10/09/25
wave16	16/09/25 to 08/10/25
wave17	14/10/25 to 05/11/25
wave18	11/11/25 to 03/12/25



Appendix 2: Deep Dive / Focus Topic list

Deep Dive/ Focus Topics: for future PCC meetings

A number of themes have been identified in PCC meetings in 2025, where a deeper look into available information and data is needed to improve our understanding. Alongside this, there have been new areas of focus in primary care due to national strategy and contract changes, where the ICB would welcome PCC scrutiny.

Listed are topics to be explored in the Q&P report in future meetings.

We must remain mindful that due to ICB changes, this list may need to be adapted.

Areas of focus	Proposed PCC Meeting Month	Completed
New GP Change Support contract and learning from last contract	February 2026	March 2026
Advice & Guidance and Referrals	tbc	
Access routes changing due to digital innovation and contractual changes (6 months of data in April 2026)	tbc	
Access and health inequalities	tbc	
Quality & Safety	tbc	
GP Staff Survey	June 2026	
GPPS (Annual Focus: following publication in June/July)	August/ October 2026	

The focus areas also include annual and routine updates such as the annual GPPS and periodic review of ONS Health Intelligence data.
 ONS Health Intelligence Survey (HIS): Focus update every 6 months – in appendix all other reports
 GPPS: Annual review



Appendix 3: Appointment versus Contact activity

Appointments versus Contact activity

Video conference/ online appointment:

- This is a scheduled appointment that takes place remotely, usually via a video digital platform or messaging service (Accurx etc)
- This appointment may be booked through online access (NHS App, website or other online system), telephone or by walking into the practice.
- The nature of the of the video conference/ online appointment is **synchronous** – real-time interaction between patient and clinician.

NB: The appointments that are recorded in this category will depend on the practice interpretation of the category.

For example, it may also include group webinar sessions.

Online consultation/ online access/ online contacts:

- This is when a patient submits a query or request through a digital platform (e.g., eConsult, PATCHS, NHS App, Anima).
- The nature of this is **asynchronous** – the patient fills out a form or message, and the practice reviews it later.
- The purpose of these online consultations or online access is triage, admin tasks, clinical queries, prescription requests.
- The practice decides next steps (e.g., reply via message, phone call, or book an appointment).

This is the data that we will monitor to ensure that practices fulfil the new online consultation contractual requirement that online consultations must be available throughout core hours (8:00am - 6:30pm, weekdays excl. holidays) with no caps or restrictions. Where non-urgent appointment requests, medication queries, and admin requests should be accessible via Online Consultation tools.



Appendix 4: Online Consultation Contractual Compliance

October Q&P Headlines: Monitoring the new contractual requirements (from 01/10/2025)

From 1 October 2025, practices were required to comply with 3 contractual requirements:

- Online consultations (OC) must be available throughout core hours (8:00am - 6:30pm, weekdays excl. holidays) with no caps or restrictions. Non-urgent appointment requests, medication queries, and admin requests should be accessible via OC tools.
- Ensure GP Connect allows:
 - a. read only access to patients' care records (GP Connect Access Record HTML and Structured) by other NHS commissioned providers for the purposes of direct patient care,
 - b. Community Pharmacy registered professionals to send consultation summaries into the GP practice workflow (GP Connect Update Record).
- Publish the NHS England patient charter, You and your general practice on the practice website

There is a clear national and regional expectation that ICBs are proactively monitoring compliance with all contract requirements, supporting practices and taking enforcement action where appropriate.

We are working on our approach to monitoring and reporting on practice compliance to the new requirements and looking to agree a consistent approach with other London ICBs. We will ensure the process is supportive of practices and reflective of the strong relationship we have built with practices over time.



**North Central London ICB
Primary Care Committee Meeting **Low risk paper**
Virtual Decision**

Report Title	Commissioning Decisions on PMS Agreement Changes	Date of report	20 February 2026	Agenda Item	
Lead Director / Manager	Sarah McDonnell-Davies, Chief Transformation Officer	Email / Tel		Sarah.mcdonnell1@nhs.net	
GB Member Sponsor	Sarah McDonnell-Davies, Chief Transformation Officer				
Report Author	GP Commissioning & Contracting Team	Email / Tel		nclicb.nclprimarycare@nhs.net	
Name of Authorising Finance Lead	Not applicable	Summary of Financial Implications			
		Not applicable			
Name of Authorising Estates Lead	Not applicable	Summary of Estates 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 APPROVE the proposed changes outlined below and any conditions.				
Identified Risks & 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 & Key Decisions	Not applicable				
Next Steps	Issue appropriate variations with conditions where applicable				
Appendices	Not applicable				

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 practice¹ 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 01/01/2026	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																
F85004 Eagle House Surgery	Enfield	12341	Practice is a member of Enfield Unity PCN comprising: 10 practices with 161,280 patients at 01/01/26	Addition of Dr Imad Ahmed	<p>Application to add Dr Imad Ahmed to the PMS Agreement effective from 01/07/25.</p> <p>The changes will leave five contractors on the PMS Agreement.</p> <p><u>Practice provision (per week)</u></p> <table> <tr> <td>GP appointments</td> <td>949</td> </tr> <tr> <td>GP sessions</td> <td>65</td> </tr> <tr> <td>Nurse appointments</td> <td>400</td> </tr> <tr> <td>Nurse sessions</td> <td>42</td> </tr> </table> <p><u>Recommended provision (per week)</u></p> <table> <tr> <td>GP appointments</td> <td>896</td> </tr> <tr> <td>GP sessions</td> <td>48</td> </tr> <tr> <td>Nurse appointments</td> <td>399</td> </tr> <tr> <td>Nurse sessions</td> <td>21</td> </tr> </table> <p><u>Shortfall:</u> Provision of GP and nurse appointments meets requirements.</p> <p><u>Additional staff:</u> The practice also offers: 270 HCA appointments (30 sessions) 180 PA appointments (50 sessions) 80 Pharmacist appointments (8 sessions)</p> <p><u>GP Survey:</u> 63% describe their overall experience of this GP practice as good (ICS result: 73% National result: 75%)</p>	GP appointments	949	GP sessions	65	Nurse appointments	400	Nurse sessions	42	GP appointments	896	GP sessions	48	Nurse appointments	399	Nurse sessions	21	To approve
GP appointments	949																					
GP sessions	65																					
Nurse appointments	400																					
Nurse sessions	42																					
GP appointments	896																					
GP sessions	48																					
Nurse appointments	399																					
Nurse sessions	21																					

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					<p>39% were offered a choice of time or day when they last tried to make a general practice appointment (ICS result: 56% National result: 54%) 13% usually get to see or speak to their preferred healthcare professional when they would like to (ICS result: 38% National result: 40%)</p>																	
E83027 The Practice @ 188	Barnet	10828	Practice is a member of PCN 6 comprising: 9 practices with 67882 patients at 01/01/26	Addition of Ryan Bentley (non-clinical)	<p>Application to add Ryan Bentley (non-clinical) to the PMS Agreement effective from 05/12/25.</p> <p>The changes will leave two contractors on the PMS Agreement.</p> <p><u>Practice provision (per week)</u></p> <table> <tr> <td>GP appointments</td> <td>822</td> </tr> <tr> <td>GP sessions</td> <td>47</td> </tr> <tr> <td>Nurse appointments</td> <td>387</td> </tr> <tr> <td>Nurse sessions</td> <td>22</td> </tr> </table> <p><u>Recommended provision (per week)</u></p> <table> <tr> <td>GP appointments</td> <td>767</td> </tr> <tr> <td>GP sessions</td> <td>41</td> </tr> <tr> <td>Nurse appointments</td> <td>341</td> </tr> <tr> <td>Nurse sessions</td> <td>18</td> </tr> </table> <p><u>Shortfall:</u> Provision of GP and nurse appointments meets requirements.</p> <p><u>Additional staff:</u> The practice also offers: 150 HCA appointments (9 sessions) 120 PA appointments (10 sessions) 360 Pharmacist appointments (20 sessions) 64 MSK FCP appointments (6 sessions)</p>	GP appointments	822	GP sessions	47	Nurse appointments	387	Nurse sessions	22	GP appointments	767	GP sessions	41	Nurse appointments	341	Nurse sessions	18	To approve
GP appointments	822																					
GP sessions	47																					
Nurse appointments	387																					
Nurse sessions	22																					
GP appointments	767																					
GP sessions	41																					
Nurse appointments	341																					
Nurse sessions	18																					

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					<p><u>GP Survey:</u> 61% describe their overall experience of this GP practice as good (ICS result: 73% National result: 75%) 22% were offered a choice of time or day when they last tried to make a general practice appointment (ICS result: 56% National result: 54%) 27% usually get to see or speak to their preferred healthcare professional when they would like to (ICS result: 38% National result: 40%)</p>																	
F85002 Medicus Health Partners (MHP)	Enfield	94174	Practice is a member of Enfield Unity PCN comprising: 10 practices with 161280 patients at 01/01/26	24-hour retirement of Dr Gloria Okafor	<p>Application for the 24-hour retirement of Dr Gloria Okafor from the PMS Agreement effective from 22/02/26.</p> <p>The changes will leave thirty-two contractors on the PMS Agreement.</p> <p><u>Practice provision (per week)</u></p> <table> <tr> <td>GP appointments</td> <td>6832</td> </tr> <tr> <td>GP sessions</td> <td>379</td> </tr> <tr> <td>Nurse appointments</td> <td>2962</td> </tr> <tr> <td>Nurse sessions</td> <td>155</td> </tr> </table> <p><u>Recommended provision (per week)</u></p> <table> <tr> <td>GP appointments</td> <td>6781</td> </tr> <tr> <td>GP sessions</td> <td>357</td> </tr> <tr> <td>Nurse appointments</td> <td>3014</td> </tr> <tr> <td>Nurse sessions</td> <td>159</td> </tr> </table> <p><u>Shortfall:</u> There is a shortfall of 52 nurse appointments and 4 nurse sessions per week.</p> <p><u>Additional staff:</u> The practice also offers (per week): 142 HCA appointments 105 PA & ECP appointments 754 Pharmacist appointments</p>	GP appointments	6832	GP sessions	379	Nurse appointments	2962	Nurse sessions	155	GP appointments	6781	GP sessions	357	Nurse appointments	3014	Nurse sessions	159	To approve
GP appointments	6832																					
GP sessions	379																					
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Nurse sessions	155																					
GP appointments	6781																					
GP sessions	357																					
Nurse appointments	3014																					
Nurse sessions	159																					

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					<p><u>Practice have stated the following:</u> <i>We are currently recruiting for a nurse to fill this. In the meantime, some ECPs and Pharmacists are doing flu vaccinations so that nurses can concentrate on more complex patient requirements.</i></p> <p><u>GP Survey:</u> 59% describe their overall experience of this GP practice as good (ICS result: 73% National result: 75%) 48% were offered a choice of time or day when they last tried to make a general practice appointment (ICS result: 56% National result: 54%) 24% usually get to see or speak to their preferred healthcare professional when they would like to (ICS result: 38% National result: 40%)</p>	
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North Central London ICB
Primary Care Committee Meeting Low risk paper
Virtual Decision

Report Title	Andover Medical Centre -Direct Payments for premises reimbursable costs	Date of report	20 February 2026	Agenda Item	
Lead Director / Manager	Vanessa Piper, Assistant Director of Primary Care, Contracting	Email / Tel		vanessa.piper@nhs.net	
Board Member Sponsor	Sarah McDonnell-Davies, Chief Transformation Officer				
Report Author	Henry Claridge, Strategic Estate Lead	Email / Tel		henry.claridge@gbpconsult.co.uk	
Name of Authorising Finance Lead	Sarah Rothenberg, Deputy Director Finance Business Partnering – Primary Care	Summary of Financial Implications No financial implications. Existing premises reimbursable costs will be reimbursed via direct payments to the landlord.			
Name of Authorising Estates Lead	Not applicable.	Summary of Estates Implications Not applicable.			
Report Summary	<p>Andover Medical Centre (Islington) is a General Medical Services (GMS) practice. As of February 2026, the practice has a registered patient list of 6,712. In 2022, the Primary Care Committee (PCC) approved the relocation of Andover Medical Centre to Newington Barrow Way, which is an Islington Council owned facility .The practice is due to relocate in March 2026.</p> <p>Committee members are asked to approve the setup of Direct Payments to the London Borough of Islington (LBI), the landlord of Andover Medical Centre - for premises reimbursement costs.</p> <p>The NHS Premises Costs Directions 2024, for primary care premises, state Direct payments can be considered if the contractor and the ICB agrees.</p> <p>Andover Medical Centre has requested the set-up of direct payments. The contractor is aware they continue to be liable to pay LBI non-reimbursable costs. The contractor will be notified that by commencing direct payments, the ICB does not take on any liability for the lease held between Andover Medical Centre and LBI The practice will need to continue to meet its obligations under the lease terms and negotiate a new lease if it is due to expire.</p>				

Recommendation	Members of the Committee are asked to APPROVE the setup of Direct payments to LBI for Andover Medical Centre’s premises reimbursable costs.
Identified Risks and Risk Management Actions	The practice will be notified that the ICB would not become liable for the lease, non-reimbursable costs and the practice accounting with LBI for the reimbursable costs.
Conflicts of Interest	Not applicable.
Resource Implications	The practice will continue to be reimbursed under the existing agreed premises costs.
Engagement	Not applicable
Equality Impact Analysis	Not applicable – there is no change to service provision.
Report History and Key Decisions	Not applicable.
Next Steps	The practice will be notified of the following: <ol style="list-style-type: none"> 1. The commencement and method of direct payments to LBI. 2. Request the contract holders to sign a section 55 agreement which relates to the terms set out in the NHS Premises Costs Directions 2024.
Appendices	Not applicable.

Background

Andover Medical Centre has approached NCL ICB, to request if the ICB can consider paying the reimbursable costs via a Direct Payment to London Borough of Islington (LBI).

The reimbursable costs relate to the following:

- Lease Rent
- Non-Domestic Rates
- Water and sewage
- Clinical waste
- Management fee (related to the reimbursable costs only)

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

Directions 55 of the National Health Service (General Medical Services – Premises Costs) Directions 2024 states that:

- (1) Where a contractor and NHS England agree, NHS England 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 NHS England 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 NHS England as financial assistance under these Directions which are greater than or equal to the amount of the shortfall, where the contractor and NHS England agree, NHS England 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.

Responsibility for non-reimbursable costs

The ICB is not liable to pay the non-reimbursable costs. Therefore, once approved the contract holder will be notified that they will be required to continue to liaise with LBI to receive a copy of their annual statement, so they are aware of the non-reimbursable costs required to be paid to LBI.

Liability of the Lease and its terms

If PCC members agree to the process of direct payments, the contract holders will be notified that the ICB does not take on any liability for the lease held between the practice (tenant) and LBI (landlord).

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 LBI.

Under the lease terms the practice will be responsible for maintaining its own accounts and ensuring

the premises charges are settled by year end with LBI. Any irregularities in the payments for reimbursable costs the practice can then liaise with the ICB.

Next steps

If PCC members approve the commencement of direct payments, then the practice will be notified of the following:

1. The commencement and method of direct payments to LBI
2. Request the contract holders to sign a section 55 agreement which relates to the terms set out in the NHS Premises Costs Directions



North Central London ICB
Primary Care Committee Meeting Low risk paper
Virtual Decision

Report Title	Hendon Way Surgery - Direct Payments for premises reimbursable costs	Date of report	20 February 2026	Agenda Item	
Lead Director / Manager	Vanessa Piper, Assistant Director of Primary Care, Contracting	Email / Tel		vanessa.piper@nhs.net	
Board Member Sponsor	Sarah McDonnell-Davies, Chief Transformation Officer				
Report Author	Henry Claridge, Strategic Estate Lead	Email / Tel		henry.claridge@gbpconsult.co.uk	
Name of Authorising Finance Lead	Sarah Rothenberg, Deputy Director Finance Business Partnering – Primary Care	Summary of Financial Implications No financial implications. Existing premises reimbursable costs will be reimbursed via direct payments to the landlord.			
Name of Authorising Estates Lead	Not applicable.	Summary of Estates Implications Not applicable.			
Report Summary	<p>Hendon Way Surgery (Barnet) is a General Medical Services (GMS) practice. As of February 2026, the practice has a registered patient list of 9,535. In January 2026, the Primary Care Committee (PCC) approved the relocation of Hendon Way Surgery to a new facility, by the end of 2026/27, within the West Hendon Broadway development.</p> <p>Committee members are asked to approve the setup of Direct Payments to the Central London Community Healthcare NHS Trust (CLCH), the landlord of Hendon Way Surgery - for premises reimbursement costs.</p> <p>The NHS Premises Costs Directions 2024, for primary care premises, state Direct payments can be considered if the contractor and the ICB agrees.</p> <p>Hendon Way Surgery has requested the set-up of direct payments. The contractor is aware they continue to be liable to pay CLCH non-reimbursable costs. The contractor will be notified that by commencing direct payments, the ICB does not take on any liability for the lease held between Hendon Way Surgery and CLCH. The practice will need to continue to meet its obligations under the lease terms and negotiate a new lease if it is due to expire.</p>				

Recommendation	Members of the Committee are asked to APPROVE the setup of Direct payments to CLCH for Hendon Way Surgery's premises reimbursable costs.
Identified Risks and Risk Management Actions	The practice will be notified that the ICB would not become liable for the lease, non-reimbursable costs and the practice accounting with CLCH for the reimbursable costs.
Conflicts of Interest	Not applicable.
Resource Implications	The practice will continue to be reimbursed under the existing agreed premises costs.
Engagement	Not applicable
Equality Impact Analysis	Not applicable – there is no change to service provision.
Report History and Key Decisions	Not applicable.
Next Steps	The practice will be notified of the following: <ol style="list-style-type: none"> 1. The commencement and method of direct payments to CLCH. 2. Request the contract holders to sign a section 55 agreement which relates to the terms set out in the NHS Premises Costs Directions 2024.
Appendices	Not applicable.

Background

Hendon Way Surgery has approached NCL ICB, to request if the ICB can consider paying the reimbursable costs via a Direct Payment to Central London Community Healthcare NHS Trust (CLCH).

The reimbursable costs relate to the following:

- Lease Rent
- Non-Domestic Rates
- Water and sewage
- Clinical waste
- Management fee (related to the reimbursable costs only)

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

Directions 55 of the National Health Service (General Medical Services – Premises Costs) Directions 2024 states that:

- (1) Where a contractor and NHS England agree, NHS England 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 NHS England 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 NHS England as financial assistance under these Directions which are greater than or equal to the amount of the shortfall, where the contractor and NHS England agree, NHS England 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.

Responsibility for non-reimbursable costs

The ICB is not liable to pay the non-reimbursable costs. Therefore, once approved the contract holder will be notified that they will be required to continue to liaise with CLCH to receive a copy of their annual statement, so they are aware of the non-reimbursable costs required to be paid to CLCH.

Liability of the Lease and its terms

If PCC members agree to the process of direct payments, the contract holders will be notified that the ICB does not take on any liability for the lease held between the practice (tenant) and CLCH (landlord).

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 CLCH.

Under the lease terms the practice will be responsible for maintaining its own accounts and ensuring the premises charges are settled by year end with CLCH. Any irregularities in the payments for reimbursable costs the practice can then liaise with the ICB.

Next steps

If PCC members approve the commencement of direct payments, then the practice will be notified of the following:

1. The commencement and method of direct payments to CLCH
2. Request the contract holders to sign a section 55 agreement which relates to the terms set out in the NHS Premises Costs Directions



North Central London ICB
Primary Care Committee Meeting Low risk paper
Virtual Decision

Report Title	The Miller Practice - Direct Payments for premises reimbursable costs	Date of report	20 February 2026	Agenda Item	
Lead Director / Manager	Vanessa Piper, Assistant Director of Primary Care, Contracting	Email / Tel	vanessa.piper@nhs.net		
Board Member Sponsor	Sarah McDonnell-Davies, Chief Transformation Officer				
Report Author	Henry Claridge, Strategic Estate Lead	Email / Tel	henry.claridge@gbpconsult.co.uk		
Name of Authorising Finance Lead	Sarah Rothenberg, Deputy Director Finance Business Partnering – Primary Care	Summary of Financial Implications No financial implications. Existing premises reimbursable costs will be reimbursed via direct payments to the landlord.			
Name of Authorising Estates Lead	Not applicable.	Summary of Estates Implications Not applicable.			
Report Summary	<p>The Miller Practice (Islington) is a General Medical Services (GMS) practice. As of February 2026, the practice has a registered patient list of 9,111. In 2025, the Primary Care Committee (PCC) approved the relocation of The Miller Practice to Sotheby Mews, which is an Islington Council owned facility The practice is due to relocate by the end of 2028.</p> <p>Committee members are asked to approve the setup of Direct Payments to the London Borough of Islington (LBI), the landlord of The Miller Practice - for premises reimbursement costs.</p> <p>The NHS Premises Costs Directions 2024, for primary care premises, state Direct payments can be considered if the contractor and the ICB agrees.</p> <p>The Miller Practice has requested the set-up of direct payments. The contractor is aware they continue to be liable to pay LBI non-reimbursable costs. The contractor will be notified that by commencing direct payments, the ICB does not take on any liability for the lease held between The Miller Practice and LBI. The practice will need to continue to meet its obligations under the lease terms and negotiate a new lease if it is due to expire.</p>				

Recommendation	Members of the Committee are asked to APPROVE the setup of Direct payments to LBI for The Miller Practice's premises reimbursable costs.
Identified Risks and Risk Management Actions	The practice will be notified that the ICB would not become liable for the lease, non-reimbursable costs and the practice accounting with LBI for the reimbursable costs.
Conflicts of Interest	Not applicable.
Resource Implications	The practice will continue to be reimbursed under the existing agreed premises costs.
Engagement	Not applicable
Equality Impact Analysis	Not applicable – there is no change to service provision.
Report History and Key Decisions	Not applicable.
Next Steps	The practice will be notified of the following: <ol style="list-style-type: none"> 1. The commencement and method of direct payments to LBI. 2. Request the contract holders to sign a section 55 agreement which relates to the terms set out in the NHS Premises Costs Directions 2024.
Appendices	Not applicable.

Background

The Miller Practice has approached NCL ICB, to request if the ICB can consider paying the reimbursable costs via a Direct Payment to London Borough of Islington (LBI).

The reimbursable costs relate to the following:

- Lease Rent
- Non-Domestic Rates
- Water and sewage
- Clinical waste
- Management fee (related to the reimbursable costs only)

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

Directions 55 of the National Health Service (General Medical Services – Premises Costs) Directions 2024 states that:

- (1) Where a contractor and NHS England agree, NHS England 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 NHS England 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 NHS England as financial assistance under these Directions which are greater than or equal to the amount of the shortfall, where the contractor and NHS England agree, NHS England 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.

Responsibility for non-reimbursable costs

The ICB is not liable to pay the non-reimbursable costs. Therefore, once approved the contract holder will be notified that they will be required to liaise with LBI to receive a copy of their annual statement, so they are aware of the non-reimbursable costs required to be paid to LBI.

Liability of the Lease and its terms

If PCC members agree to the process of direct payments, the contract holders will be notified that the ICB does not take on any liability for the lease held between the practice (tenant) and LBI (landlord).

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 LBI.

Under the lease terms the practice will be responsible for maintaining its own accounts and ensuring

the premises charges are settled by year end with LBI. Any irregularities in the payments for reimbursable costs the practice can then liaise with the ICB.

Next steps

If PCC members approve the commencement of direct payments, then the practice will be notified of the following:

1. The commencement and method of direct payments to LBI
2. Request the contract holders to sign a section 55 agreement which relates to the terms set out in the NHS Premises Costs Directions



North Central London ICB
Primary Care Committee Meeting Low risk paper
Virtual Decision

Report Title	The Everglade Medical Practice- Direct Payments for premises reimbursable costs	Date of report	20 February 2026	Agenda Item	
Lead Director / Manager	Vanessa Piper, Assistant Director of Primary Care, Contracting	Email / Tel		vanessa.piper@nhs.net	
Board Member Sponsor	Sarah McDonnell-Davies, Chief Transformation Officer				
Report Author	Henry Claridge, Strategic Estate Leads	Email / Tel		henry.claridge@gbpconsult.co.uk	
Name of Authorising Finance Lead	Sarah Rothenberg, Deputy Director Finance Business Partnering – Primary Care	Summary of Financial Implications No financial implications. Existing premises reimbursable costs will be reimbursed via direct payments to the landlord.			
Name of Authorising Estates Lead	Not applicable.	Summary of Estates Implications Not applicable.			
Report Summary	<p>The Everglade Medical Practice (Barnet) is a General Medical Services (GMS) practice. As of February 2026, the practice has a registered patient list of 11,102. In October 2025, the Primary Care Committee (PCC) approved the relocation of The Everglade Medical Practice to Colindale Gardens, which is a new build facility. The practice is due to relocate by the end of 2026.</p> <p>Committee members are asked to approve the setup of Direct Payments to the Central London Community Healthcare NHS Trust (CLCH), the landlord of The Everglade Medical Practice- for premises reimbursement costs.</p> <p>The NHS Premises Costs Directions 2024, for primary care premises, state Direct payments can be considered if the contractor and the ICB agrees.</p> <p>The Everglade Medical Practice has requested the set-up of direct payments. The contractor is aware they continue to be liable to pay CLCH non-reimbursable costs. The contractor will be notified that by commencing direct payments, the ICB does not take on any liability for the lease held between The Everglade Medical Practice and CLCH. The practice will need to continue to meet its obligations under the lease terms and negotiate a new lease if it is due to expire.</p>				

Recommendation	Members of the Committee are asked to APPROVE the setup of Direct payments to CLCH for The Everglade Medical Practice's premises reimbursable costs.
Identified Risks and Risk Management Actions	The practice will be notified that the ICB would not become liable for the lease, non-reimbursable costs and the practice accounting with CLCH for the reimbursable costs.
Conflicts of Interest	Not applicable.
Resource Implications	The practice will continue to be reimbursed under the existing agreed premises costs.
Engagement	Not applicable
Equality Impact Analysis	Not applicable – there is no change to service provision.
Report History and Key Decisions	Not applicable.
Next Steps	The practice will be notified of the following: <ol style="list-style-type: none"> 1. The commencement and method of direct payments to CLCH. 2. Request the contract holders to sign a section 55 agreement which relates to the terms set out in the NHS Premises Costs Directions 2024.
Appendices	Not applicable.

Background

The Everglade Medical Practice has approached NCL ICB, to request if the ICB can consider paying the reimbursable costs via a Direct Payment to Central London Community Healthcare NHS Trust (CLCH).

The reimbursable costs relate to the following:

- Lease Rent
- Non-Domestic Rates
- Water and sewage
- Clinical waste
- Management fee (related to the reimbursable costs only)

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

Directions 55 of the National Health Service (General Medical Services – Premises Costs) Directions 2024 states that:

- (1) Where a contractor and NHS England agree, NHS England 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 NHS England 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 NHS England as financial assistance under these Directions which are greater than or equal to the amount of the shortfall, where the contractor and NHS England agree, NHS England 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.

Responsibility for non-reimbursable costs

The ICB is not liable to pay the non-reimbursable costs. Therefore, once approved the contract holder will be notified that they will be required to continue to liaise with CLCH to receive a copy of their annual statement, so they are aware of the non-reimbursable costs required to be paid to CLCH.

Liability of the Lease and its terms

If PCC members agree to the process of direct payments, the contract holders will be notified that the ICB does not take on any liability for the lease held between the practice (tenant) and CLCH (landlord).

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 CLCH.

Under the lease terms the practice will be responsible for maintaining its own accounts and ensuring the premises charges are settled by year end with CLCH. Any irregularities in the payments for reimbursable costs the practice can then liaise with the ICB.

Next steps

If PCC members approve the commencement of direct payments, then the practice will be notified of the following:

1. The commencement and method of direct payments to CLCH
2. Request the contract holders to sign a section 55 agreement which relates to the terms set out in the NHS Premises Costs Directions



North Central London

Integrated Care Board

North Central London ICB

Primary Care Committee Meeting **Low risk paper**

Virtual Decision

Report Title	Morris House Group Practice – Request for Additional Space	Date of report	20 February 2026	Agenda Item	
Lead Director / Manager	Vanessa Piper, Assistant Director of Primary Care Contracting	Email / Tel		vanessa.piper@nhs.net	
Board Member Sponsor	Sarah McDonnell-Davies, Chief Transformation Officer				
Report Author	Honorine Focho & Mike Stone	Email / Tel		honorine.focho@nhs.net	
Name of Authorising Finance Lead	Sarah Rothenberg, Deputy Director of Finance Business Partnering (Primary Care) NCL ICB	Summary of Financial Implications			
		<p>The practice is in a Community Health Partners (CHP) building and is requesting an additional space for multi-purpose support usage:</p> <ol style="list-style-type: none"> 1. This is the transfer of a shared, bookable 1st floor meeting room (42. 83sq.m) to the Practice. A space that is rarely being used throughout the working week and which can be better utilised as multi-purpose support space for the practice. 2. The current Void costs for the space is £54,320.80/annum inc. VAT 3. The reimbursables for the space is £47,340.98/annum inc. VAT 4. There would be a saving of - £6,979.83/annum for the ICB overall but a cost of £47,340.98/annum to the delegated budget 5. Current practice annual reimbursement is £529,040.94/annum inc. VAT inclusive of Rent, Rates, Water, Clinical Waste and Management Fees. 6. Total reimbursables for the practice inclusive of new space £ 576,381.92/annum inc. VAT 			

		7. Length of current lease term 25 years and approximately 7 years remaining. The request is time-limited for 2 years
Name of Authorising Estates Lead	Diane MacDonald, Deputy Director of Strategic Estates Finance	<p>Summary of Estates Implications</p> <p>Approval of the transfer of the meeting room to the practice for an initial 2 years and will cost the ICB £ 47,340.98/ annum, inc. VAT. During the second year the ICB will further review the requirement for the room.</p> <p>There is approx. £74k from the PCN pilot that could be allocated to part fund the two-year increase. This includes the amount allocated to Morris House for inclusion in the pilot.</p>
Report Summary	<p>The Morris House Group Practice (Haringey) has five partners, who hold a GMS contract with a list size of 14,725 patients (October 2025).</p> <p>The partners are requesting additional premises reimbursement for a shared, bookable meeting room, for the practice's sole use, as a multi-purpose support space, the ICB is currently paying void costs on this space.</p> <p>The practice request is to support.</p> <ul style="list-style-type: none"> • MDT working, • Patient triage • List growth • Workforce recruitment and retention • Training for Medical School Students, GP Trainees, Pharmacist Trainees, Pharmacist Technician Trainees and FY2 doctors. • Staff and PCN meetings <p>There has been a 15.88% list size increase from April 2017 to April 2025. The practice is in the Haringey Northeast Primary Care Network (PCN), which comprises 5 practices with a PCN list size of 53,977 patients.</p> <p>The practice opens core hours (0800 – 1830) with extended hours provision offered throughout the week until 1915hrs. In addition to this the practice offers Enhanced Access appointments weekdays 1830-2030hrs and Saturdays 0800-1800hrs, through their PCN Enhanced Access scheme.</p> <p>Development within the area</p> <p>There are proposals for 290 homes at Broadwater Farm and 215 new homes in the Selby Urban Village. The Morris House Group Practice is 0.5 miles and 1 mile respectively from the two development sites.</p> <p>There are also some smaller and larger schemes in the future as development sites have been identified, which is anticipated to attract at least 1,050 residents.</p> <p>Access Considerations</p> <p>National workforce reporting system</p>	

Practice workforce whole time equivalent (WTE) numbers are in line with ICB and National averages. National Workforce System (September 2025), shows the practice employs; -

- 15 GPs (9 WTE)
- 2 Nurse (2.1 WTE)
- 7 Direct Care Patient Staff (7.4WTE)
- 29 Admin Staff (25.3 WTE)

Practice Code	F85019	List size	14738	Month	Sep-2			
Practice Name	MORRIS HOUSE GROUP PRACTICE Per 1000 Patients							
Staff Group	Practice FTE	NCL ICB average FTE	National average FTE	Practice	NCL ICB average	National average	Difference vs ICB average	Difference vs National average
GP	9.03	5.91	6.15	0.61	0.55	0.59	0.07	0.0
Nurse	2.13	1.36	2.79	0.14	0.11	0.25	0.03	-0
Direct Patient Care	7.4	1.95	2.87	0.5	0.17	0.26	0.33	0.2
Administration	25.29	10.14	12.36	1.72	0.96	1.19	0.76	0.5

Table 1 Workforce Analysis per 1000 Patients

Booked appointments.

There is under provision of all appointment types (GP appointment data September 2025), the practice has been notified of the under provision of appointments and requested to review the access and where improvements should be made.

Staff Group	Appointments per month	Appointments per 1000 patients	NCL ICB average per 1000 patients	National average per 1000 patients	Difference vs ICB average	Difference National average
GP	2421.00	164.07	239.70	232.98	-75.63	-6
Other Practice Staff	2123.00	143.87	175.72	262.63	-31.84	-1
Unknown	0.00	0.00	2.68	10.81	-2.68	-
Total	4544.00	307.94	418.10	506.42	-110.16	-19
Face to Face	4136	280.29	221.32	326.26	58.97	-4
Home Visit	15	1.02	1.60	5.55	-0.58	
Telephone	316	21.42	152.81	123.25	-131.39	-10
Video / Online	53	3.59	37.59	39.79	-33.99	-3
Unknown	24	1.63	4.78	11.58	-3.16	
Face to Face	92%		56%	68%	36%	
Remote	8%		44%	32%	-36%	

Space Requirements

The practice is operating out of sufficient clinical space; they have a total of 14 consulting rooms (11 clinical rooms and 3 treatment rooms), provides a ratio of 1 room: 1051 patients.

Department Health, HBN 1 space estimator, calculates the practice should be operating out of 12 clinical rooms (9 Clinical rooms and 3 treatment rooms); which is a room: 1,227 patients.

It should be noted

- 1 clinical room is used for training purposes that means it's not used for seeing patients. Should the transfer of the meeting room be approved, the training function will move to the 1st floor and the ground floor clinical room will be used for patient appointments.
- that this request for additional space is for a room that can be utilised for multiple support activities over and above the need for clinical space for F2F patient appointments. Practices are embracing new ways of MDT working and need alternative and additional space for supporting such activities it needs for running a growing and innovating primary care and training practice. All new primary care schemes in NCL are including such spaces within their design.

Cost Implications

The practice operates from a Community Health Partnership (CHP) premises and has signed lease. The reimbursable cost of the additional meeting room (42.83 m²) is estimated to be £ 47,340.98 per annum, inc. VAT. This is based on a cost schedule provided by CHP.

The meeting room is currently void at a cost to the ICB of £ 54,320.80 per annum inc. VAT and would remain a void cost to the ICB if not part of the practice's exclusive space. Therefore, approval of the additional space will remove the current void.

- Current reimbursable cost per annum for the practice exclusive space (503.13 m²) is £ 529,040.94/annum inc. VAT.
- Proposed reimbursable cost for current and new space (545.96m²) is £576,381.92 per annum inc. VAT.
- Cost difference increase of £47,340.98
- Eliminate a void cost to the ICB of £54,320.80

There is approx. £74k from the PCN pilot that could be allocated to part fund the two year increase. This includes the amount allocated to Morris House for inclusion in the pilot.

Lease arrangement and next steps

- If the application is approved, the new space will be separately leased by the landlord, CHP to the practice
- The ICB is reimbursing via direct payments, the additional space would be included for direct payments

In order to not create a precedent, where there are sufficient consulting rooms per the capacity calculator for the number of patients, while supporting the Practice for additional training space as a training Practice and MDT working, the request is for an initial two years at which time it will be reviewed. This has been communicated with the Practice.

Recommendation	<p>Committee members are requested to consider the case and APPROVE:</p> <ul style="list-style-type: none"> • the practice's request for additional space for an initial 2-year period and change in premises cost reimbursement. • the allocation of approx. £74k from the PCN pilot, including the amount allocated for Morris House for inclusion of the PCN pilot.
Identified Risks and Risk Management Actions	<p>Risk: This space is currently void and the void cost to the ICB is £ 54,320.808 inc. VAT would remain a void cost to the ICB if not part of the practices exclusive space.</p> <p>Mitigation: Approval of the additional space will remove the current void.</p>
Conflicts of Interest	Not applicable
Resource Implications	<ul style="list-style-type: none"> • Current reimbursable cost pa £ 529,040.94 • Proposed new reimbursable cost pa £576,381.92. • Cost difference increase pa £47,340.98. • Eliminate a void cost of £54,320.80.
Engagement	Not applicable
Equality Impact Analysis	Not applicable
Report History and Key Decisions	Not applicable
Next Steps	<p>If PCC approve the additional space</p> <ol style="list-style-type: none"> 1. Practice will be requested to submit the new lease which includes the additional space 2. Direct payments will be amended.
Appendices	Not applicable