NHS
North East London

Primary Care Contracts Sub-Committee

16 July 2024; 13:00-14:40; Venue: MS teams

AGENDA

	Item	Time	Lead	Attached/ verbal	Action required
1.0 1.1. 1.2. 1.3	**Welcome, introductions and apologies** Declaration of conflicts of interest Minutes of the meeting held on 21 May 2024 Matters arising and actions log	13:00	Chair	 Verbal Attached Attached Verbal	 Note Note Approve Note
2.0	**Questions from members of the public**	13:05	Chair	Verbal	Note
3.0	**AT Medics Change of Control**	13:20	Alison Goodlad	Attached	Approve
4.0	**Commissioning Intentions – Expiring Contracts with provision to extend for a further term** • Newham Transitional Practice • SMA Medical Centre • Allerton Road Surgery • Carpenters Practice • Goodman's Fields Medical Practice	13:35	 Abdul Rawkib Benjamin Smith Abdul Rawkib Benjamin Smith Abdul Rawkib	 Attached Attached Attached Attached Attached	 Approve Approve Approve Approve Approve
5.0	**Specialist support for the ongoing review of primary care business rates**	13:50	Ian Clay	Attached	Approve
6.0	**NEL ICB Policy for Management of Additional Roles Reimbursement Scheme (ARRS) Flexibility**	14:05	Fiona Erne	Attached	Approve
7.0	**Dental, Optometry & Pharmacy Update including 2024/25 Non-recurrent UDA commissioning proposal**	14:15	Jeremy Wallman Kelly Nizzer	Attached	Note Endorse
8.0	**Primary Care Finance Report**	14:25	Rob Dickenson	Attached	Note
9.0	**Risk Report**	14:30	Alison Goodlad	Attached	Note
10.0	**Any other business**	14:35	Chair	Verbal	Note
Items for information only		14:40			
11.0	NEL bid for funding for dental and optometry hypertension case finding pilots			Attached	Note
Date of next meeting: 17 September 2024					

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- Declared Interests as at 09/07/2024

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Alison Goodlad	Deputy Director of Primary Care	Primary care contracts sub-committee	Indirect Interest	Northamptonshire NHS Foundation Trust	Sister is Mental Health Practitioner	0022-01-08		Declarations to be made at the beginning of meetings
Benjamin Molyneux	Associate Medical Director, NEL ICB	Clinical Advisory Group Community Health Collaborative sub-committee Primary Care Collaborative sub-committee Primary care contracts sub-committee	Financial Interest	Locum GP	I work as an ad hoc self-employed GP at GP practices in NEL	2023-05-01		Declarations to be made at the beginning of meetings
Diane Jones	Chief Nursing Officer	Clinical Advisory Group Community Health Collaborative sub-committee ICB Board ICB Quality, Safety & Improvement Committee ICS Executive Committee Primary care contracts sub-committee	Non-Financial Professional Interest	Royal College of Nursing (RCN)	Professional membership	2020-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Royal College of Midwives (RCM)	Professional membership	1994-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Nursing & Midwifery Council (NMC)	Professional membership	1992-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Clinical Senate	Member	2017-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Homerton Hospital	Midwife (honorary contract)	2015-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Group B Strep Support (GBSS)	Director and Trustee	2020-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Sign Health	I am a Trustee of the charity	2023-05-01		
Dr Paul Francis Gilluley	Chief Medical Officer	Clinical Advisory Group ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub committee Primary care contracts sub-committee	Non-Financial Professional Interest	British Medical Association	I am a member of the organisation.	2022-07-01		
			Non-Financial Professional Interest	Royal College of Psychiatrists	Fellow of the College	2022-07-01		
			Non-Financial Professional Interest	Medical Defence Union	Member	2022-07-01		
			Non-Financial Professional Interest	General Medical Council	Member	2022-07-01		
			Non-Financial Personal Interest	Stonewall	Member	2022-07-01		
			Non-Financial Personal Interest	National Opera Studio	Trustee on the Board	2023-08-01		

Raliat Onatade	Chief Pharmacist and Director of Medicines and Pharmacy	Clinical Advisory Group Formulary & Pathways Group (FPG) Primary care contracts sub-committee	Non-Financial Professional Interest	North Thames Genomic Medicine Service Alliance	I am also Chief Pharmacist for North Thames Genomic Medicine Service Alliance, which is an NHS organisation hosted by UCL Partners. North East London is part of the North Thames region for Genomic Medicines, therefore the role is complementary, rather than in conflict.	2021-04-01		
			Indirect Interest	Roche	I have signed a Consultancy Agreement with Roche to attend a meeting designed to improve Roche's understanding of the recent changes to the NHS in England, the opportunities and challenges with the new Integrated Care System (ICS) structure and the delegation of specialised commissioning. Roche will apply these insights to be a more constructive industry partner. My role (in accordance with all applicable clauses of the ABPI Code of Practice) will entail a single 1 hour virtual speaker session at the Roche Policy, Value and Access Chapter meeting on 15 November 2023. I will be paid £220 per hour, and payment will be for 1 hour preparation time and 1 hour meeting (the actual session).	2023-10-24	2023-11-15	
Henry Black	Chief Finance and Performance Officer	ICB Audit and Risk Committee ICB Board ICB Finance, Performance & Investment Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub committee Primary Care Collaborative sub committee Primary care contracts sub committee	Indirect Interest	BHRUT	Wife is Assistant Director of Finance	2018-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	GSTT NHS Trust	Daughter employed as a graduate trainee	2023-09-01		
Sarah See	Managing Director of Primary Care	ICS Executive Committee Primary Care Collaborative sub-committee Primary care contracts sub-committee	Non-Financial Personal Interest	GP - Waltham Forest	Registered with a GP practice in Waltham Forest; members of the practice team works with the NHS NEL, LW LMC and NHSE/I	2001-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Old Church Surgery (Chingford)	Niece works for GP practice	2022-06-05		Declarations to be made at the beginning of meetings

Jignasa Joshi	NEL ICS Optometry Lead	Primary Care Collaborative sub committee Primary care contracts sub committee	Non-Financial Personal Interest	NE London LOC	Chair of the NE London Local Optical Committee	2015-04-23		
			Non-Financial Professional Interest	NE London Optometry Provider Group.	I am a lead & principal contact for the NEL Optometry Provider Group, formerly known as the NEL /ELC Optometry Collaborative Group.	2023-01-09		
			Non-Financial Professional Interest	Primary Eyecare (East London & City)	I am a director of this company which is a vehicle for primary care optometry practices to be commissioned to provide services outside the NHS GOS contract.	2016-12-21		
			Non-Financial Personal Interest	Primary Care Optometrist	I am a practicing optometrist in primary care in the NE London area	2002-04-01		
Shilpa Shah	LPC CEO attend meetings as a guest	Formulary & Pathways Group (FPG) Primary Care Collaborative sub-committee Primary care contracts sub-committee	Non-Financial Personal Interest	Samaritans	Director of Branch Operations at Samaritans National voluntary role.	2022-10-01		
			Non-Financial Personal Interest	Waltham Forest Samaritans	Listening volunteer at Waltham Forest Samaritans	2015-07-15		
			Financial Interest	Pharmacy Services Partnership	I am a consultant manager to the Pharmacy Services Partnership which is a Pharmacy Provider Company	2023-04-01		
Sue Evans	Associate Non Executive Member	Primary care contracts sub-committee	Non-Financial Professional Interest	Worshipful Company of Glass Sellers' of London (City Livery Company) Charity Fund	Company Secretary / Clerk to the Trustees'	2014-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	North East London NHS	Self and family users of healthcare services in NEL	2017-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	St Aubyn's School Charitable Trust	Trustee and Director of Company Ltd by Guarantee	2013-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Health Research Authority	Member of Research Ethics Committee	2023-07-01		Declarations to be made at the beginning of meetings

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- Nil Interests Declared as of 09/07/2024

Name	Position/Relationship with ICB	Committees	Declared Interest
Gohar Choudhury	Assistant Head of Primary Care	Primary care contracts sub-committee	Indicated No Conflicts To Declare.
William Cunningham-Davis	Director of Primary Care Delivery	Newham Health and Care Partnership Newham ICB Sub-committee Primary care contracts sub-committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Lorna Hutchinson	Assistant Head of Primary Care	Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Abdul Rawkib	Senior Primary Care Commissioning Manager	Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Rob Dickenson	Senior Finance Manager - Primary Care	Primary Care Collaborative sub-committee Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Jeremy Wallman	Head of Primary Care Commissioning; Dentistry, Optometry and Pharmacy	Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Kate Hudson	Observer of Primary Care Contracts Sub Committee	Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Amy Wilkinson	Director of Partnerships, Impact and Delivery	City & Hackney ICB Sub-committee City & Hackney Partnership Board Primary care contracts sub-committee	Indicated No Conflicts To Declare.

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Minutes of the Primary Care Contracts Sub-Committee
Held on 21 May 2024; 13:00-15:00; Via MS teams

Members:	
Sue Evans (SE) - Chair	Associate Non-Executive Member, NHS North East London
Sarah See (SSe)	Managing Director of Primary Care, NHS North East London
Amy Wilkinson (AW)	Hackney Place Director, representing NEL Place Based Partnerships
Ben Molyneux (BM)	Assistant Medical Director, NHS North East London
Paul Gilluley (PG)	Chief Medical Officer, NHS North East London
Rob Nicholls (RN)	Director of Nursing & Safeguarding – Deputy for Diane Jones
Attendees:	
William Cunningham-Davis (WCD)	Director of Primary Care Delivery, NHS North East London
Alison Goodlad (AG)	Deputy Director of Primary Care, NHS North East London
Lorna Hutchinson (LH)	Senior Primary Care Commissioning Manager, NHS North East London
Gohar Choudhury (GC)	Head of Primary Care, NHS North East London
Jeremy Wallman (JW)	Head of Primary Care Commissioning; Dentistry, Optometry and Pharmacy, NHS North East London
Rob Dickenson (RD)	Deputy Director of Finance – Primary Care and London Services, NHS North East London
Kate Hudson (KH)	Londonwide Local Medical Committee, Director of Primary Care (for NEL, SEL & SWL)
Asif Imran (AI)	Barking, Dagenham and Havering Local Medical Committee
Jignasa Joshi (JJ)	NEL Integrated Care System Optometry Lead
Jordanna Hamberger (JH)	Head of Primary Care (Havering), NHS North East London - item
Kesti Gosling (KG)	Communications Manager, NHS North East London
Keeley Chaplin (KC)	Governance Systems Lead, NHS North East London (minutes)
Apologies:	
Diane Jones (DJ)	Chief Nursing Officer, NHS North East London
Henry Black (HB)	Chief Finance and Performance Officer, NHS North East London
Raliat Onatade (RO)	Chief Pharmacist and Director of Medicines and Pharmacy
Shilpa Shah (SSh)	CEO, North East London Pharmaceutical Committee
Tam Bekele (TB)	East London and City Local Dental Committee
Som Hirekodi (SH)	Barking and Havering LDC
Reza Manbajood (RM)	East London and City Local Dental Committee

Item No.	Item title	Action
1.0	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting, including members of the public. Apologies were noted as above.	
1.1.	Declaration of conflicts of interest	
	The Chair reminded members of their obligation to declare any interest they may have on issues arising at the meeting which might conflict with the business of the committee.	

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	No additional conflicts were declared. Declarations made by members of the committee are listed on the register of interests. The register is included in the pack of papers and available from the secretary of the committee.	
1.2.	Minutes of the meeting held on 18 March 2024	
	The minutes of the meeting held on 18 March 2024 were accepted as an accurate record.	
1.3.	Matters arising/action log	
	Members noted the action log and agreed to close: ACT001, ACT002, ACT003, ACT004, ACT005, ACT007.	
2.0	**Questions from members of the public**	
	The Chair advised that questions had been received from members of the public and questions were read. AG provided the answers below: **Q.** On April 15th, your Managing Director, Sarah See, stated that "the NHS will continue its due diligence process to ensure the NHS has all the information needed regarding the companies involved" (in the take-over of AT Medics.) 1. My first question is: how can you carry out due diligence on a company that was only incorporated on November 30th 2023, just 4 weeks before it assumed control, without authorisation, of 10 GP surgeries in the NELICB area, including 6 in my own borough of Newham, (and over 60 in the whole country), and which appears to have had no previous experience of providing actual healthcare, the nature of its business being listed as "Temporary employment agency activities"? (Source: Companies House) 2. My second question relates to the parent company: Twenty20 Capital Investments Ltd. which would be the ultimate owner of the contracts for all these surgeries, and whose business classification is listed as: "Activities of venture and development capital companies" as well as "Activities of employment placement agencies" etc. The Chairman, Tristan Ramus, recently stated that: "The core principles of Twenty20 Capital's investment philosophy have driven an outstanding shareholder return in under three years." Yet this is a company that is listed as having liabilities of £398 million and a debt ratio of 95.69%. (Source: Endole). Do you consider such a Venture Capital company, driven by the model of maximising profits in the shortest possible time (and the risks associated with such a high level of debt) is suitable to take care of the health care of thousands of patients in North East London? **A. A1.** The due diligence report has now been published and can be found in the Due Diligence Report published with the papers on our website. **A2.** The NHS commissions GP practices by entering into contracts with providers of primary medical services. Most GP practices are operated by private businesses that are either owned by GPs or other organisations such as AT Medics Ltd who hold the contracts. As a provider of NHS services, care remains free at the point of delivery.	

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	Q. On 15 April 2024, NHS NE London confirmed that a change of control of GP surgeries from Operose Health/AT Medics (Centene Corporation) to T20 Osprey Midco Ltd (HCRG) had been effected without permission on 28 December 2023 – and that this had not been communicated to the ICB until 15 March 2024. This 'change of control' clearly breaches the requirement set out in s54.1 of the APMS contract, which states: 54.1 The Contractor shall not sell, assign, sub-contract or in any way dispose of any of its rights or duties under the Contract in relation to the Services or any part thereof without the prior written authorisation of the Commissioner and subject to such conditions as the Commissioner in its absolute discretion may impose. Why, given the clear and serious breach of contract, has the ICB not adhered to s62, by serving notice on the contractor terminating the contract forthwith? **A.** AT Medics have been served with a breach notice and have been informed that we consider this to be a serious breach and are currently considering next steps. The findings from the Due Diligence report will be considered alongside further information on the quality and performance of AT Medics practices. The July meeting of the NEL ICB primary care contracts sub-committee will be looking at this.	
3.0	**AT Medics Change of Control**	
	AG outlined the background on the change of control of Operose Health which owns AT Medics: • AT Medics Ltd holds six Alternative Provider Medical Services (APMS) contracts in north east London (NEL). • A due diligence exercise was undertaken to assess the standing of the new owner and understand implications of a change of control that had taken place without seeking prior commissioner authorisation. No compliance issues were identified. • The ICB will not be using the information from the exercise to give retrospective approval for change of control, but instead will use this information alongside other considerations to inform future decision making around next steps. • Ownership has transferred to a special purpose vehicle company. • Operose confirmed that there is no intention to transfer data outside of the UK, and there is no planned transfer of assets or data generally. • Operose and AT Medics have stated that they will continue to operate as a financially sustainable standalone business focused on delivery of primary care services. • Three of the six practices are coming up to their contract end date or break clause so will be considering future options and next steps in this context. The primary care contracts sub-committee: • noted the issuing of a breach notice to AT Medics • noted the findings from the Due Diligence process • noted that a further report will be taken to the July sub-committee to consider options and next steps.	

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4.0 Planning for Expiring GP APMS contracts

LH provided a high level report on the ten APMS primary medical service contracts that will come to an end or to a break clause at various dates up to August 2025.

- The report sets out the plan to ensure there are contractual arrangements in place for patients to continue to receive primary medical services when the respective contracts come to an end.
- The new Provider Selection Regime (PSR) provides new routes for selecting providers for contract awards and will be used to identify what is the most suitable route for the future provision of services to patients.
- Taking account of the new regime will mean contracts that are due to expire in March 2025 are not likely to be on new contractual arrangements by the contract end date. Therefore, an extension will allow time to work through commissioning intentions and identify the most appropriate route to select a provider.
- There are no known performance issues with these practices.

The sub-committee:

1) approved the extension of four contracts approaching their contract life-time end date, up to a maximum extension date of 30 September 2025. These are:
    - Frances Road – Waltham Forest
    - Island Medical – Tower Hamlets
    - Broad Street Medical Practice – Barking & Dagenham
    - E16 Health – Newham

    (noting Aldersbrook Medical Centre has already been confirmed)
2) noted that commissioning intentions for the four practices with provision to extend for a further five years, will be taken to the July sub-committee for approval.
3) noted that commissioning intentions for those five contracts that are approaching the contract life-time end date will be presented to the September sub-committee for approval.

5.0 Havering - New PCN formation – Liberty PCN

JH informed members of the proposal of five practices in Havering to segregate from their current Primary Care Network (PCN) (South PCN) and form a new PCN (Liberty PCN). JH highlighted the following:

- It covers a population of 50k, with remaining 11 practices covering a population of 65k.
- There are no financial implications as the funding for South PCN will be redistributed based on list sizes.
- There are no boundary changes that would affect current provider services.
- If the proposal is not agreed, it could potentially cause dis-engagement from the five practices looking to break away from the current South PCN formation.
- There is one co located practice that is not included in this proposal however dialogue remains open if they wish to join at a later date.
- All member practices and Local Medical Committee (LMC) are supportive of the changes proposed and have received endorsement from the Havering borough partnership.
- South PCN have set up a task and finish group for the realignment.

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	Key points discussed were: • The task and finish group are working on the logistics of services to be realigned such as ARRS workforce. • The co located practice that has not been included in the proposal will be welcomed if they would like to join later. • If approved, the new PCN can be established in July and transition work has commenced, looking at the split of ARRS staff and ensuring it is fluid. • When the new PCN is established the patient cohort will remain as it is and will have the same services such as the local hub. The Committee approved the application for the creation of Liberty PCN from 1 July 2024.	
6.0	**Redbridge - Aldersbrook APMS practice**	
	Gohar briefed the sub-committee on the Aldersbrook Medical Centre: • The APMS contract for the Aldersbrook Medical Centre was due to expire and initial discussions were held with the provider regarding options available and a report was provided to this sub-committee in December 2023 to consider these options. • During discussions with the provider, it became apparent that they were running the practice at a loss and were no longer able to sustain services, particularly with the contract being equalised. • In January 2024 the provider gave notice to end the contract but, following further discussions, they have agreed to extend the contract until end March whilst a suitable provider is sought. • The new contract will be on a GMS or PMS contract, as an additional site to an existing practice which should provide stability for patients as well as the new provider. • The new contract will fall under the new PSR rules. A prior information notice will be issued to limited competition where local practices will be able to express an interest. • The tender process will be worked through and the ICB will continue to work with the PPG to ensure they are included in the process. • It is hoped this process will be completed by November-December 2024 and it will be presented to the sub-committee for approval. • The new contract will then be in place for 1 April 2025. The primary care contracts sub-committee **noted** the verbal update.	
7.0	**Dental, Optometry & Pharmacy Report**	
	Jeremy Wallman provided sub-committee members with a verbal update on the month 12 position which focussed on dental performance. Key points noted were: • In NEL over 95% of activity has been delivered and is top in London. • NEL dental performance is amongst the best in the country. This is mainly due to additional investment being put into dental practices early in the year and take on additional staff. • New NHS patients' books have remained open. • Initial indications are that delivery of activity is back to pre-pandemic levels. • Scoping for additional investment in the 2024/25 budget has commenced.	

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	• Overall it is a positive position and credit was given to dental practices that stepped up and offered additional access. • The dental recovery plan is now being rolled out ensuring there is capacity to see new patients as well as continuing to treat existing patients. • All ICBs that have primary care delegated functions are required to provide an annual self declaration providing assurance of delegated primary care functions to the local regional team for NHS England (NHSE). JW will be providing this for the London ICBs. The primary care contracts sub-committee **noted** the verbal update and that a fully reconciled report for 2023/24 will be provided at the next meeting.	
8.0	**Primary Care Finance Report**	
	Rob Dickenson (RD) briefed the sub-committee on the month 12 position: • Annual accounts were submitted to NHSE within required timescales, following review by the Finance and Performance Committee and sign-off by the Audit Committee. External Audit have since commenced the audit process which is due to conclude by the end of June 2024. • The unaudited year end position is reporting a primary care overspend of £33.6m which is primarily driven by prescribing pressures. • The ICB Funded Primary Care position has an overspend of £44m however this is offset by an £10m underspend in delegated dentistry, optometry and pharmacy services. • The system operating plan was submitted to NHSE in early May 2024 and is reporting a planned system deficit of £55.5m. • The net recurrent increase to budget is £13.5m, with an additional £1.8m of non-recurrent funding. • The SDF transformation fund will have a similar value of allocation to 2023/24. The following points were discussed: • The medicines management team have been working on the causes for the prescribing overspend and are reviewing practice level detail to understand the drivers and provide support if required. • There is one more year of ARRS funding and the ICB is waiting for information on what, if any, funding will be provided from 2025 onwards. There has been no percentage increase to the baseline to drawdown. The primary care contracts sub-committee **noted** the primary care finance report from month 12. *Paul Gilluley left the meeting.*	
9.0	**Primary Care Risk Report**	
	AG presented the report noting that one risk has been closed due to successful mobilisation of all new APMS practices as at 1 April 2024. A further risk has been added for potential planned action by GPs following receipt of a BMA letter issued on 18 April 2024. The ballot is due to take place on 16 July. Across London discussions are taking place on various mitigating options and plans will be put in place once confirmed if action is being taken. The primary care contracts sub-committee **noted** the update.	

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10.0	**Any other business**	
	None.	
11.0	**Items for information only**	
11.1.	Results of committee effectiveness survey	
11.2.	GP Contracts update report	
11.3.	Redbridge – Aldersbrook Medical Centre	
	The above items were presented for information and were duly noted.	
	Date of Next meeting – 16 July 2024	

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NHS North East London

Primary Care Contracts Sub-committee

16 July 2024

Title of report	AT Medics Change of Control
Author	Alison Goodlad, Deputy Director Primary Care
Presented by	Alison Goodlad, Deputy Director Primary Care
Contact for further information	nelondon.nel-primarycare@nhs.net
Executive summary	On 30 November 2023 NHS North East London (the ICB) was asked for authorisation for a change of control by Operose Health which owns AT Medics. AT Medics run six practices across North East London. The ICB commenced a due diligence exercise to assess the standing of the new owner and understand any implications of the change of control. In March 2024, the ICB was informed that a change of control had already taken place on 28 December 2023. A breach notice was issued to AT Medics in respect of the Change of Control being enacted without seeking consent first. The Due Diligence process has concluded, and its findings were shared at the May meeting of the Primary Care Contracts Sub Committee for noting. This paper considers options and next steps.
Action required	The Primary Care Contracting Sub Committee is asked to: **Agree** the recommended option that no further contractual action will be taken in respect of the unauthorised change of control. Each contract will be considered on a case-by case basis as it reaches a review point for renewal or expiry.
Previous reporting	The Due Diligence Report and Breach notice were shared at the May meeting of the Primary Care Contracts Sub Committee for noting
Next steps/ onward reporting	• To write to AT Medics informing them that no further contractual action will be taken in addition to the breach notice previously issued. In respect of the delay in informing us that the change of control had already taken place, we will seek assurance from them of better conduct in future. • To progress commissioning intention reviews for the three AT Medics contracts coming up for renewal and final expiry in 2025. Decisions will be made on the Carpenters Practice contract and Goodman's Field contract at this meeting and on the E16 Health contract at the September meeting.
Conflicts of interest	None

Strategic fit	To enhance productivity and value for money
Impact on local people, health inequalities and sustainability	Ensure access to safe and adequate primary care services for local people
Impact on finance, performance and quality	There are no additional resource implications/revenue or capital costs arising from this report
Risks	In order to understand any potential risks to the delivery of patient care, a due diligence exercise was undertaken to assess the standing of the new owner and understand any implications of the change of control. This paper seeks to come to a balanced decision, weighing up the risks of continuing with the current AT Medics contracts against the risks of seeking alternative means of providing care to these patients, considering legal and contractual issues and ensuring that we comply with our duty to commission safe, effective patient care.

1.0 Background

1.1 On 30 November 2023, the NHS was asked by AT Medics for authorisation for a change of control. The change of control was of the ownership of Operose Health Ltd to be transferred from MH Services International (UK) Ltd, a subsidiary of Centene Corporation, to T20 Osprey Midco Ltd. The NHS then commenced a due diligence exercise to assess the standing of the new owner and understand any implications of the change of control, including making formal enquiries to Operose Health Ltd.

1.2 AT Medics Ltd was set up by GPs in 2004 and is a large provider of general practice services. It was acquired by Operose Health Ltd in 2021 who were ultimately owned by Centene Corporation. AT Medics Ltd holds six Alternative Provider Medical Services (APMS) contracts in North East London. AT Medics Ltd is part of the Operose Health Group, which holds several other contracts in London and elsewhere in England. The APMS contracts that it currently holds in North East London are:

- The Loxford Practice – Redbridge
- Lucas Avenue Practice – Newham
- Carpenters Practice – Newham
- E16 Health – Newham
- Trowbridge Surgery– City & Hackney
- Goodman’s Field Centre – Tower Hamlets

1.3 Operose Health Ltd also has operational management control of John Smith Medical Centre, Barking and Dagenham – Chilvers & McCrae Ltd (PMS practice). Under the terms of the PMS contract, the contract holder does not have to seek our consent to undergo a change of control.

1.4 The ICB was notified on 15 March 2024 that a change of control took place on 28 December 2023. That is, the NHS was not informed of this at the time. Under the terms of the APMS contracts, providers may not undergo a change of control without the NHS's prior authorisation.

1.5 On 1 May AT Medics were serviced notice by NHS North East London that they had breached Clause 54.3 of the APMS contract in that they had undergone a Change of Control without the prior authorisation of the Commissioner.

1.6 AT Medics were informed that we consider this to be a serious breach and are currently considering what further action to take under the Contracts. AT Medics responded to the breach notice, acknowledging the breach and giving an assurance that they do not intend to further breach their contracts with us.

2.0 Findings from the Due Diligence Process

2.1 The NHS continued its due diligence process to ensure the NHS has all the information needed regarding the companies involved. This process has now concluded. The ICB will not be using this information to give retrospective approval for change of control, but instead use this information alongside other considerations to inform future decision making around next steps.

2.2 A summary of the findings was shared with this Sub Committee in May. Key points are as follows:

- No compliance issues have been identified.
- Ownership has transferred to T20 Osprey Midco Ltd which is a special purpose vehicle company without a track record. However, the sale of AT Medics, AT Medics Holdings LLP and Operose Healthcare Ltd is a buyout of those businesses by the wider HCRG group of companies and its owners, two individual private investors.
- Operose confirmed that there is no intention to transfer data outside of the UK, and there is no planned transfer of assets or data generally.
- Operose and AT Medics have stated that they will continue to operate as a financially sustainable standalone business focused on delivery of primary care services following the Change of Control, and that the arrangements relating to staffing and data protection, will remain the same.
- New debt was registered against AT Medics, AT Medics Holdings LLP and Operose which Operose reported was a refinancing of existing debt of the Buyer's wider group of companies. AT Medics is now subject to additional potential liabilities. Whilst this is not unusual in transactions of this nature, we have sought further information and assurance to consider the implications and risks. AT Medics have further reported that the arrangement which resulted in the routine registration of a bank charge at Companies House against group companies, was a positive endorsement of the financial stability of the Group. As a result of this, Operose Health is borrowing less than one-third of the amount borrowed under its previous US-based owner.
- The Group of companies is accredited by NHS England as a 'Hard to Replace' provider, and as such is subject to stringent quarterly audits of its financial position which they have passed. We have sought feedback from the relevant NHSE England Department and London ICBs will be meeting with this department within the next couple of weeks.

3.0 Findings from local communication and engagement

3.1 In common with other London ICBs, NEL undertook an extensive public and patient engagement on the proposed Change of Control. AT Medics supported the public engagement exercise and all London ICBs shared their public engagement plans with them. From March 2024 the ICB has undertaken the following activities:

- Published information on its website
- Shared information to be publicised in relevant practices
- Shared information with AT Medics for them to send to patients in a text message to notify them of the proposal
- Briefed local stakeholders including Chairs of Health and Scrutiny Committees, local MPs and Healthwatch
- Issued a survey to allow for comments and feedback (214 responses)
- Hosted a dedicated Webinar on 24 January 24 open to patients, the public and stakeholders
- Briefed on the proposed change of control at meetings of the ICB Board
- Following notification of the Change of Control having taken place, NEL ICB published a statement on its advising of the change
- Verbal briefings were provided to local stakeholders
- Primary Care Contracts Sub Committee Meetings have been held in public from May 2024 onwards

3.2 Feedback from patients and the public can be summarised into the following themes:

Patient services

- Concerns raised around difficulty in getting an appointment
- Some dissatisfaction with the reception team and administrative inefficiencies
- Negative feedback on the ease of use and functionality of the Dr IQ App
- Positive feedback on the quality of care received, particularly from the GPs
- Concerns were expressed around future skill mix and the potential for a move away from GPs to staff who were less well qualified
- Concern at implications for GP practice services because of the change of control and how this could cause disruption by impacting staffing, service delivery and patient care
- Comments also expressed the potential for a positive change with a view to improved access and quality of care for patients.

Ownership

- Concerns that this is the second change of control in recent years and there is a possibility that the company will be sold on again in a few years' time
- Concerns were expressed that profit would be prioritised over patient care
- Opposition was expressed to the privatisation of the NHS and GP practice services, being owned by private companies, with the interests of such companies being questioned
- Calls were made for services to be under NHS control and for alternatives to profit-led companies to be considered.

4.0 AT Medics contracts – overview

4.1 A summary of the contracts held by AT Medics is outlined below, highlighting number of sites, list size, contract length, renewal and end dates and CQC rating. Decisions on the future of the contract take place a year before each break point or contract end date, following a commissioning intentions exercise and are made by the Primary Care Contracts Sub Committee.

Contract	Place	No of sites	List size	Contract length	Contract end date	CQC rating
Trowbridge	Hackney	1	8,019	5+5+5	Break clause 1/4/27 **Decision by: 1/4/26** Final end date 1/4/37 Next decision by:	Good overall (Good on every domain)
Goodman's Field	Tower Hamlets	1	34,847	5+5+5	Break clause 8/8/25 **Decision: 16/7/24** Final end date 8/8/35	Not currently inspected
Lucas Ave	Newham	1	14,551	5+5	Final end date 31/7/26 **Decision by 31/7/25**	Good overall (Good on every domain)
Carpenters Practice	Newham	3	24,983	5+5+5	Break clause 30/6/25 **Decision: 16/7/24** Final end date 30/6/35	Good overall (Good on every domain)
E16 Health	Newham	2	22,800	5+5	Final end date 3/6/25 **Decision: 17/9/24**	(Good on every domain)
Loxford	Redbridge	1	33,706	5+5	Final end date 31/7/26 **Decision by 31/7/25**	Good overall (Good on every domain)

4.2 The total list size of these practices combined is 138,907. Goodman's Field (34,847) and Loxford (33,706) are the practices with the two highest list sizes in North East London ICB. All of these practices with the exception of Trowbridge have list sizes higher than the national average which is currently 10,001 patients.

4.3 All six contracts have review points for end dates or contract renewal dates within the next two years with three of these occurring this year, two next year and one in two years' time.

- Carpenters Practice and Goodman's Field have break clauses in 2025 and a decision on contract renewal following a commissioning intentions review will be made at this Sub Committee meeting.
- The E16 Health Contract comes to an end in June 2025 and a decision will be made on this at the September Sub Committee meeting.
- Lucus Avenue and Loxford reach their final end date in July 2026 and a decision on the future of these contracts will be made in a year's time.
- Trowbridge contract was procured two years' ago in 2022 and reaches a break point in April 2027 and a decision would need to be made in April 2026.

4.4 Five of the contracts are rated Good by the CQC overall and Good on every domain. Goodman's Field has not been rated by the CQC since the practice went through a merger and relocation two years' ago. Following an inspection in May 2021, Carpenters Practice was rated Inadequate but was subsequently rated Good overall and in every domain in July 2022 and at a follow up review in July 2023, the CQC found no evidence to reassess the rating.

5.0 Findings from the Annual APMS Contract Review Process

5.1 All practices on APMS contracts are subject to an annual review. Practices are required to provide information on achievements, challenges and the actions taken to address them and interventions to improve patient access and overall experience. Where concerns are identified, these are followed up further in a formal review meeting. There were no concerns identified at any of the six AT Medics practices at their last review that led to a further formal meeting.

5.2 A summary of key points from the annual reviews for all AT Medics practices is provided below. Key themes arising from these reviews indicate that these practices tend to be in areas with young populations and high list size growth. There are challenges with recruiting GPs and in some cases a high dependence on locums which they are working to address. A common theme is issues with patients getting through on the phone. Mechanisms to address this include activating callback and increasing administrative staff at times of high demand. Many of the practices cite issues with patient engagement and challenges trying to maintain an active Patient Participation Group and are working to try and address this.

	Summary of key points from annual review
Trowbridge	Following feedback from pts on availability of appts, practice increased its workforce, with additional GP and care co-ordinators. 84% registered for online consult. All day Sat and evening appts offered to meet needs of young practice pop'n. Admin lead working with nurse to support recalls and follow ups to address challenges in preventative care uptake. Improvements in pt survey for phone access, being treated with care and concern and overall experience. Decline in pt survey scores for satisfaction with type of appt offered, helpfulness of recept staff.
Goodman's Field	Following feedback from pts on availability of appts, practice team has been expanded. (17 new posts incl 2 GPs) In order to address feedback on long phone waiting times, callback function enabled. High numbers of pts requesting repeat presc by phone have led to raising awareness of pts doing this online. 10% increase in online consult take up. Young peoples' event held to help encourage engagement with this population. Monthly drop-in sessions introduced for complaints/feedback. Improvements made in most areas of pts survey esp phone access (9% improvement). Decline in pt survey scores for satisfaction with type of appt offered, helpfulness of recept staff.
Lucus Avenue	Conducted primary care prevention reviews or cardiovascular disease assessments for 329 patients. Challenges with space being addressed through improvement grant application. High use of locums being addressed through initiatives to attract salaried GPs and increase staff stability. Difficulties in establishing a Strong PPG being addressing through enhanced communication strategies. Internal pt survey undertaken alongside national survey and action plan in place to address areas of improvement. i.e. increased mapping of demand and capacity to improve phone access and workshops to improve helpfulness of receptionists
Carpenters Practice	Significant list size growth. Challenges recruiting GPs and high use of locums. Initiatives put in place to recruit newly qualified GPs and retain staff. Undertaken practice pt survey in addition to national pt survey and action plan in place to address areas of improvement. Patients have fed back that they don't find it easy to contact the practice. Practice has increased admin staff for call handling in busy periods and introduced pt callback. Difficulties in engaging PPG. Using a variety of methods to promote this.
E16 Health	Highly diverse population with1227 refugees and asylum seekers registered at the practice. Migrant health slots created and double slots where interpreters are required. Challenges in recruiting GPs and high reliance on locums. Initiatives put in place to recruit newly qualified GPs and retain staff. Practice has increased admin staff for call handling in busy periods and introduced pt callback. Difficulties in engaging PPG. Using a variety of methods to promote this. Improvements made in pt survey on choice of appt and satisfaction with type of appt and getting to speak to their preferred GP.
Loxford	Significant increase in list size. Issues with patient access. The practice has introduced a triage-based hub to help address this and introduced cloud-based telephony, incl callback and increased admins staff to help pts get through in the phone. Issues with vacancies within the nursing team have now been resolved and larger nursing team in place including HCAs and introduction of late evening and weekend clinics. Issues with a lack of clinical space hampering the ability to meet pt demand. Use of additional space in the building has recently been approved.

6.0 Review of Options

6.1 Following the issuing of a breach notice for undergoing a change of control without seeking consent first, AT Medics were informed that we consider this to be a serious breach and that we are currently considering what further action to take under the contracts. "*This breach notice is entirely without prejudice to, and we fully reserve, our ability to exercise any of our rights under the Contracts, and to enforce any of the terms and conditions of the Contracts, at any time. This includes, without limitation, our right to terminate the Contracts.*"

6.2 Consideration is given below to the two main options. These are:

- Take no further contractual action but review and take a decision on the future of each contract as it comes up for renewal or expiry on a case-by-case basis in the same way as we would do for any other APMS provider.
- Terminate the contracts, with different options for notice periods.

6.3 The benefits and risks of both options are outlined below.

7.0 Consider each contract on a case-by case basis as it comes up for renewal or expiry

7.1 Pursuing this option means that each contract would be considered through the Commissioning Intentions process a year before it comes up for renewal or expiry. The breach would be still taken into consideration but as one information point, alongside a range of other data and intelligence to assess performance and quality.

7.2 **Benefits**

- Three of the six APMS contracts are coming up for renewal or expiry shortly meaning that following a review of quality and performance, a decision can be made by the end of September 2024 on half of these contracts. Carpenters Practice and Goodman's Field have break clauses in 2025 and a decision on contract renewal following a commissioning intentions review will be made at this Sub Committee meeting. The E16 Health Contract comes to an end in June 2025 and a decision will be made on this at the September meeting.
- We are introducing additional rigour to the Commissioning Intentions process using a more comprehensive range of data and intelligence to assess performance and quality and inform decision making when considering the future of all APMS contracts. This will help to ensure robust and informed decision making and reduce the risk of continuing with a poor-quality provider.
- This option ensures that there is the opportunity for the continuation of good practice where applicable and where concerns are raised, there is the opportunity for the current provider to work to address these.
- Each contract will be subject to regular annual reviews and where concerns are identified, a more formal review will be undertaken. If necessary, the provider will be required to put remedial timed actions in place. This will enable the Commissioner to monitor any future adverse impacts from the change in ultimate ownership of AT Medics/Operose.
- This option provides stability to patients in the continuation of service provider
- There is no need to seek alternative providers unless required, following review, which reduces the risk of not identifying an appropriate provider and putting patient services at risk.
- There is a low risk of legal challenge from the provider/ owner if a decision on the future of each contract is made as it comes up for renewal or expiry on a case-by-case basis.

7.3 **Risks**

- The repercussive risk of setting of a precedent and expectation with APMS providers that changes of control do not require prior ICB approval and/or that effecting a change of control without prior approval will not result in termination for doing so, despite this being a serious breach of contact.
- There is a risk that the ICB is perceived as not taking the matter seriously. A high level of trust and transparency needs to exist between the ICB and its primary care providers and the way the breach of contract took place, demonstrates a lack of transparency by the provider.
- The risk of a future deterioration of performance or financial instability following the change of ownership of AT Medics/Operose.

8.0 Terminate the contracts

8.1 The APMS contract allows for a general right of termination with nine months' notice and a right to terminate the contract for serious breach.

8.2 Termination would be on the grounds that AT Medics underwent a change of control without prior authorisation. Termination cannot be made on the grounds of an objection to the nature of the ownership of Operose and AT Medics. Under delegated commissioning, NEL ICB is required to comply with the NHS England duty not to prefer one type of provider over another.

8.3 A decision to terminate would need to consider the notice period. This could be termination with immediate effect or on a longer notice period. Under this option the Committee could link any termination date to the minimum nine month notice period available under the APMS contract. There is also the option to link any termination date to the next natural break point in each contract. It is likely that a minimum of at least nine months' notice would be required to allow patient, public and stakeholder involvement and equalities analysis, a provider selection process, and a safe and orderly transition of services to a new provider.

8.4 **Benefits**

- The ICB retains its strong contractual position regarding breach of contract where a provider effects a Change of Control without first having obtained the ICB's permission. It is a strong discouragement to APMS providers to breach the contract in this manner and retains the ICB's ability to properly vet and assess the suitability of those seeking control of APMS contracts.
- This would have support from some stakeholders and patient representatives.

8.5 **Risks**

- The ICB would be terminating for reasons other than current quality and performance. All lists are too large to disperse to neighbouring practices. There is a risk of securing good quality, suitable alternative providers for 139,000 patients at six practices. Many of these are large complex practices. Two practices are the largest in North East London (both have over 33,000 patients) and demonstrate continuing trends in list size growth. One practice is based on two sites, with another practice being based on three sites with associated logistical challenges. There are also several other APMS contracts that are coming to an end and are likely to need to go out to procurement this year. We are planning to undertake work to help develop local providers to take on APMS contracts/lists, although this may take some time.

- The risk of disruption to continuity of patient care if there was a change of service provider, particularly if there was a need to put temporary caretaking arrangements in place first.
- The risk of any potential for disruption to or impact on services during notice periods, for example, the provider may limit their engagement with the ICB.
- This may be seen as an overly punitive contractual response by the provider, patients or wider stakeholders.
- This brings an increased risk of legal challenge from the provider / new owners. Legal advice indicates that the shorter the notice period before termination, the more likely the risk of a legal challenge. Immediate termination would be extremely high risk. The level of risk would reduce with giving a notice period of up to ninth months and reduce further to a medium level of risk by giving a notice period of over nine months.

9.0 Conclusion

9.1 Pursuing the option to terminate would send a strong message that providers should not effect a Change of Control without first having obtained the ICB's permission and would be a strong discouragement for providers to breach the contract in this manner in future.

9.2 However, when deciding whether to terminate a contract, commissioners are required to consider the needs of their local populations for primary medical services and how a decision to terminate could be justified, bearing in mind, the impact on patient access to services. There is a risk that termination for reasons other than current quality and performance would be disruptive to continuity of patient care and an associated risk of not being able to secure suitable alternative providers for six practices with a total of 139,000 patients. This brings a risk of legal challenge from the provider/new ownership, particularly if there was a notice period of less than nine months.

9.3 Considering each contract as it comes up for renewal by undertaking a thorough commissioning intentions process, means that decisions on the future of each contract would be made on an assessment of quality and performance. There are no significant performance concerns that would mean that there would be a risk to patient care with these contracts continuing until they reach a decision point at a break clause or end of contract. As many of these decision points are coming up shortly, decisions on three of the six contracts can be made by September 2024.

10.0 Recommendation

10.1 Having considered the benefits and risks of each option to reach a balanced decision, the recommendation is that no further contractual action will be taken in respect of the unauthorised change of control in addition to the breach notice previously issued. Each contract will be considered on a case-by case basis as it reaches a review point for renewal or expiry following a commissioning intentions process.

10.2 It is recognised that AT Medics did not inform us that the change of control had been enacted until several months after the event and in writing to them to inform them of our position following the issuing of the breach notice, we will be seeking further assurance from them of better conduct in future.

11.0 Next steps

11.1 Subject to agreement of the recommendation, next steps are outlined below:

- To write to AT Medics informing them that no further contractual action will be taken in addition to the breach notice previously issued. In respect of the delay in informing us that the change of control had already taken place, we will seek assurance from them of better conduct in future.

- To progress commissioning intention reviews for the three AT Medics contracts coming up for renewal and final expiry in 2025. Decisions will be made on the Carpenters Practice contract and Goodman's Field contract at this meeting and on the E16 Health contract at the September meeting.

North East London

Primary Care Contracts Sub-committee

16 July 2024

Title of report	APMS Commissioning Intentions - Newham Transitional Practice
Author	Abdul Rawkib, Primary Care Commissioning Manager, NEL ICB
Presented by	Abdul Rawkib, Primary Care Commissioning Manager, NEL ICB
Contact for further information	a.rawkib@nhs.net
Executive summary	Newham Transitional Practice (NTP) is a specialist APMS contract for providing services for people experiencing homelessness and social exclusion. The contract has been managed by the East London Foundation Trust (ELFT) since April 2020. The contract provides a maximum contract term of 15 years with provision for 5-year break clauses throughout. The contract is approaching the expiry of its initial five-year term on 31 March 2025 and is subject to extension by mutual agreement for a further 5-year term pending its commissioning review. Contract performance is reviewed annually but a more comprehensive review has been undertaken in view of the commissioning options to be considered at the contract's five-year break-clause. The Strategic Commissioning Review presents an overview of contract performance and other factors to be considered in determining the future of the contract beyond the initial expiry date. NTP has maintained good performance across a range of indicators and in some areas performed above the borough /ICB average notably in GP access and the GP Patient Survey. Areas identified for improvement include QOF and childhood immunisation, which is being addressed by initiatives to tackle vaccine hesitancy in the wider community. Overall, there are no contract compliance issues or concerns with this practice to terminate the contract at the initial expiry date, so ordinarily we would look to extend the contract for a further five years. However, NEL ICB is currently developing a homeless strategy. This is a partnership framework to allow place partners to address the needs of this population. One of the pillars of this strategy is to develop plans to improve and maintain access to primary, community and mental health services. The aim is that the strategy will be launched in November 2024. Extending the contract for a further year in the first instance and completing a further review in July 2026 would enable us to consider the recommendations from the strategy when considering the future commissioning of this service.

<table>
<tr><td>Action / recommendation</td><td>The Committee is asked to approve the recommendation of extending the contract by a further extend the contract for a further year in the first instance until 31 March 2026, to allow the ICB to consider the recommendations from the NEL Homeless Strategy, currently under development, when considering the future commissioning of this service.</td></tr>
<tr><td>Previous reporting</td><td>This report has been discussed at the Newham Primary Care Transformation Group and the extension proposal supported</td></tr>
<tr><td>Next steps/ onward reporting</td><td>• Issue contract extension notice
• Continue monitoring progress and the areas for improvement will be reviewed as part of the 24/25 contract review
• Undertake a further commissioning intentions exercise in July 2025.</td></tr>
<tr><td>Conflicts of interest</td><td>Any conflicts of interest to be managed in line with the Terms of Reference (ToR) of the Committee.</td></tr>
<tr><td>Strategic fit</td><td>Which of the ICS aims does this report align with?
• To improve outcomes in population health and healthcare
• To tackle inequalities in outcomes, experience and access
• To support broader social and economic development</td></tr>
<tr><td>Impact on local people, health inequalities and sustainability</td><td>Extending this contract will ensure the ongoing provision of specialised services for the homeless population within Newham.
The presence of such specialised services allows primary medical services to be tailored to the unique needs of these vulnerable populations, thereby helping to address health inequalities related to socio-economic deprivation. Additionally, it plays a vital role in narrowing the gaps in physical health outcomes among a population characterised by a high incidence of mental illness and substance misuse.</td></tr>
<tr><td>Impact on finance, performance and quality</td><td>Extending the existing contract will commit £650,000 revenue expenditure per annum from the delegated primary care budget.
This is not a new cost pressure and is already accounted for in the budget.</td></tr>
<tr><td>Risks</td><td><table><tr><th>Risk</th><th>Mitigation</th></tr><tr><td>Current contract does not contain KPIs specific to the homeless population</td><td>Ongoing negotiations with current provider to implement new KPIs from Q2</td></tr></table></td></tr>
<tr><td>Appendices</td><td>Appendix 1 – Newham Transitional Practice Strategic Review</td></tr>
</table>

NHS North East London

GP Contract Strategic Commissioning Review Business Case

Place:	**PCN:**
Newham	Stratford PCN
Practice name:	**Practice code:**
Newham Transitional Practice	F84740
Raw list size:	**Weighted list:**
4296 (1 April 2024)	4041.72 (1 April 2024)
Current provider:	
East London Foundation Trust (ELFT)	
Contract Start Date:	**Contract End date:**
1 April 2020	31 March 2025
Contract Term Provision for Extension/Break Clause:	
This contract was procured for a term of 15 years (5+5+5) with the option to extend until 31 March 2035.	
Reason for contract review:	
This contract is approaching its first five-year break clause, with the option to extend for a further five years until 31 March 2030.	
Practice website:	
https://newhamtransitionalpractice.co.uk/	

Report Completed by:
Abdul Rawkib, Commissioning Manager, NHS North East London
Equality Impact Assessment Completed:
Not required as no change to service provision.
Summary of Recommendation:
The recommendation is to extend the contract for a further year in the first instance until 31 March 2026, to allow time for the work on the NEL Homeless Strategy to conclude this autumn. Once this has completed, this will inform the future commissioning of this service and a further commissioning intentions exercise will be undertaken in July 2025.
1.0 Contract Overview / History / Context
1.1. Newham Transitional Practice (NTP) was commissioned in April 2020 as a specialised primary care medical service for patients experiencing homelessness. This is one of the few such services in London and nationally for patients who experience difficulty registering with mainstream practices, including recent UK entrants, the socially excluded and/or those have difficulty providing registration details to register with a mainstream GP practice. The East London Foundation Trust (ELF) who were awarded the contract have been operating services across two sites: • 30 Church Road, London E12 6AP (main site) • 10 Vicarage Lane, London E15 4ES (branch site) 1.2 The contract was procured to deliver the following service outcomes: • Improve identification of homeless patients in primary care • Increase primary care access for target population • Increase use of planned health care • Increase in uptake of mental health and substance misuse services • Reduction in the inappropriate use of secondary care • Provision of safe environments that promote physical and psychological well being

1.3 The contract is approaching its first five-year break clause

1.4 NEL is currently developing a homeless strategy. This is a partnership framework to allow place partners to address population needs. One of the pillars of this strategy is to develop plans to improve and maintain access to primary, community and mental health services. The aim is that the strategy will be launched in November 2024.

2.0 Practice Specific Information

2.1 NTP is situated in the East Ham and Stratford and Bow ward. Both practice sites are in a purpose-built health centre and are co-located with other practices. The practice operates in line with GMS/PMS core hours (Monday to Friday, 8am – 6.30pm (excluding bank holidays)).

2.2. Clinical workforce

Clinical workforce FTE - exc. Locums, trainees and apprentices							
Practice/Org	GP	Nurses	Direct Patient Care	GP FTE p1000	Nurse FTE p1000	DPC FTE p1000	Patients to GP FTE
NEWHAM TRANSITIONAL PRACTICE	4.2	3.0	1.0	1.0	0.7	0.2	1027

2.3 The practice list size has been stable over the last three years with minimal growth. This is depicted in figure 1.0 below. It is important to note that under the service delivery model, patients can register with the specialist practice and receive the best possible primary care, until such a time as the persons needs can be provided for under the standard primary care offer. Therefore, patients are not expected to remain on the practice register long term, and high patient turnover is anticipated.

Figure 1.0 – Patient list size growth

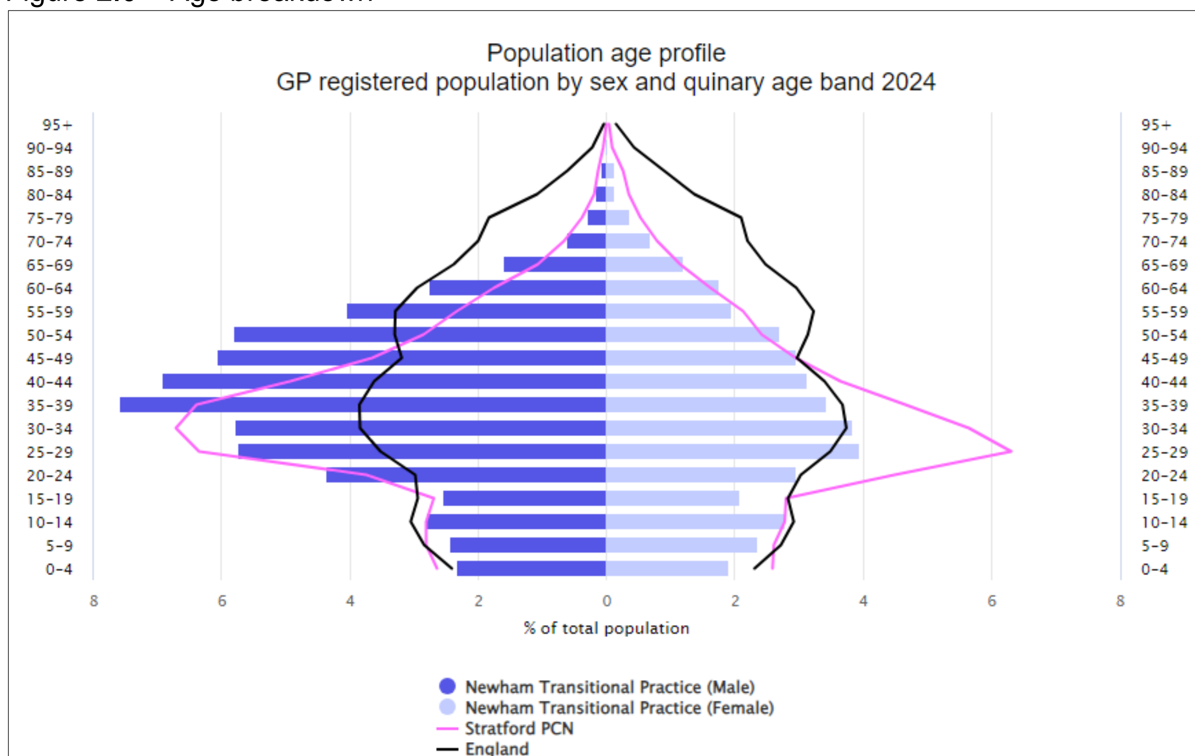
Period	Raw List Size	Variation to Previous Year (count)	Variation to Previous Year (%)
Apr-24	4,296	378	9.6
Apr-23	3,918	- 190	-4.6

Apr-22	4,108	114	2.9
Apr-21	3,994		

Source: PCSE list size data

2.4 The patient list mainly consists of the working age population and has a higher ratio of males to females. A breakdown of the age categories can be seen in figure 2.0 below:

Figure 2.0 – Age breakdown



Source: [National General Practice Profiles]

3.0 Quality Performance - Compare performance (CEG data) against PCN, borough and national

if the practice is an outlier in any area, comment if this is being addressed by the practice e.g improvement plan in progress being monitored as part of the annual contract review:

3.1 QOF Performance

The practice QOF performance has been satisfactory over the last few years although the achievement has been slightly lower than the borough average (see figure 3.0 below). It is important to note that the make-up of this practice population with complex needs and greater challenges in engaging with local health services. Moreover, QOF is a national measure for all GP practices and is not tailored for the homeless population.

Figure 3.0 – QOF Achievement

Financial year	Practice Achievement	Newham Average	Variance
2022-23	531.53 out of 635 points	536.42	4.89 percentage points below
2021-22	545.46 out of 635 points	548.08	2.62 percentage points below
2020-21*	N/A	N/A	N/A

*Data unavailable due to the impact of COVID-19

Source: NHS Digital QOF Data

3.2 Childhood Imms

In 2023-24 the uptake of childhood immunisations for this practice, particularly MMR was below the Newham average. The contractor states that this is due to the nature of the practice patient list.

Patients becoming 12m	DTaP/IPV/Hib/HepB(%)	Men B(%)	PCV(%)	Rotavirus(%)
Newham Transitional Practice	92.3%	84.6%	92.3%	92.3%
Newham Average	**88.1%**	**85.0%**	**91.4%**	**85.8%**

Patients becoming 24m	DTaP/IPV/Hib/HepB (%)	MMR(%)	HiB/Men C (%)	PCV (Booster)(%)
Newham Transitional Practice	50%	50%	25%	25%
Newham Average	**87.6%**	**81.2%**	**80.2%**	**79.8%**

Patients becoming 5 yrs	DTaP/IPV/Hib/HepB(%)	MMR (Primary)(%)	DTaP/IPV (Booster)(%)	MMR (Booster)(%)	HiB/Men C(%)
Newham Transitional Practice	75%	50%	25%	25%	50%
Newham Average	**89.4%**	**88.3%**	**81.1%**	**81.5%**	**87.7%**

(Source: CEG data 2023-24)

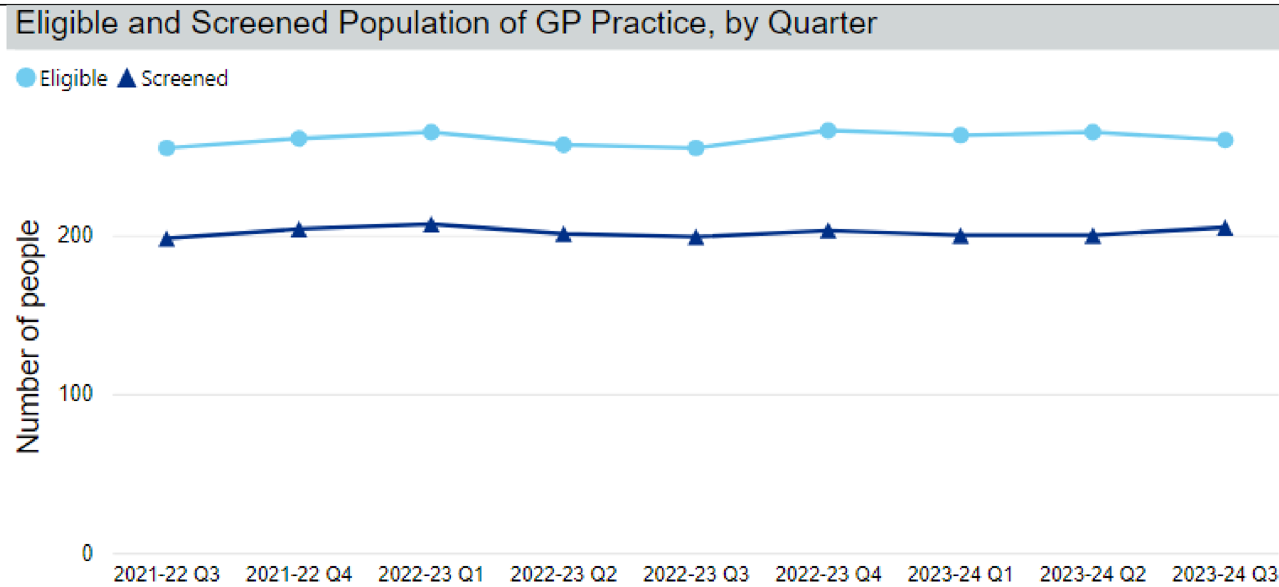
3.3 Flu

In 2023-24 the uptake of the seasonal flu vaccine was higher than the Newham average.

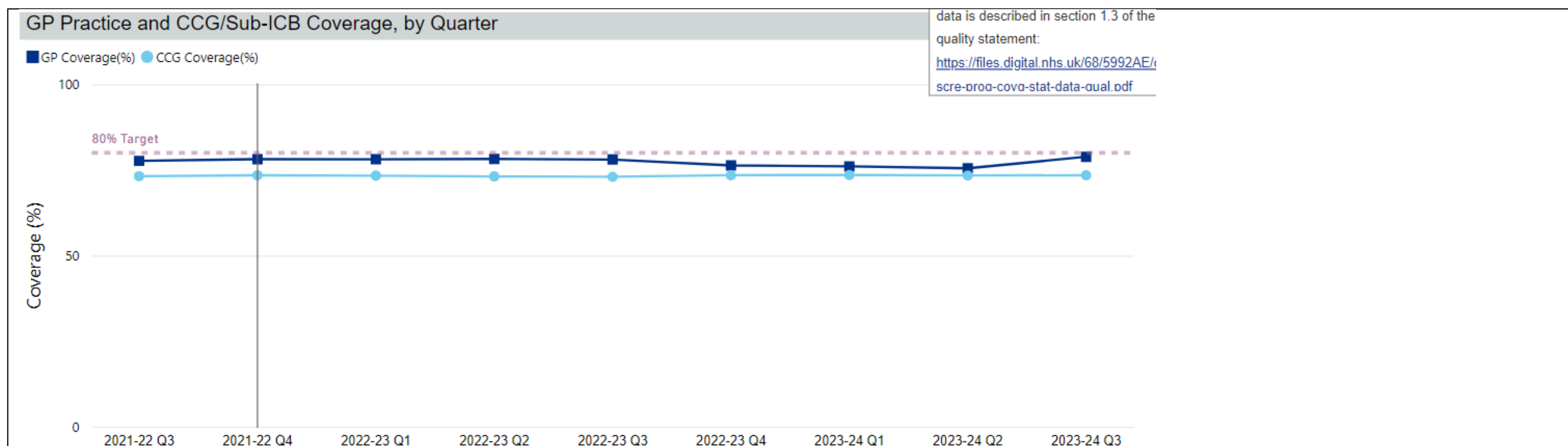
Seasonal Flu Uptake 23-24	Patients Age 65+
Newham Transitional Practice	64%
PCN Average	56%
Newham Average	60%

(Source: CEG data 2023-24)

3.4 Cervical Screening – Newham Transitional practice achieved slightly above the NEL average. However coverage for the practice and NEL are lower than the 80% national target.



(Source: NHS Digital)



(Source: NHS Digital)

4.0 Service Delivery

The practice nurse team work alongside the East London Foundation Trust (ELFT) Outreach Service to deliver clinical sessions at visiting hotels, hostels, charity centres, community hubs and other settings for homeless and vulnerable people in Newham. These services include New Patient Health Checks, Long Term Conditions Reviews, Health Promotion and New Patient Registration. The outreach clinics help to reduce vulnerable and homeless people in Newham presenting inappropriately at A&E when their issues could be dealt with and managed in a primary care setting.

4.1 Access

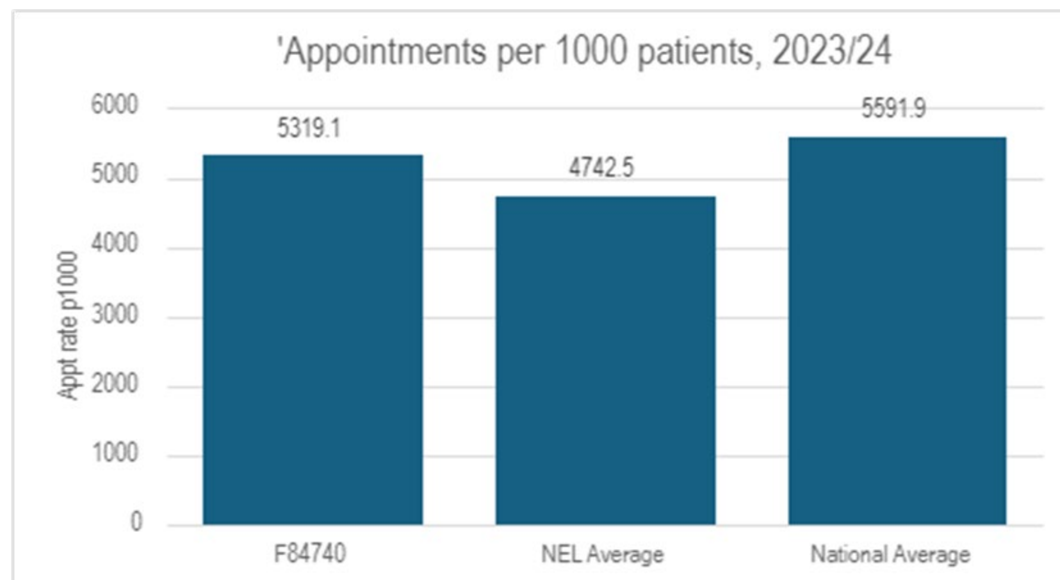
In 2023-24 the practice delivered 5,319 appointments per 1000 patients compared to the NEL average of 4,743 and national average of 5592.

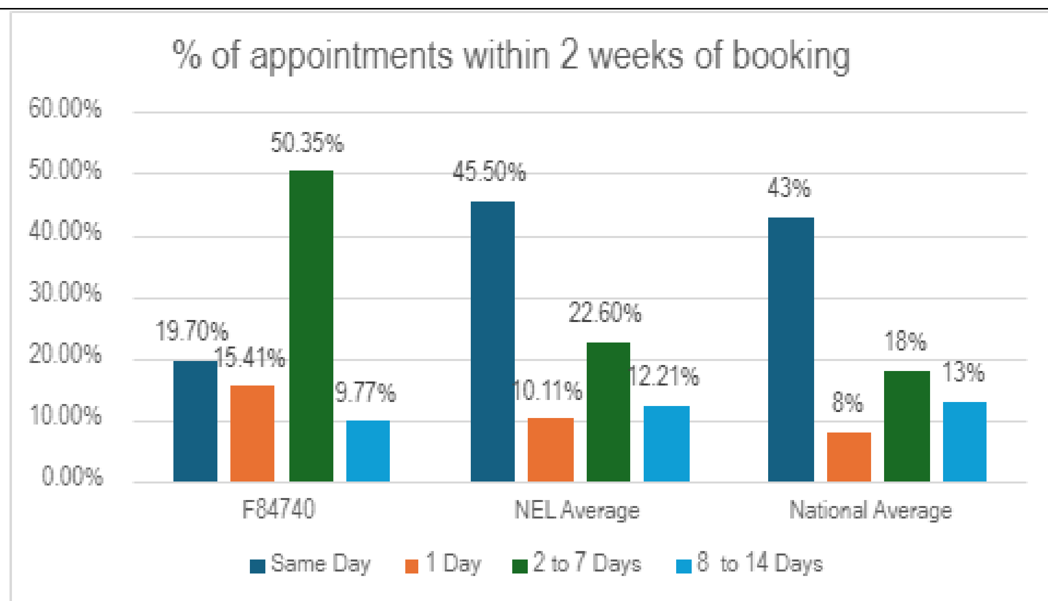
95% of appointments took place within 2 weeks of booking compared to 90% in NEL average and 82% national average. NHSE operational planning guidance indicates that a minimum of 85% of GP appointments should take place within 2 weeks of booking.

Newham Transitional practice offers more appointments per 1000 patients than the NEL average but few than the national average. However, the majority of appointments took place within 2 weeks of booking.

GPAD data 2023-24

	Appt rate p1000	Same Day	1 Day	2 to 7 Days	8 to 14 Days
Newham Transitional Practice	5319.1	19.70%	15.41%	50.35%	9.77%
NEL Average	4742.5	45.50%	10.11%	22.60%	12.21%
National Average	5591.9	43%	8%	18%	13%





4.2 A&E data

In 2023/24 the practice rate of in hours calls to NHS111 was significantly below the Newham and the NEL average. This could be partly attributed to the comparative higher rate of appointments offered per 1000 and the community outreach services provided.

Period April 23 – March 24

Practice/Benchmark	In hours calls per 1000 patients
Newham Transitional	48
PCN	82

Newham	79
NEL	66

(Source: NEL BI – PC Dashboard Suite)

4.3 Prescribing Quality and Efficiency

The NHS Community Pharmacy Blood Pressure Check Service supports risk identification and prevention of cardiovascular disease (CVD).

Service	Period	Number of referrals-Practice
Hypertension Case-finding NHS England » NHS Community Pharmacy Blood Pressure Check Service	November 2023 -May 2024	1
Ambulatory Blood Pressure Monitoring	November 2023 -May 2024	1
CPCS	March 2022-December 2023	44
Pharmacy First	January	2

The practice has engaged with partners and stakeholders to implement these services. However, the practice's referral rate is significantly lower than that of their PCN and the ICB's referral rates

The Prescribing Quality and Efficiency Scheme (PQES) is an initiative aimed at enhancing the quality, cost-effectiveness, and safety of prescribing and medicines optimisation within Primary Care.

.Medicines Safety	**Practice Output**
To address the MHRA alert regarding the use of Valproate by women and girls, practices are asked to submit evidence of	Achieved

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revieing patients on Valproate. If there are no patients on Valproate, another MHRA alert can be chosen to demonstrate implementation	
Opioid and Dependency Forming Medicines (DFM) prescribing clinical review	Achieved
Learning From Patient medicines-related safety events. Practices to report on prescribing errors/near misses via the Learning From Patient Safety Events (LFPSE) portal.	Achieved

Antimicrobial resistance (AMR) has been identified as one of the most pressing global challenges we face this century. In fact, the World Health Organisation (WHO) has declared AMR as one of the top 10 global public health threats, and AMR is listed on the UK Government's National Risk Register.

Practices are therefore asked to review their antimicrobial prescribing to ensure that this in line with local and national guidelines. Practices should aim to achieve the set targets for the antimicrobial prescribing metrics.

Antibacterial items/STAR-PU position March 24 (12 months rolling data)	**Proportion of co-amoxiclav, cephalosporin & quinolone items position March 24 (12 months rolling data)**	**Amoxicillin 500mg capsule: % of total items, 5 days (Quantity=15) March 24 (12 months rolling data)**	**OptimiseRx:**

≤0.871	≤10%	>40%	≥ 20% acceptance rate
0.618	6.47%	38.89%	23 %

4.4 KPIs

The contract was commissioned to include KPIs. KPI payments are based on 20% of the overall contract value which equates to £130,000. As this contract was commissioned at the peak of Covid-19, the practice was not commissioned to deliver specific homeless KPIs, but rather deliver on the Newham Outcome Measures (OMs) which is expected of all GP practices in Newham. There are ongoing discussions with NTP to start delivering homeless specific KPIs, which will be aligned with other homeless contracts across NEL.

4.5 Innovation

The practice provides outreach clinics in the community including hostels for vulnerable people and community centres where they provide primary health care and refer patients to the appropriate services when required. They also work closely with community mental health services and hostels for people that have been discharged from prison. Service users can collect hot and cold food, clothes, get haircuts and showers.

5.0 Contract & Regulatory Compliance

5.1 The practice was last inspected by the CQC in 2016 and was rated Good. There are no compliance issues in relation to the yearly eDEC submissions by the practice or contractual breaches.

5.2 The last annual contract review for financial year 2022/23 was undertaken earlier this year and there were no performance concerns highlighted.

6.0 Premises and Estates

6.1 Both practice sites are situated in a purpose-built health centre. The practice has a lease arrangement in place with Community Health Partnership (CHP).

7.0 Patient Experience

7.1 PPG - The practice has been unable to stablish a patient participation group, mainly due to challenges around the nature of the transient client group with complex needs but the practice continues publicise and promote this.
7.2 GP Patient Survey (GPPS)

The practice GPPS results for 2023 was above the ICB average for all survey questions. Figure 4.0 has a summary of some of the key questions that were analysed:

Figure 4.0 – GPPS Results 2023

	Practice Result	ICB Result	Above / Below ICB Average
Describe their overall experience of this GP practice as good	88%	64%	Above
Satisfied with the general practice appointment times available	85%	51%	Above
Find it easy to get through to this GP practice by phone	85%	48%	Above

Source: GP Patient Survey

8.0 Contract Value

8.1 This contract is under a block arrangement of £650,000 per annum. This is a fixed amount over the lifetime of the contract. 20% of the annual contract value (£130,000) is attached to the delivery of KPIs.

9.0 Options/ Preferred Option/Risks (e.g Contract extension; List Dispersal; appropriate PSR route)

	Pros	Cons	Risks	Mitigation
Option 1 – Do nothing	The contract will come to end on 31 March 2025 with no provision for continuity of patient care			
Option 2 – Extend contract	• Service delivery to this specialist population will not be disrupted. There are no significant performance concerns in relation to the delivery of the contract. • Current provider has long-standing experience of working in Newham and with this patient cohort.	• Taking a decision now, and extending the contract for a further 5 years on its current terms, would mean that we wouldn't be able to take into account the outcomes from the NEL Homeless Strategy which is currently being developed and due to launch in November.	• Current KPIs are not specific to meeting the needs of the homeless population • There may be recommendations from the homeless review that we may not be able to take into account by extending the service at this current time.	• Extend for one year in the first instance to allow time for the work on the NEL homeless strategy to conclude this autumn to inform the future commissioning of this service.
Option 3 – Terminate contract and disperse the list or tender a new contract	• The list size of 4,000 patients could be dispersed and patients directed to register at a mainstream practice. • Tendering a new contract will provide an opportunity to develop a new model and service specification	• Disruption to services for this client group who already have challenging needs and are disengaged with local health services. • Loss of a good provider with experience of working with the homeless population in Newham.	• Limited providers in the market with a track record of delivering specialist homeless contracts • Mainstream practices will not have the resources to provide patient care in outreach services	• Market testing will need to be undertaken and ensure a sufficient timeframe for the tender process • Services would need to be commissioned with local practices to fill the gap of patient care in outreach services and other specialist services currently provided

Preferred Option:

The preferred option is to extend the contract for a further year in the first instance until 31 March 2026. This option enables the ICB to consider the recommendations from the NEL Homeless Strategy currently under development and due to launch in November 2024 when considering the future commissioning of this service.

10.0 Next steps

- Issue provider with contract variation extension notice
- Continue with regular contract reviews
- Undertake a further commissioning intentions exercise in July 25

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Primary Care Contracts sub-committee

16 July 2024

Title of report	APMS Contract Commissioning Intentions – SMA Medical Centre
Author	Benjamin Smith, Primary Care Commissioning Manager
Presented by	Benjamin Smith, Primary Care Commissioning Manager
Contact for further information	benjamin.smith10@nhs.net
Executive summary	SMA is an APMS contract in Waltham Forest that has been managed by the Hurley Group since April 2020. The contract has a maximum contract term of 15 years with provision for 5-year break clauses throughout. The contract which delivers services to 11,700 patients is approaching the expiry of its initial five-year term on 31 March 2025 and is subject to extension by mutual agreement for a further 5-year term pending its commissioning review. Contract performance is reviewed annually but a more comprehensive review has been undertaken in view of the commissioning options to be considered at the contract's five-year break-clause. The Strategic Commissioning Review presents an overview of contract performance and other factors to be considered in determining the future of the contract beyond the initial expiry date. Overall, the practice has maintained a satisfactory performance across the range of indicators, performing above the borough /ICB average notably in the Quality Outcomes Framework (QOF); access indicators (delivery of appointments per 1000 patients and the percentage of appointments taking place within two weeks of booking). There are no contract compliance issues or concerns with this practice to justify terminating the contract at the initial expiry date therefore the preferred option is to extend the contract for a further five years until 31 March 2030.
Action / recommendation	**Decision:** Approve extending the contract for a further five years until 31 March 2030.
Previous reporting	The proposal to extend was discussed and endorsed at the Waltham Forest Local Forum on 20 June 2024.
Next steps/ onward reporting	Issue provider with extension notice – August 2024
Conflicts of interest	Any conflicts of interest to be managed in line with the Terms of Reference (ToR) of the Committee.

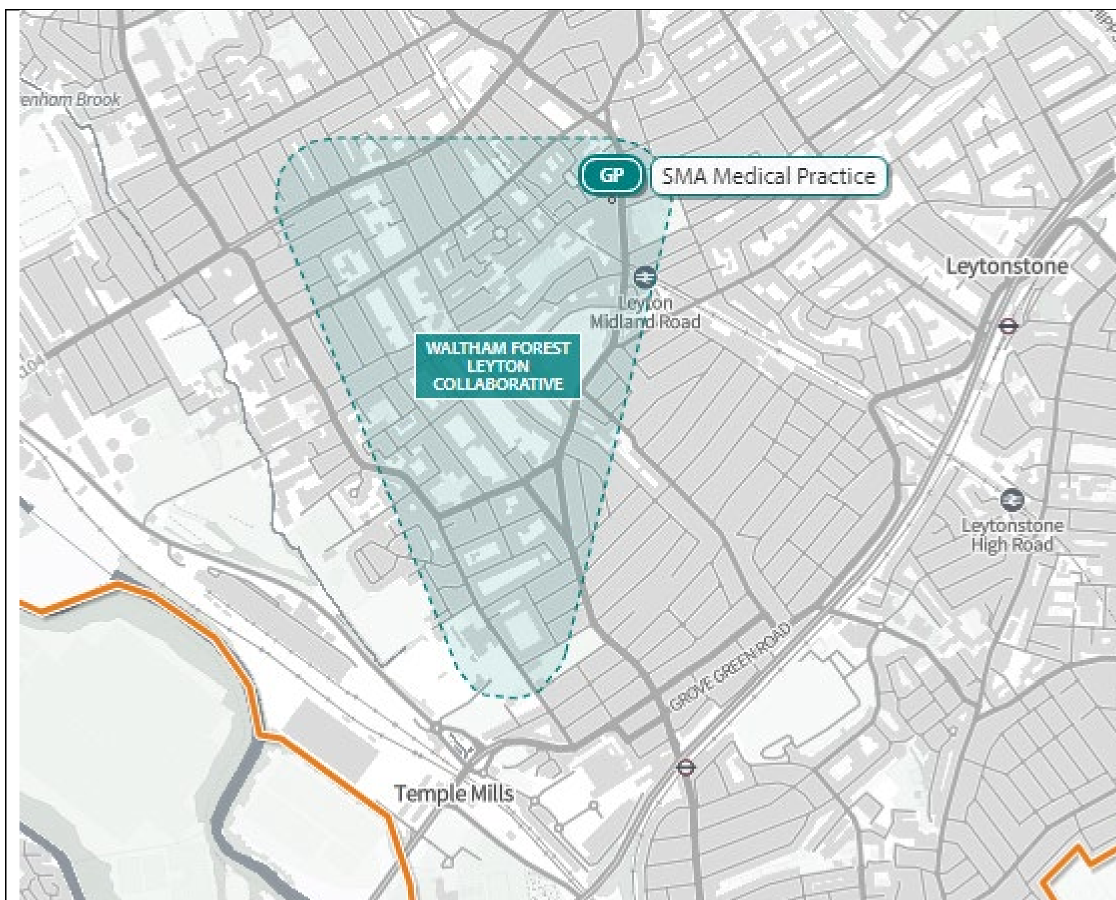
Strategic fit	Which of the ICS aims does this report align with? • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access
Impact on local people, health inequalities and sustainability	EQIA not required as no change to service provision.
Impact on finance, performance and quality	There are no financial, performance or quality implications
Risks	If contract arrangements are not confirmed within 9 months of the expiry date, patient care may be disrupted on the expiry of the contract in March 2025.

NHS North East London

GP Contract Strategic Commissioning Review Business Case

Place:	**PCN:**
Waltham Forest	Leyton Collaborative
Practice name:	**Practice code:**
SMA Medical Centre	F86038
Raw list size (April 2024)	**Weighted list (April 2024)**
11777	10332.1514
Current provider:	
Hurley Clinic Partnership	
Contract Start Date:	**Contract End date**
1 April 2020	31 March 2025
Contract Term Provision for Extension/Break Clause:	
Option to extend to 31 March 2030 further option to extend to 31 March 2035.	
Reason for contract review:	
Contract expires on 31 March 2025 and decision is required on whether to extend the contract further.	
Practice website:	
https://www.smamedicalcentre.com/	

Report Completed by:
Benjamin Smith, Primary Care Commissioning Manager
Equality Impact Assessment Completed:
Not required as no change to service provision.
Summary of Recommendation:
Recommendation is to extend the contract for a further five years until 31 March 2030.
1.0 Contract Overview / History
1.1 Up to January 2018, SMA Medical Centre was managed under a single-handed contractor, under a PMS contract which ended when the GP handed back his contract. 1.2 A caretaker contractor was then appointed in January 2018 to undertake the management of the practice. Hurley Clinic Partnership were awarded the caretaker contract and were successful in procuring the substantive contract, which commenced on 1 April 2020. 1.3 There are no terms to be varied within the contract.
2.0 Practice Specific Information
2.1 SMA Medical Centre operates from purpose-built premises within a highly residential area of Leyton in Waltham Forest. The practice operates in line with GMS/PMS core hours (Monday to Friday, 8am – 6.30pm (excluding bank holidays).



2.2 Practice Address:

SMA Medical Centre

693-695 High Road

Leyton

London

E10 6RA

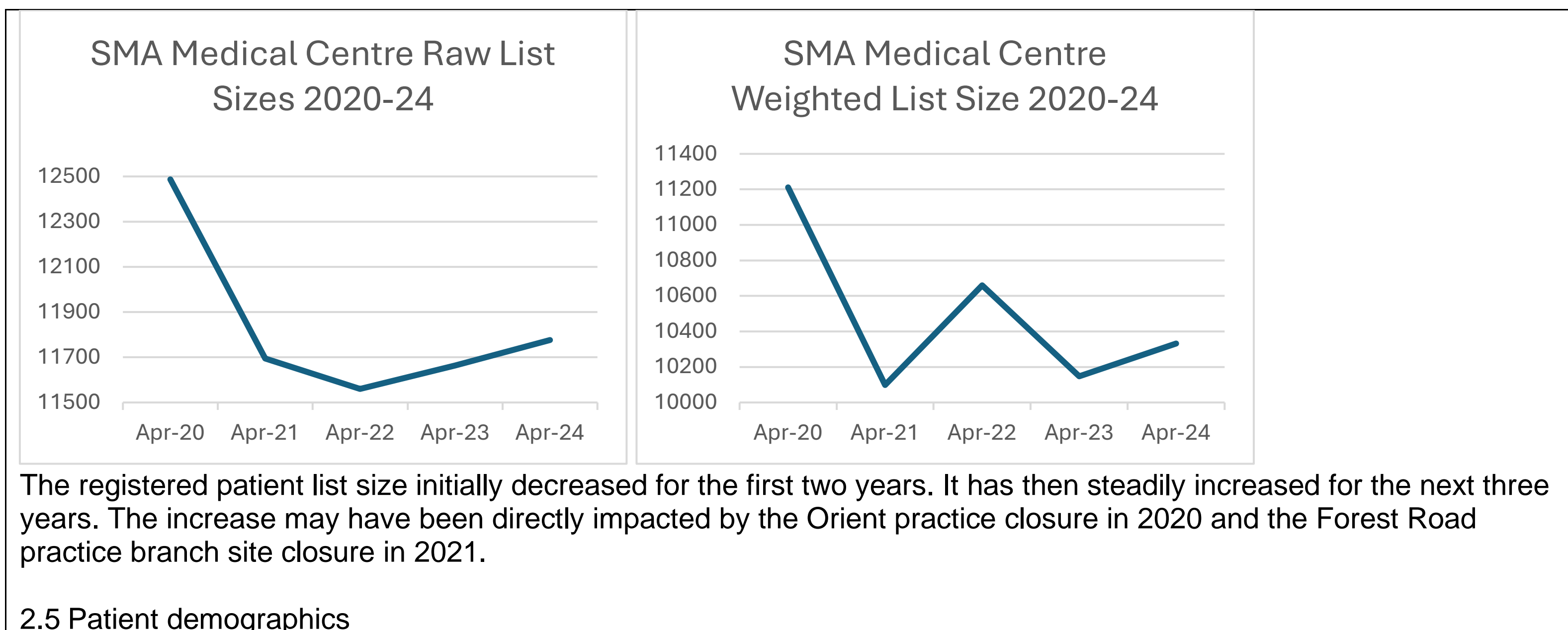
2.3 Clinical workforce (Figure 2.0)
The clinical workforce at SMA Medical Centre is smaller than the ICB and London average. The practice has a lower patient to GP FTE ratio than local, regional and national comparators. The nurses FTE per 1000 registered patients is equal to the ICB and London average but below the England average.

Practice/Org	GP	Nurses	Direct Patient Care	GP FTE p1000	Nurse FTE p1000	DPC FTE p1000	Patients to GP FTE
SMA MEDICAL PRACTICE	2.1	1.0	0.0	0.2	0.1	0.0	5520
NEL ICB				0.3	0.1	0.2	2906
LONDON				0.4	0.1	0.2	2700
ENGLAND				0.4	0.3	0.3	2367

Source: *General Practice Workforce, 31 March 2024 – NHS England Digital*

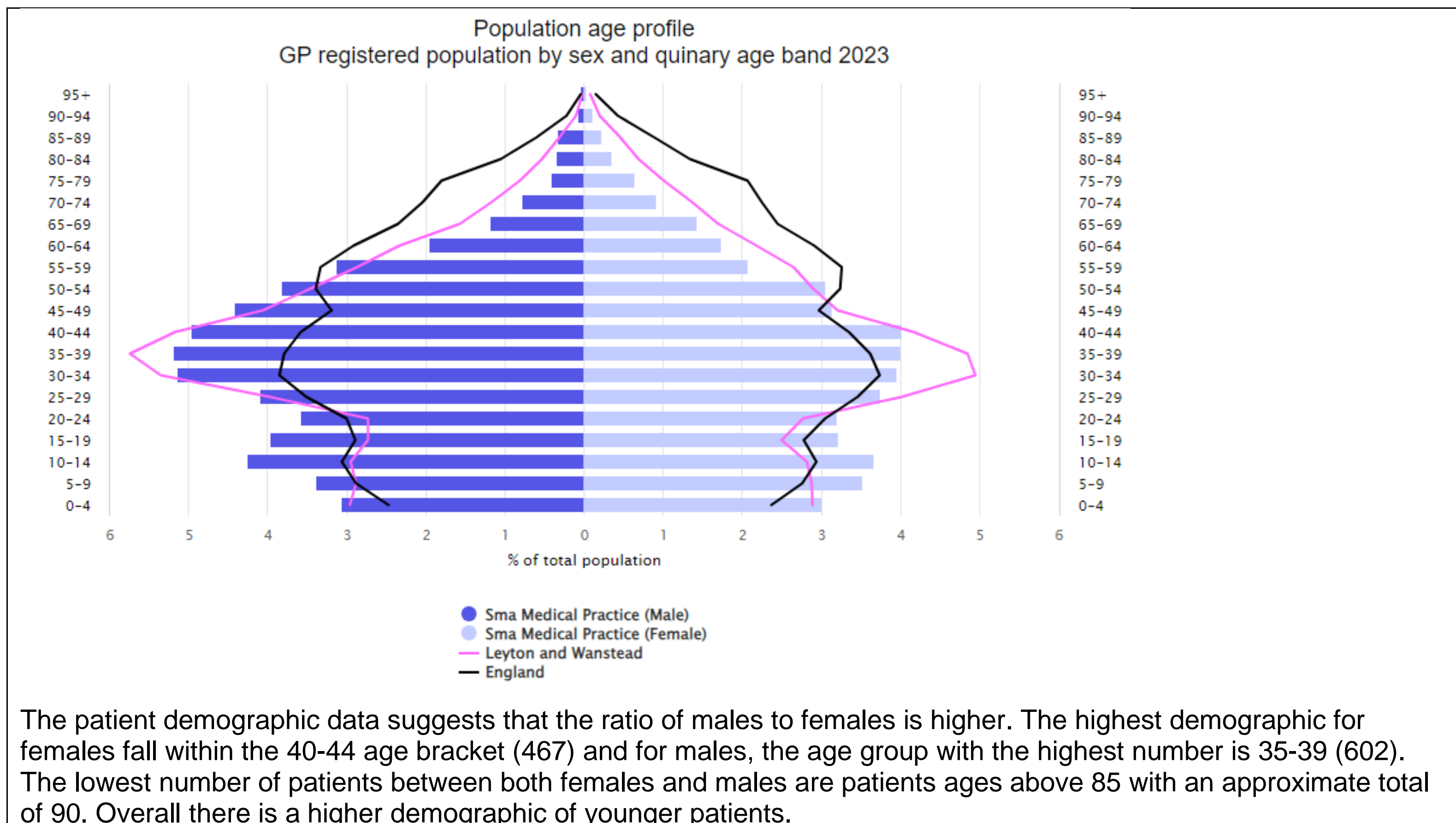
2.4 Patient List (Figure 3.0)

Date	Raw List Size
April 2024	11777
April 2023	11664
April 2022	11560
April 2021	11694
April 2020	12487

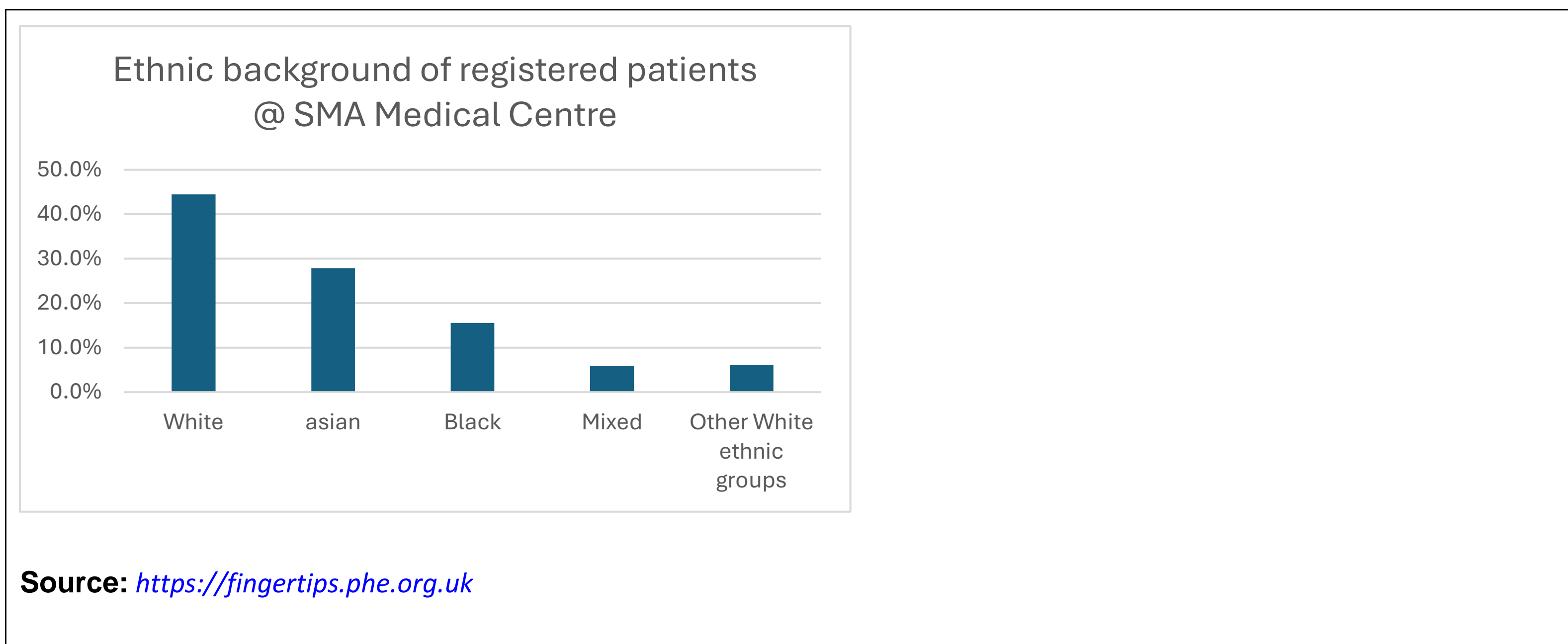


The registered patient list size initially decreased for the first two years. It has then steadily increased for the next three years. The increase may have been directly impacted by the Orient practice closure in 2020 and the Forest Road practice branch site closure in 2021.

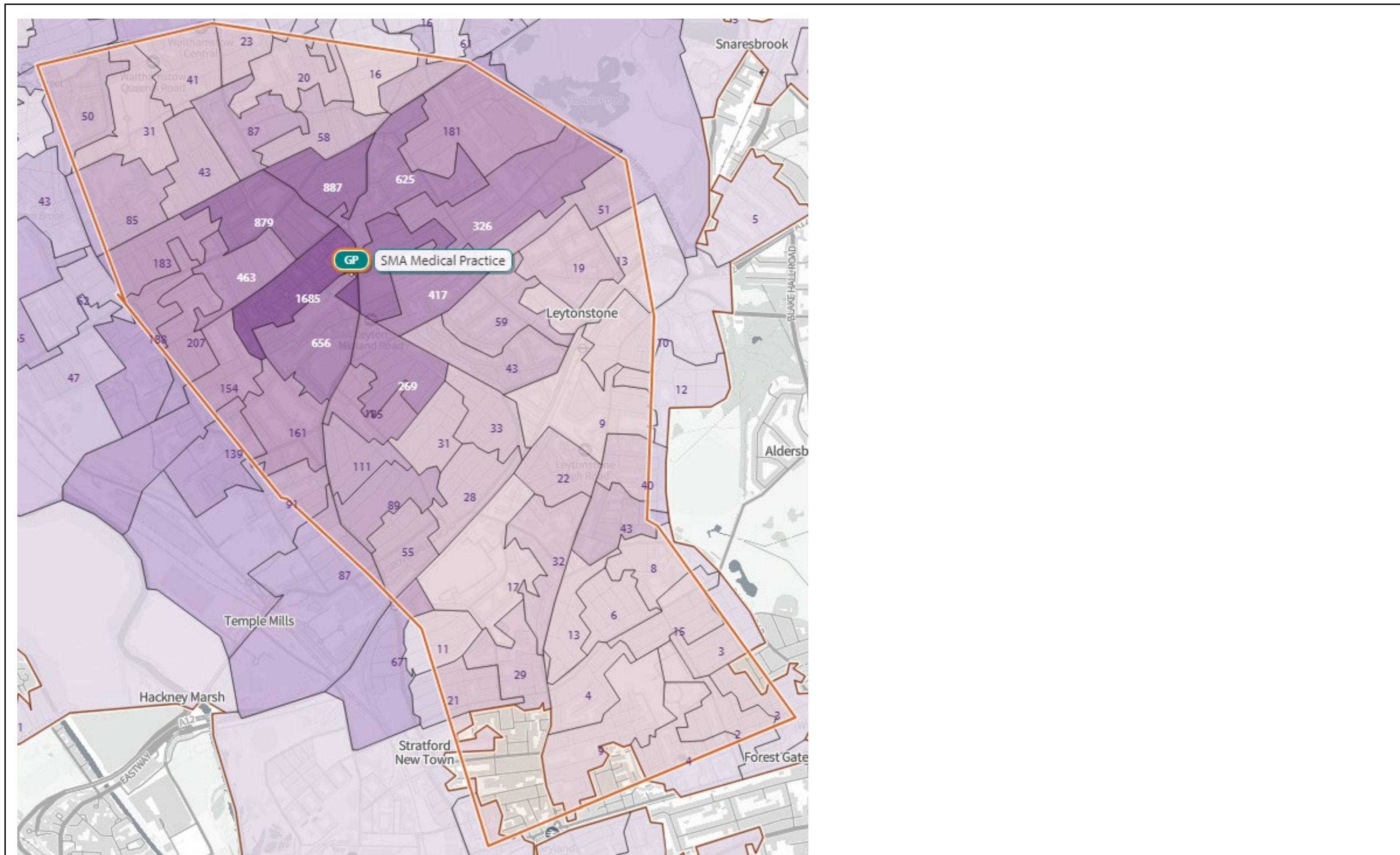
2.5 Patient demographics



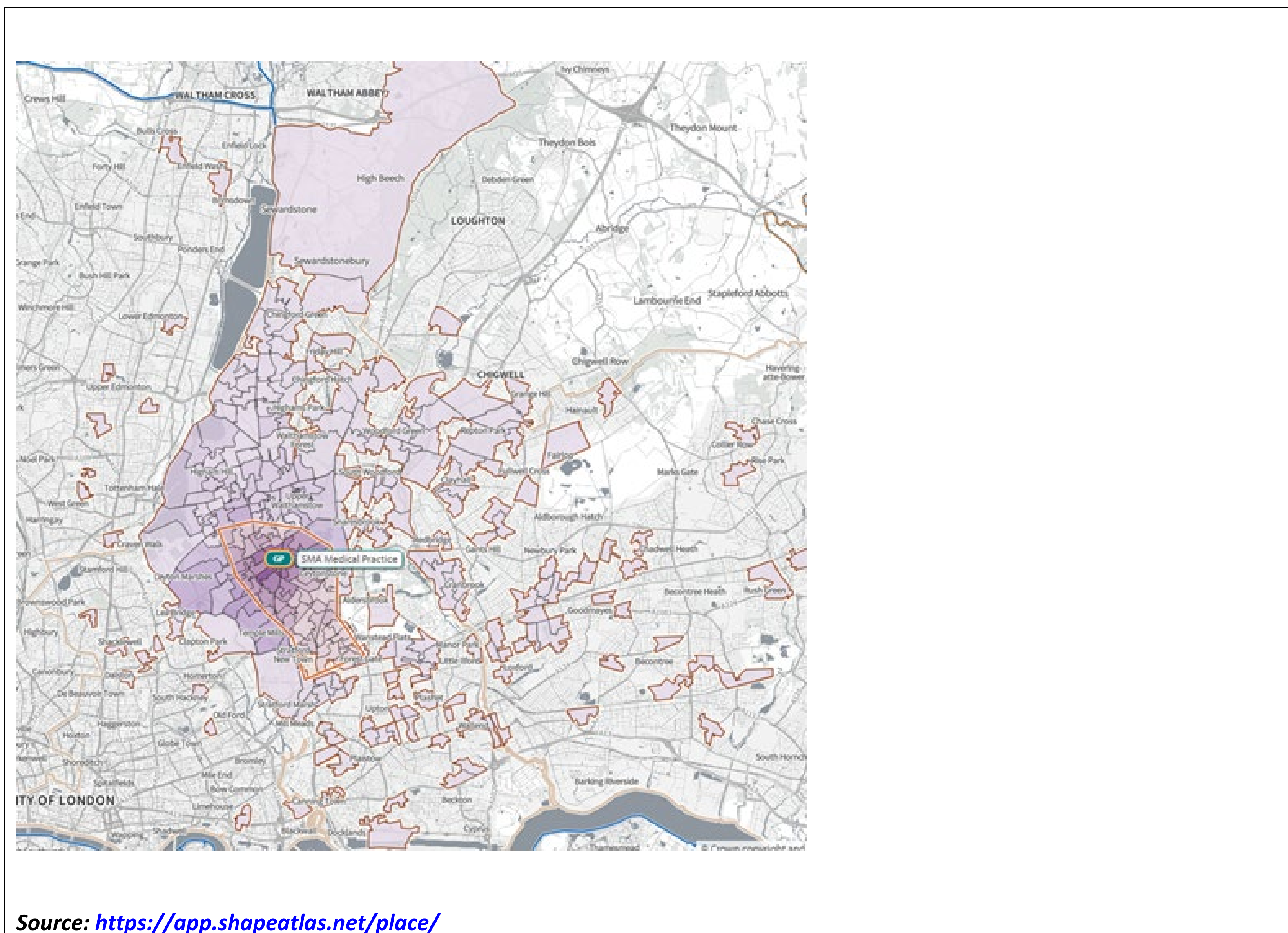
The patient demographic data suggests that the ratio of males to females is higher. The highest demographic for females fall within the 40-44 age bracket (467) and for males, the age group with the highest number is 35-39 (602). The lowest number of patients between both females and males are patients ages above 85 with an approximate total of 90. Overall there is a higher demographic of younger patients.



Source: *https://fingertips.phe.org.uk*



Based on January 2024 data, there is a total list size of 11775 registered patients who reside within the borough of Waltham Forest and 34 registered patients who reside outside the borough. 99.71% in borough and 0.29% out of borough.



Source: https://app.shapeatlas.net/place/

3 Quality Performance - Compare performance (CEG data) against PCN, borough and national
if the practice is an outlier in any area, comment if this is being addressed by the practice e.g improvement plan in progress being monitored as part of the annual contract review:

3.1 QOF Performance

The practice has maintained good performance in QOF over the last few years. The practice has achieved higher than the borough average which can be seen in figure 4.0 below:

Figure 4.0 – QOF Achievement

Financial year	Practice Achievement	Waltham Forest Average	Variance
2022-23	571.68 out of 635 points	570.25	1.43 percentage points above
2021-22	567.46 out of 635 points	566.62	0.84 percentage points above
2020-21*	N/A	N/A	N/A

*Data unavailable due to the impact of COVID-19
Source: NHS Digital QOF Data

3.2 Childhood Immunisations;

12mth	DTaP/IPV/Hib/HepB	Men B	PCV	Rotavirus
SMA	73.9%	82.2%	89.1%	85.3%
Waltham Forest	89.2%	88.3%	92.5%	88.3%

24mth	DTaP/IPV/Hib/HepB	MMR	HiB/Men C	PCV (Booster)	Men B (Booster)
SMA	84.7%	81%	84.6%	78.4%	79.1%
Waltham Forest	89.5%	84.3%	80.5%	84.1%	85.0%

5yr	DTaP/IPV/Hib/HepB	MMR (Primary)	DTaP/IPV (Booster)	MMR (Booster)	HiB/Men C
SMA	88.2%	89%	86.7%	86.7%	89%
Waltham Forest	87.2%	86.6%	77.9%	79.7%	86.1%

Data source: Yearly Childhood Immunisations Dashboard, 23/24, CEG

In 2023-24 the uptake of childhood immunisations for SMA, is below the Waltham Forest average however MMR age 5 years is higher. The practice experience similar borough wide issues as other practices in the Leyton Collaborative PCN e.g families are hesitant to vaccinate younger children and decline offer when invited to attend practice appointments, this could be due to the transient population, including the refugee and asylum-seeking patients. Some children may have already received immunisations before travelling therefore refuse double vaccination, issues include no evidence of vaccination records.
Immunisation facilitators continue to support practices by contacting parents and answering questions to eliminate concerns, ensure coding is correct and continue with call/recall.

3.3 Flu 2023/24:

Cohort	SMA	NEL
1. Patients aged 65 and over (exc care home & housebound)	58%	64%
2. Patients living in residential or care home	33%	68%
4a. Patients aged 50-64 at clinical risk	45%	50%
5. Patients aged 18-49 yrs with clinical risk (exc housebound)	30%	32%
6a. Pregnant patients at clinical risk	25%	47%
6b. Healthy Pregnant Patients	32%	27%
8a. Children aged 2-3 at clinical risk	57%	45%
8b. Healthy Children aged 2-3 yrs	25%	24%
11. Carers	19%	55%

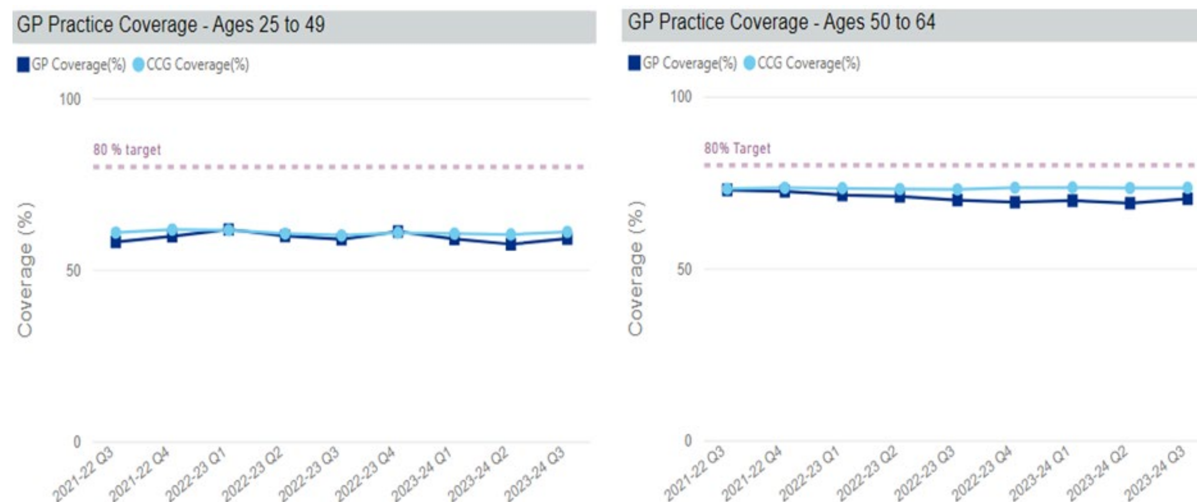
(Source: CEG dashboard data 23-24)

The uptake for seasonal flu vaccine is historically lower than the NEL average in most cohorts with the exception of some high-risk groups e.g. healthy pregnant patients, children aged 2-3 yrs at clinical risk and health children aged 2-3yrs.

3.4 Cervical Screening 2023/24:

SMA achieved lower than the NEL average for both age groups, however the coverage for ages 50 to 64 is higher than ages 25 – 49yr. In both age groups, coverage for both the practice and NEL are lower than the 80% national average. The first invitation is sent to eligible people at the age of 24.5 years. People aged 25 to 49 receive invitations every 3 years. People aged 50 to 64 receive invitations every 5 years. Cervical screening is primarily carried out at GP surgeries The Federation carry out cervical screening at primary care GP hub clinics in the evenings. Up to 8 hubs operating every day, 7 days a week. The Federation also support with call-recall on behalf of practices for evening provision.

Cervical Screening Age 25 to 49 **59%** Cervical Screening Age 50 to 64 **70.25%**
(WF 61.05%, Manor 47.18%, Leyton HC 73.27%) (WF 73.43%, Manor 66.44%, Leyton HC 79.23%)



(Source: Cervical Screening, NHS Digital)

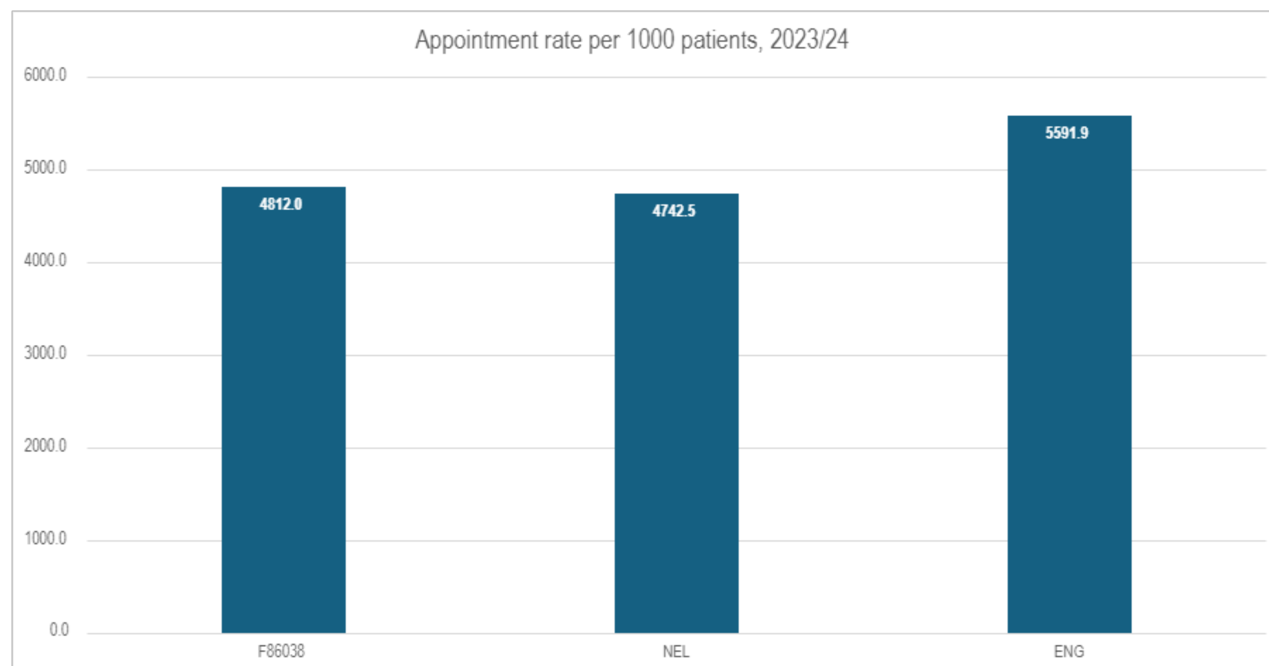
4 Service Delivery (Place to input this section)

4.1 Access

In 2023-24 the SMA delivered 4,812 appointments per 1000 patients compared to the NEL average of 4,743 and national average of 5592.

98% of appointments took place within 2 weeks of booking compared to 90% in NEL average and 82% national average. NHSE operational planning guidance indicates that a minimum of 85% of GP appointments should take place within 2 weeks of booking.

SMA offers slightly higher appointments per 1000 patients than the national average.



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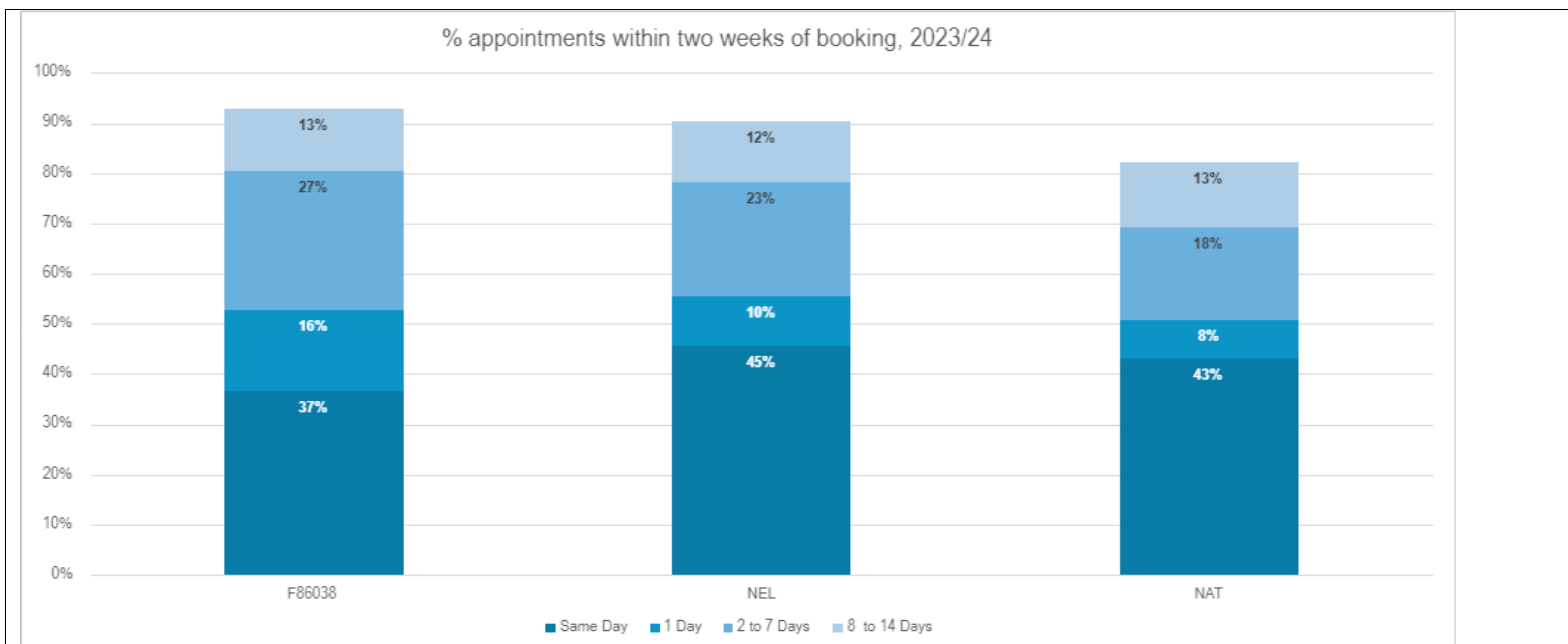


	Appt rate p1000	Same Day	1 Day	2 to 7 Days	8 to 14 Days
SMA F86038	4,812	37%	16%	27%	13%
NEL Average	4,742	45%	10%	23%	12%
National Average	5,591,	43%	8%	18%	13%

Data source: Appointments in General Practice – NHS Digital

4.2 A&E data

In 2023/24 SMA rate of in hours calls to NHS111 is similar to the Leyton Collaborative PCN average and notably higher than the Borough and NEL average. This could be partly attributed to a larger number of calls to 111 during the winter period or patients calling 111 when experiencing difficulty accessing a routine appointment during core hours.

SMA also provide additional services for Refugee and Asylum seekers this will also reflect on the preference for telephone access and the 111 service as an alternative option for minor illness service/NHS111 which in turn will impact on A&E services/admissions for triage or as an immediate onward referral.

Practice/Benchmark	In hours calls per 1000 patients
SMA	73
PCN	75
Waltham Forest	64
NEL	66

Data source: NEL BI – PC Dashboard Suite

4.3 Pharmacy and Medicines Optimisation

The NHS Community Pharmacy Blood Pressure Check Service supports risk identification and prevention of cardiovascular disease (CVD).

Service	**Period**	**Number of referrals-Practice**
Hypertension Case-finding NHS England » NHS Community Pharmacy Blood Pressure Check Service	November 2023 -May 2024	7
Ambulatory Blood Pressure Monitoring	November 2023 -May 2024	178
CPCS	March 2022-December 2023	2677

Pharmacy First NHS England » Pharmacy First	January	840

The practice has engaged with partners and stakeholders to implement these services. They continue to improve the uptake and referral rates. The practice undertook a Quality Improvement programme to enhance and expand the Community Pharmacy Consultation Service (CPCS) and the Pharmacy referral service that have shown significant potential in improving patient outcomes.

The Prescribing Quality and Efficiency Scheme (PQES) is an initiative aimed at enhancing the quality, cost-effectiveness, and safety of prescribing and medicines optimisation within Primary Care.

Medicines Safety	**Practice Output**
To address the MHRA alert regarding the use of Valproate by women and girls, practices are asked to submit evidence of revieing patients on Valproate. If there are no patients on Valproate, another MHRA alert can be chosen to demonstrate implementation	Achieved
Opioid and Dependency Forming Medicines (DFM) prescribing clinical review	Achieved
Learning From Patient medicines-related safety events. Practices to report on prescribing errors/near misses via the Learning From Patient Safety Events (LFPSE) portal.	Achieved

Antimicrobial resistance (AMR) has been identified as one of the most pressing global challenges we face this century. In fact, the World Health Organisation (WHO) has declared AMR as one of the top 10 global public health threats, and AMR is listed on the UK Government’s National Risk Register.

Practices are therefore asked to review their antimicrobial prescribing to ensure that this in line with local and national guidelines. Practices should aim to achieve the set targets for the antimicrobial prescribing metrics.

	Antibacterial items/STAR-PU position March 24 (12 months rolling data)	Proportion of co-amoxiclav, cephalosporin & quinolone items position March 24 (12 months rolling data)	Amoxicillin 500mg capsule: % of total items, 5 days (Quantity=15) March 24 (12 months rolling data)	OptimiseRx:
target	≤0.871	≤10%	>40%	≥ 20% acceptance rate
Practice achievement	0.701	11.40%	30.27%	20.96%

4.4 KPIs

As this is an equalised contract (in-line with GMS/PMS) there are no KPI payments applicable to this contract.

Innovation:

SMA took part in a laughtercise for staff as part of a QI event on staff wellbeing, and a learning event to discuss and manage frequent attenders.

Evidence of leaning Event, network - QI W

Evidence of learning Event Network - QI - I

5.0 Contract & Regulatory Compliance

5.1 The practice rated Good by the CQC (last inspection April 19). There are no compliance issues in relation to the yearly eDEC submissions by the practice.

5.2 No breach notices have been issued to Hurley Group for this contract

5.3 The last annual contract review for financial year 2022/23 was undertaken earlier this year, areas that were highlighted for improvement are being addressed and progress will be reviewed in the 24/25 review.

6.0 Premises and Estates

6.1 This is a rented premises. The premises are owned by the former contractor. The lease expiry date is 15 January 2035.

7.0 Patient Experience

7.1 Patient Participation Group (PPG)
SMA meet at least 4 times a year – face to face, they have two Proactive PPG Chairs – over 80 members with good attendance. PPG has engaged with practice team on several initiatives including Health Awareness days at the practice. PPG Chairs have attended the recent PPG Forum (Healthwatch) Meeting 06.02.2024

7.2 GP Patient Survey (GPPS)
The GPPS results for 2023 was below the ICB average for some of the key questions that were analysed (see figure 5.0 below):

Figure 5.0 – GPPS Results 2023

	Practice Result	ICB Result	Above / Below ICB Average
Describe their overall experience of this GP practice as good	51%	64%	Below
Satisfied with the general practice appointment times available	49%	51%	Below
Find it easy to get through to this GP practice by phone	44%	48%	Below

Source: GP Patient Survey

8.0 Contract Value

SMA Medical Centre	Price
Global Sum price	£1,111,429.53
London Allowance	£25,673.86
Risk Premium	£51,660.76
Sub-total	**£1,188,764.14**
Less: OOH deduction (% of Global Sum & London Weighting)	-£ *54,012.41*
Total	**£1,134,751.73**

9.0 Options/ Preferred Option/Risks (e.g Contract extension; List Dispersal; appropriate PSR route)

	Pros	Cons	Risks	Mitigation
Option 1 – Do nothing	The contract will automatically terminate on 30 March 2025 with no provision for patient care			
Option 2 – Extend contract	There are no significant performance concerns in relation to the delivery of the practice contract, therefore no risk to patient safety.	Some areas identified where the practice could improve. i.e the GP patient survey, immunisations and cervical screening	No improvement will be made	Performance and quality will be closely monitored through the annual contract review in 24/25

North East London

	Extension will result in no disruption to patient services – existing provider will continue to deliver primary medical services.			
Option 3 – Terminate contract and tender a new contract	A new contractor may be able to achieve higher performance in the areas highlighted for improvement	Disruption to patient services Additional costs will be incurred for an interim caretaking contract that would have to be put in place until the new contract is awarded	Procuring a suitable provider with the capability to deliver patient services at scale	Market testing and ensuring a sufficient timeframe for procurement

The preferred option would be extending the contract for a further five years until 30 June 2030, which is option 2. This option carries the least amount of risk and minimises disruption to patient care.

10.0 Next steps

- Issue provider with a contract variation to extend to 30 June
- Continue with regular contract reviews with a particular focus on monitoring progress against the GP Patient Survey

NHS North East London

Primary Care Contracts Sub-committee

16 July 2024

Title of report	APMS Contract Commissioning Intentions - Allerton Road Surgery
Author	Abdul Rawkib, Primary Care Commissioning Manager, NEL ICB
Presented by	Abdul Rawkib, Primary Care Commissioning Manager, NEL ICB
Contact for further information	a.rawkib@nhs.net
Executive summary	Allerton Road Surgery is an APMS contract in City & Hackney that was commissioned in 2020 for a maximum contract term of 15 years with provision for 5-year break clauses throughout. The contract is approaching the expiry of its initial five-year term on 31 March 2025 and is subject to extension by mutual agreement for a further 5-year term pending its commissioning review. Contract performance is reviewed annually but a more comprehensive review has been undertaken in view of the commissioning options to be considered at the contract's five-year break-clause. The Strategic Commissioning Review presents an overview of contract performance and other factors to be considered in determining the future of the contract beyond the initial expiry date. Allerton Road Surgery has maintained good performance across a range of indicators and in some areas performed above the borough /ICB average notably in the Quality Outcomes Framework (QOF), access and the GP Patient Survey. Areas identified for improvement which include childhood immunization and flu vaccine uptake are being addressed by initiatives to tackle vaccine hesitancy in the wider community Overall, there are no contract compliance issues or concerns with this practice that would justify terminating the contract at the initial expiry date therefore, the preferred option is to extend the contract for a second term.
Action / recommendation	The Committee is asked to approve the recommendation to extend the contract by a further five years until 31 March 2030.
Previous reporting	The report has been discussed and supported at the local Primary Care Forum
Next steps/ onward reporting	• Issue contract extension notice • Continue to review the contract on an annual basis
Conflicts of interest	Any conflicts of interest to be managed in line with the Terms of Reference (ToR) of the Committee.

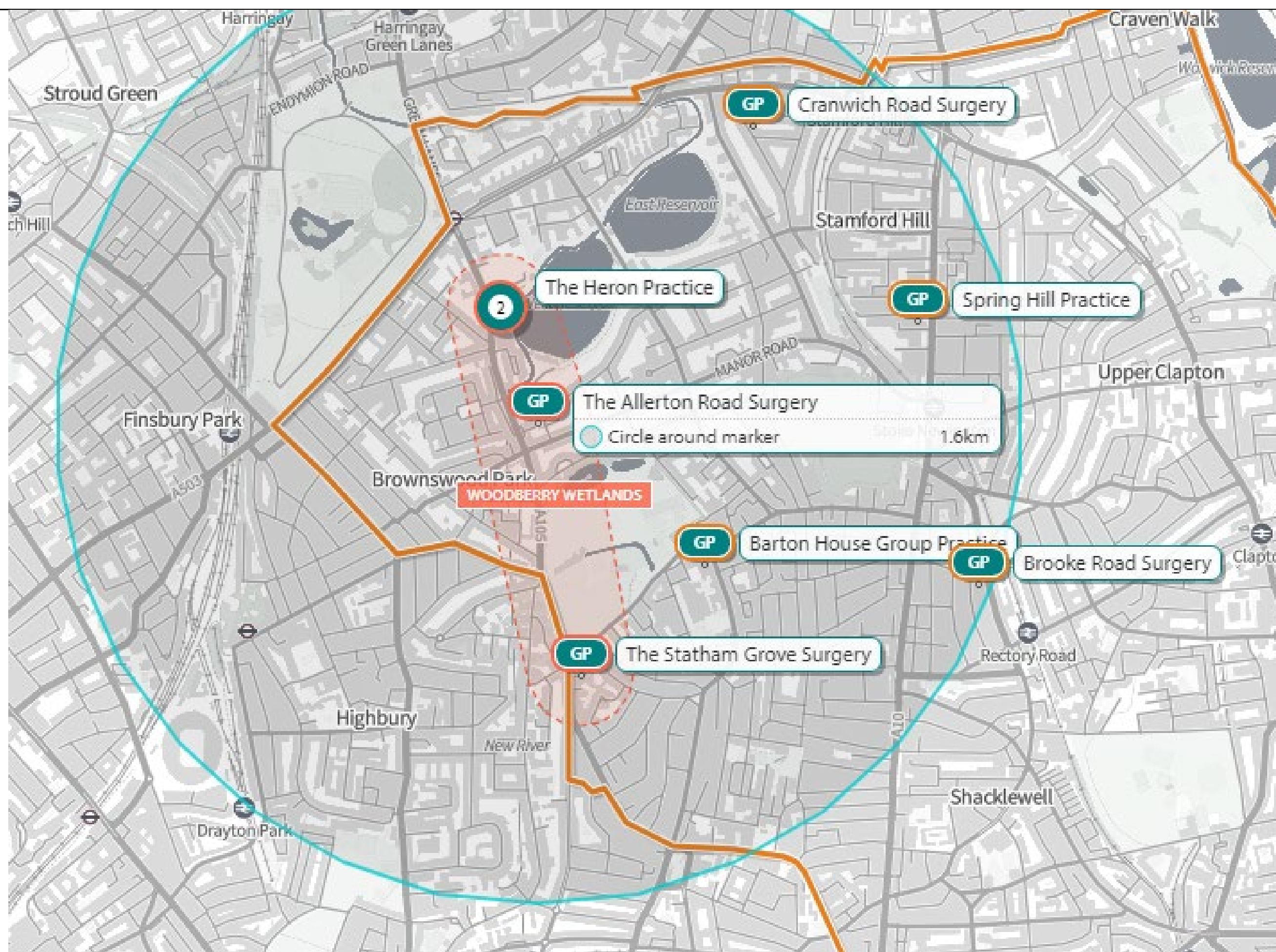
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To support broader social and economic development
Impact on local people, health inequalities and sustainability	Extending this contract will ensure the continuity of primary medical services for patients by the current provider and therefore will require no Equalities Impact Assessment (EIA), as there is no change to service provision.
Impact on finance, performance and quality	Extending the existing contract will commit £598,602 (indicative) revenue expenditure per annum from the delegated primary care budget. This is not a new cost pressure and is already accounted for in the budget.
Risks	There are no associated risks with extending this contract with the current provider as there have been no significant performance concerns identified.
Appendices	Appendix 1 – Allerton Road Surgery Strategic Review

NHS North East London

GP Contract Strategic Commissioning Review Business Case

Place:	**PCN:**
City & Hackney	Woodberry Wetlands
Practice name:	**Practice code:**
Allerton Road Surgery	F84716
Raw list size:	**Weighted list:**
5866 (1 April 2024)	5564.77 (1 April 2024)
Current provider:	
Hurley Group/Clinic Partnership	
Contract Start Date:	**Contract End date:**
1 April 2020	31 March 2025
Contract Term Provision for Extension/Break Clause:	
This contract was procured for a term of 15 years (5+5+5) with the option to extend until 31 March 2035.	
Reason for contract review:	
This contract is approaching its first five-year break clause, with the option to extend for a further five years until 31 March 2030.	
Practice website:	
https://www.allertonroadmedicalcentre.com	
Report Completed by:	
Maxine Grimes, Commissioning Manager, NHS North East London Thomas Clark, Primary Care Delivery Manager, NHS North East London	

Equality Impact Assessment Completed:
Not required as no change to service provision is being recommended.
Summary of Recommendation:
Recommendation is to extend the contract for a further five years until 31 March 2030.
1.0 Contract Overview / History
The Allerton Road Surgery contract was procured in April 2020 and awarded to the Hurley Group Partnership. The practice operates from 34a Allerton Road, London N16 5UF. The contract is approaching its first five-year break clause and has not previously been extended.
2.0 Practice Specific Information
2.1 Allerton Road practice operates from purpose-built premises within a highly residential area of Stoke Newington in north Hackney. The practice operates in line with GMS/PMS core hours (Monday to Friday, 8am – 6.30pm (excluding bank holidays).



The clinical workforce at Allerton Road Surgery is smaller than practices in Woodberry Wetlands PCN and City and Hackney more widely.

Their GP FTE per 1000 registered patients is comparable to the NEL average but lower than that of London and England. The practice has a higher patient to GP FTE ratio than local, regional and national comparators. To an extent this is mitigated by slightly higher numbers of direct patient care roles, specifically 1 FTE pharmacist and 0.8 FTE Healthcare Asst.

The practice currently has no nurses recorded in the National Workforce Reporting System (NWRS) for the month of March but they have been recently successful in recruiting a practice nurse.

The GP workforce is long-standing with two GPs, including the principal GP, having worked there for almost 10 years. The provider is also known to have a considerable staff bank and to operate at scale in relation to online requests; this model allows for the practice's substantive clinical workforce to be supplemented on a sessional basis or ad hoc basis, although no additional locum capacity was recorded during March 2024.

Clinical workforce FTE - exc. Locums, trainees and apprentices

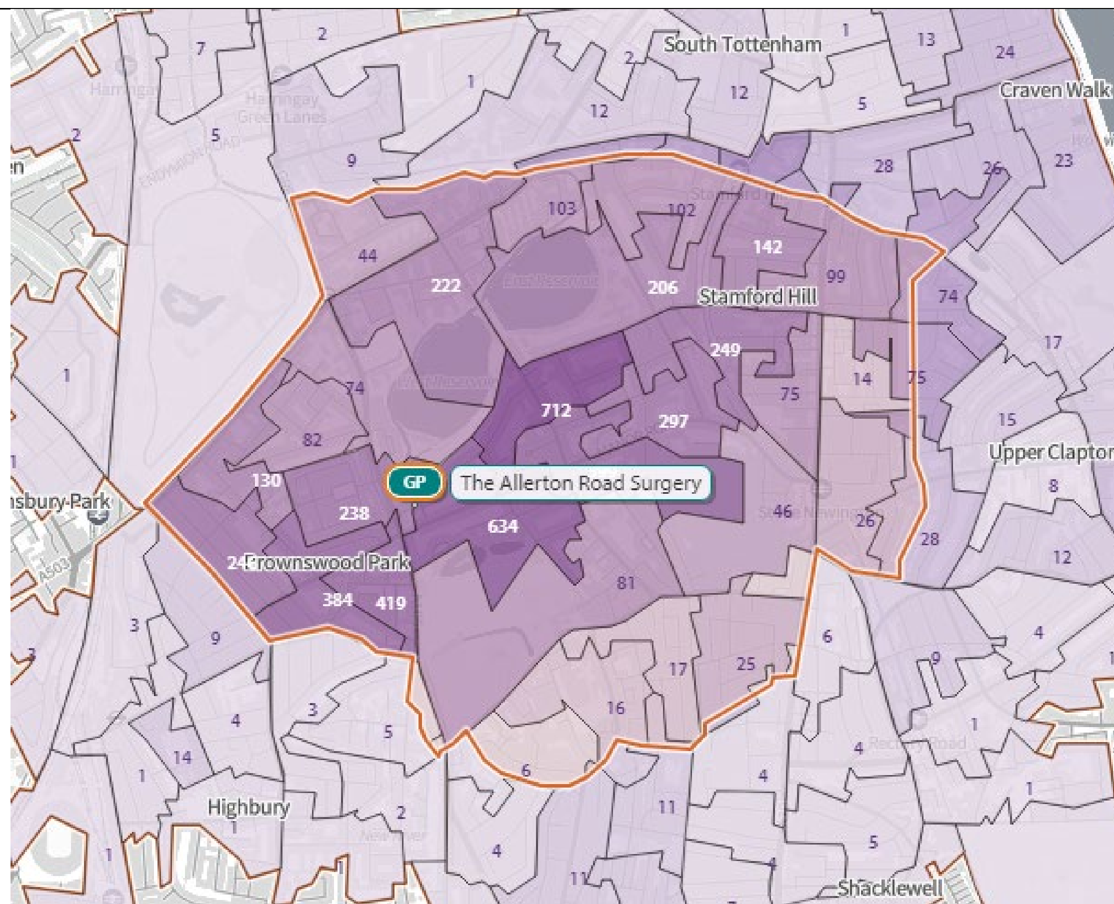
Practice/Org	GP	Nurses	Direct Patient Care (DPC)	GP FTE p1000	Nurse FTE p1000	DPC FTE p1000	Patients to GP FTE
THE ALLERTON ROAD SURGERY	1.7	0.0	1.8	0.3	0.0	0.3	3536
NEL ICB				0.3	0.1	0.2	2906
LONDON				0.4	0.1	0.2	2700
ENGLAND				0.4	0.3	0.3	2367

Data source: General Practice Workforce, 31 March 2024 – NHS England Digital

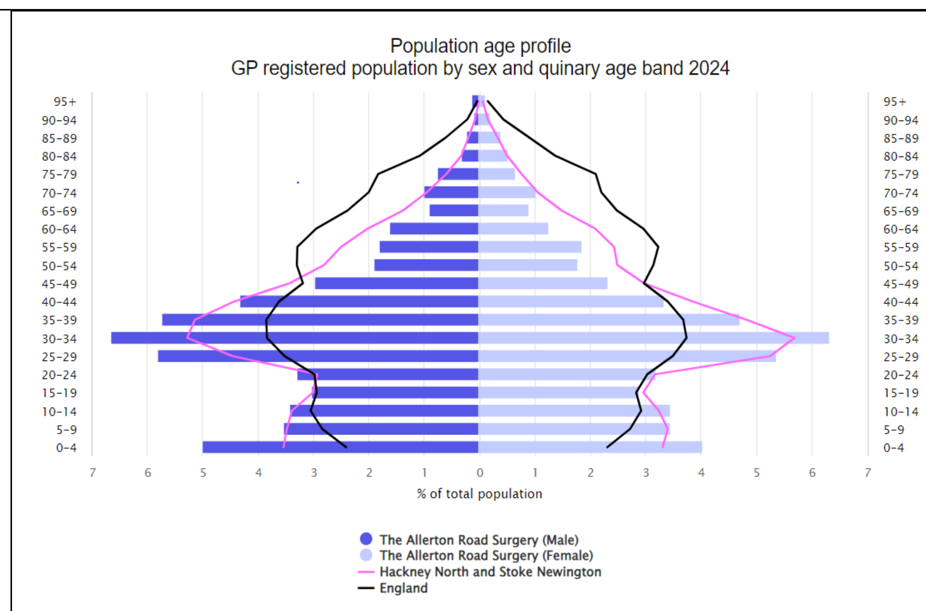
2.2 The practice list size had seen stable growth 2021-23 but reduced by 1.7% during 2023/24. Patients are concentrated in the residential streets surrounding the practice, largely within the PCNs geographical footprint with some overlap with the neighbouring PCN, Springfield Park.

Date	Raw List Size	Variation to Previous Year	% variation
Apr-24	5,866	-102	-1.7
Apr-23	5,968	168	2.9
Apr-22	5,800	148	2.6
Apr-21	5,652		

Source: PCSE list size data



2.3 The practice's location in north Hackney means that it has a significant Charedi or Orthodox Jewish population. This is reflected in the population age profile with a higher proportion of children and young adults than Hackney and England.



Source: [National General Practice Profiles - Data - OHID (phe.org.uk)]()

3.0 Quality Performance - Compare performance (CEG data) against PCN, borough and national

if the practice is an outlier in any area, comment if this is being addressed by the practice e.g improvement plan in progress being monitored as part of the annual contract review:

3.1 QOF (3 years) - The practice has maintained good performance in QOF over the last few years, with achievement slightly higher than the ICB average. Achievement was slightly lower that the national average in 2021/22 but slightly higher in 202/23. The practice tends to perform very well in relation to clinical domain indicators, achieving 100% in all but one in 2022/23. The main area of underperformance in QOF is the four vaccination and immunisation indicators under the public health domain. In 2022/23, the practice achieved 100% for the blood pressure, cervical screening, obesity and smoking indicators in the public health domain.

Financial year	Practice Achievement	ICB average	Comparison

2022-23	580.89 out of 635 points (91%)	578.01	2.88 percentage points above
2021-22	572.53 out of 635 points (90%)	571.89	1.64 percentage points above
2020-21*	N/A	N/A	N/A

*Data unavailable due to the impact of COVID-19

Source: QOF search | NHS Digital

3.2 Childhood Immunisations – Historically, Allerton Road Surgery has struggled with uptake of childhood vaccinations, mainly due to the significant Orthodox Jewish population registered with the practice who tend to have larger families resulting in higher numbers of young children registered at the practice. We know that Orthodox Jewish families are also more hesitant to vaccinate children before the age of one, meaning that immunisation doesn't necessarily align with the COVER schedule. This is borne out in statistical data with uptake at the practice being lower than City and Hackney averages but by a smaller margin for uptake of routine vaccinations by 24 months, with the 6-in1 being a good example. The practice also compares favourably across 0-5 age groups with practices in the neighbouring Springfield Park PCN that have similar demography.

12m	DTaP/IPV/Hib/HepB	Men B	PCV	Rotavirus
Allerton Road Surgery	50%	50%	57%	50%
City & Hackney	64%	64%	72%	60%

24m	DTaP/IPV/Hib/HepB	MMR	HiB/Men C	PCV (Booster)	Men B (Booster)
Allerton Road Surgery	67%	62%	56%	58%	57%
City & Hackney	73%	70%	67%	69%	69%

5y	DTaP/IPV/Hib/HepB	MMR (Primary)	DTaP/IPV (Booster)	MMR (Booster)	HiB/Men C
Allerton Road Surgery	62%	67%	45%	54%	62%
City & Hackney	78%	78%	63%	64%	74%

Data source: Yearly Childhood Immunisations Dashboard, 23/24, CEG

North East London

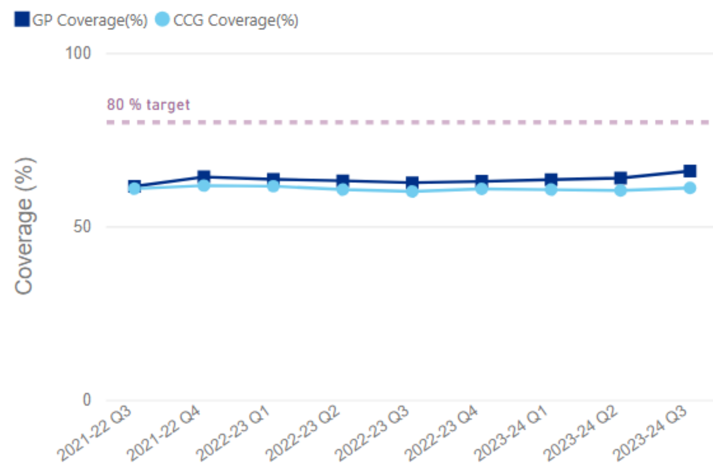
Aside from statistical data, the practice has engaged well with recent MMR/Polio catch up campaigns. This included are large scale health promotion event held in local community space which was attended by 245 patients.

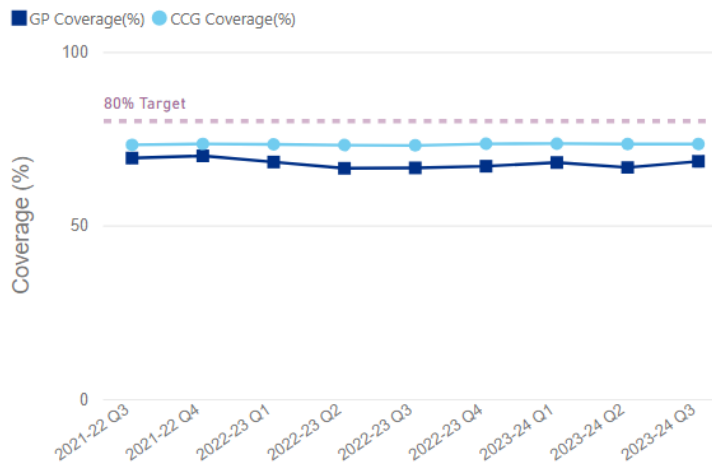
3.3 Flu – In 23/24, Allerton Road Surgery had lower uptake of the seasonal flu vaccine than the NEL average, but were comparable to the City and Hackney average with slightly better uptake among at risk groups, but significantly lower uptake among pregnant women and healthy 2 & 3 year olds. As with uptake of childhood immunisations, the practice compares favourably with practices of similar demography in the Springfield Park PCN.

Cohort	Allerton Road	C&H	NEL
1. Patients aged 65 and over (exc care home & housebound)	52%	58%	64%
2. Patients living in residential or care home	62%	69%	68%
4a. Patients aged 50-64 at clinical risk	47%	44%	50%
5. Patients aged 18-49 yrs with clinical risk (exc housebound)	30%	26%	32%
6a. Pregnant patients at clinical risk	17%	28%	47%
6b. Healthy Pregnant Patients	16%	20%	27%
8a. Children aged 2-3 at clinical risk	44%	9%	45%
8b. Healthy Children aged 2-3 yrs	18%	23%	24%

Data source: NEL Seasonal Flu Dashboard, 23/24, CEG

3.4 Cervical Screening – Allerton Road consistently achieves slightly better screening coverage than the ICB average for 25-49 year olds but slight worse for 50-64 year olds. In both age groups, coverage for both practice and ICB are lower than the 80% national target.





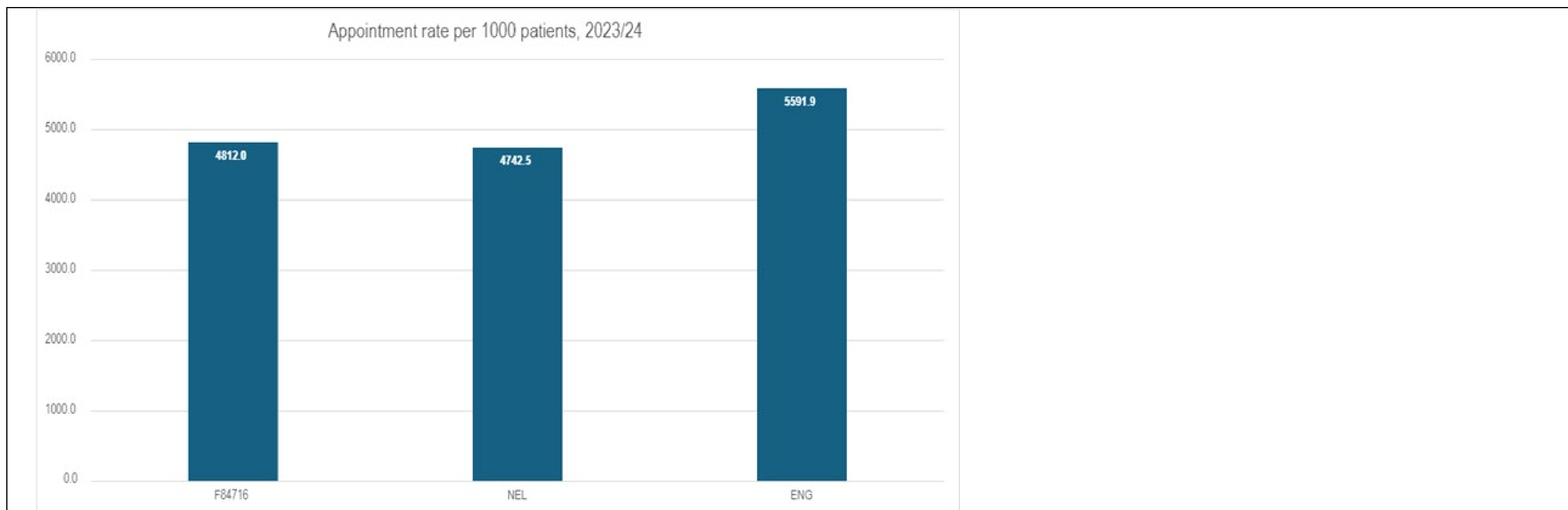
Data source: Cervical Screening (Annual) - NHS England Digital

4.0 Service Delivery

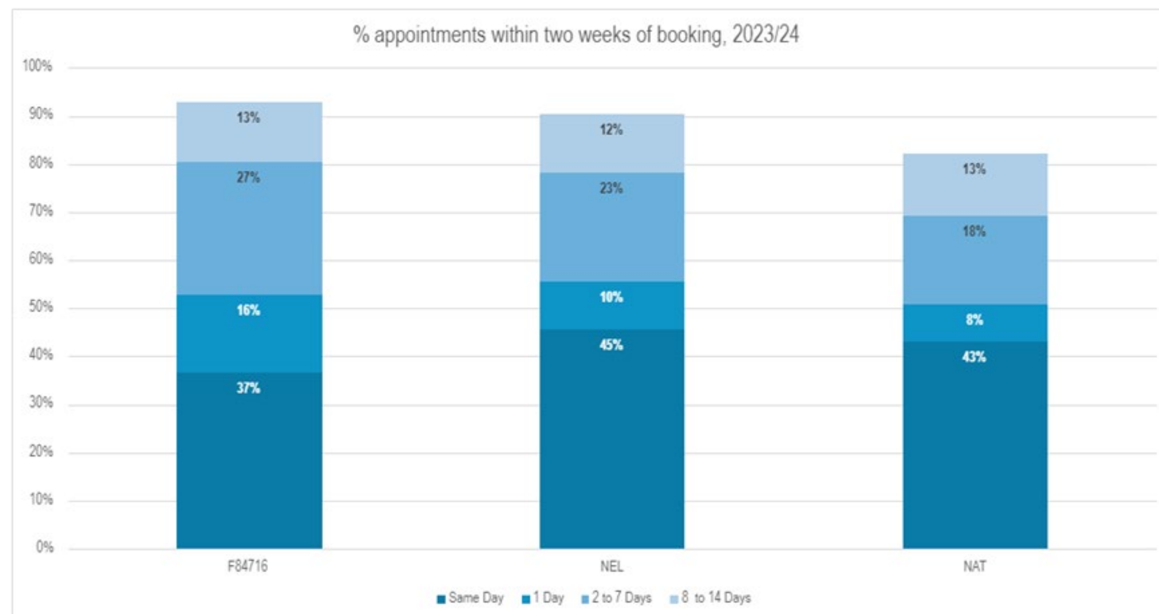
4.1 Access – In 2023/24, the practice delivered 4,812 appointments per 1000 registered patients compared to the NEL average of 4,743 and national average of 5,592.

92% of these appointments took place within 2 weeks of booking compared to 90% for NEL and 82% for England. NHSE operational planning guidance for 24/25 indicates that a minimum of 85% of GP appointments should take place within 2 weeks of booking.

In summary, Allerton Road offers fewer appointments per 1000 patients than the national average but a greater proportion of these take place within 2 weeks of booking.


Appointment rate per 1000 patients, 2023/24
6000.0
5000.0
4000.0
3000.0
2000.0
1000.0
0.0
4812.0
4742.5
5591.9
F84716
NEL
ENG

NHS North East London



Data source: Appointments in General Practice – NHS Digital

The practice has engaged well with their PCN's Capacity and Access Improvement Plan and priorities set out in the access recovery plan. They have historically sought to promote multiple modes of access, including digital, and were early adopters of advanced cloud-based telephony.

The practice demography is less likely to adopt digital access due to cultural factors and the practice has recently tried to offer improved access to face-to-facet appointments in response to GP Patient Survey feedback. Their 23/24 QOF QI project on access focused on increasing referrals the Community Pharmacy Consultation Service (CPCS).

4.2 In hours calls to NHS111 – The practices rate of in hours calls to NHS111 during 2023/24 is similar to that of NEL but is a significant outlier compared to their PCN and City and Hackney. In part this seems to be attributable to a large increase in calls to 111 during winter and a high rate of calls relating to children aged 0-4 of which the practice has a high proportion.

4.3 During a review of in hours 111 call data for the previous winter, the practice reflected that this could also be related to the practice population's preference for telephone access and calling 111 after not being able to get through to the practice or being directed toward digital access routes. The practice has a similar rate of A&E attendances during core hours to that of City and Hackney.

Practice/Benchmark	Rate p1000
Allerton Road	68.3
Woodberry W PCN	35.0
C&H	36.7
NEL	65.6

Data source: NEL BI – PC Dashboard Suite

4.4 **Pharmacy and Medicines Optimisation**

Referral and engagement with Community Pharmacy referral services:

Service	Period	Number of referrals-Practice
Hypertension Case-finding NHS England » NHS Community Pharmacy Blood Pressure Check Service	November 2023 -May 2024	10
Ambulatory Blood Pressure Monitoring	November 2023 -May 2024	37
CPCS	March 2022-December 2023	192
Pharmacy First NHS England » Pharmacy First	January	120

The practice has engaged with partners and stakeholders to implement these services. They continue to improve the uptake and referral rates.

Delivery of the Prescribing Quality and Efficiency Initiatives

Medicines Safety	Practice Output
To address the MHRA alert regarding the use of Valproate by women and girls, practices are asked to submit evidence of revieing patients on Valproate. If there are no patients on Valproate, another MHRA alert can be chosen to demonstrate implementation	Achieved

Opioid and Dependency Forming Medicines (DFM) prescribing clinical review	Achieved
Learning From Patient medicines-related safety events. Practices to report on prescribing errors/near misses via the Learning From Patient Safety Events (LFPSE) portal.	Achieved

	Antibacterial items/STAR-PU position March 24 (12 months rolling data)	**Proportion of co-amoxiclav, cephalosporin & quinolone items position March 24 (12 months rolling data)**	**Amoxicillin 500mg capsule: % of total items, 5 days (Quantity=15) March 24 (12 months rolling data)**	**OptimiseRx:**
target	≤0.871	≤10%	>40%	≥ 20% acceptance rate
Practice achievement	0.701	11.40%	30.27%	20.96%

4.5 KPIs – Not applicable.

4.6 Innovation – The provider has implemented various innovations in relation to digital access and 'e-hub' management of online consultations through the wider Hurley Group structure. At Allerton Road they operate a triage model that over the last year has sought to make better use of CPCS. One of the principal GPs has a special interest in Dermatology and holds an honorary contract with Homerton Healthcare Foundation Trust, experience that should lead to benefits for patients.
5.0 Contract & Regulatory Compliance
5.1 The practice is registered with the CQC and is currently rated Good. There are no compliance issues in relation to the practice's 2023/24 eDEC submission. 5.2 The last annual contract review for financial year 2022/23 was undertaken earlier this year and there was no other contractual or performance concerns highlighted with this practice.
6.0 Premises and Estates (embed image of premises if available from internet)
6.1 The practice previously sub-leased their building from NHS Property Services who lease from a superior landlord/freeholder. The provider is in the process agreeing a new sub-lease but this has been delayed due to a dispute with NHSPS around facilities management and repairing responsibilities within the lease. The building is purpose built but is aging and space on the first floor is inefficiently configured, with no consulting space. During 23/24, the provider successfully applied for a London Improvement Grant to reconfigure the space and install a lift. This scheme is currently in delivery.

6.2 Local estates strategy – The City and Hackney Local Infrastructure Forum has only recently been formed and is yet to discuss specific buildings in detail. However, the Woodberry Down development situated in this PCN's geographical footprint is significant area of population growth that will need to be addressed as part of the local infrastructure strategy. Additionally, the Allerton Road Surgery building is categorised as Flex A, meaning that with sufficient investment it could support the delivery of ICS strategy and be re-categorised as a core asset.

7.0 Patient Experience

7.1 PPG - The practice has an active PPG. The chair of their PPG is also the chair of Healthwatch Hackney.

7.2 GP Patient Survey (GPPS) - The GPPS results for 2023 was above the ICB average for some of the key questions that were analysed (see table below).

Question	Practice Result	ICB Result	Above / Below ICB Average
Describe their overall experience of this GP practice as good	71%	64%	Above

Satisfied with the general practice appointment times available	60%	51%	Above
Find it easy to get through to this GP practice by phone	75%	48%	Above

Source Patient Experience (gp-patient.co.uk)

8.0 Contract Value

8.1 This is an equalised APMS contract and there are no KPI payments attached to this contract. The annual core contract price for this contract is £598,602.45 (indicative based on Q1 list size for 2024-25).

9.0 Options/ Preferred Option/Risks (e.g Contract extension; List Dispersal; appropriate PSR route)

Options	Pros	Cons	Risks	Mitigations
1. Do nothing	The contract will end with no provision for the continuity of patient care			
2. Contract extension	• No disruption to patient services, continuity of provider and stable clinical team. • The provider's knowledge of the registered population obtained over several years would be retained, with benefits for relational continuity of care and population health. • There are no significant performance concerns in relation to the delivery of the practice contract, therefore no risk to patient safety.	None.	None.	n/a

3. Terminate contract and reprocure	• Potential for a new provider to address generally low uptake of immunisations among population.	• Potential disruption to services with no guarantee that new provider will match performance of current provider. Additional cost for putting in place caretaking arrangements during the tendering process • Potential loss of knowledge relating to the practice population that the current provider has obtained over several years.	• Procurement exercise fails to identify new provider	Market testing

Preferred Option – option 2

The Hurley Group continues to provide a good service to the registered population. While there are concerns around uptake of childhood and other routine immunisations programmes, this is recognised as a challenge for practices with significant Orthodox Jewish populations. The provider has consistently attempted to address the cultural barriers causing vaccine hesitancy with some success indicated in uptake rates compared to practices with similar demography. Discontinuity of provider and workforce presents a risk to progress that has been made.

There remains some concern relating to in hours call to NHS111, although to an extent this is offset by good patient satisfaction, reasonable access and provider willingness to develop their model. Commissioners will seek to build on a productive and long-term working relationship with the provider to address any outstanding concerns. Additionally, delivery of the approved LIG scheme will present opportunities for the practice to expand their workforce, make better use of ARRS staff and absorb some of the population growth resulting from the ongoing Woodberry Downs developments.

The preferred option is to extend the contract for a further five years until 31 March 2030. This option carries the least amount of risk and will not cause any disruption to patient services.

10.0 Next steps

- Issue provider with contract variation extension
- Monitor progress of improvement plan and review in the 24/25 annual review

NHS
North East London

Primary Care Contracts sub-committee

16 July 2024

Title of report	APMS Commissioning Intentions - Carpenters Practice
Author	Benjamin Smith, Primary Care Commissioning Manager
Presented by	Benjamin Smith, Primary Care Commissioning Manager
Contact for further information	benjamin.smith10@nhs.net
Executive summary	Carpenters Practice is an APMS contract in Newham that was commissioned in 2020 for a maximum contract term of 15 years with provision for 5-year break clauses throughout. The contract held by AT Medics, delivers services to over 24,900 patients across three sites. The contract is approaching the expiry of its initial five-year term on 31 March 2025 and is subject to extension by mutual agreement for a further 5-year term pending its commissioning review. Contract performance is reviewed annually but a more comprehensive review has been undertaken in view of the commissioning options to be considered at the contract's five-year break-clause. The Strategic Commissioning Review presents an overview of contract performance and other factors to be considered in determining the future of the contract beyond the initial expiry date. Overall, the practice is delivering a satisfactory performance across a range of indicators and performing above the borough /ICB average notably in the Quality Outcomes Framework (QOF); access indicators (delivery of appointments per 1000 patients and the percentage of appointments taking place within two weeks of booking). The practice received a full comprehensive CQC inspection in March 2022 and received an overall rating of Good. The last annual contract review for financial year 2022/23 was undertaken earlier this year and areas identified for improvement are being worked through as part of their improvement plan. AT Medics was issued with a Breach Notice in May 2024 following an unauthorised change of control. This Notice was not exclusive to this contract and was applied to all existing APMS contracts held by AT Medics. The preferred option is to extend the contract for a further five- year term until 30 June 2030. This option carries the least amount of risk and will not cause any disruption to patient services.

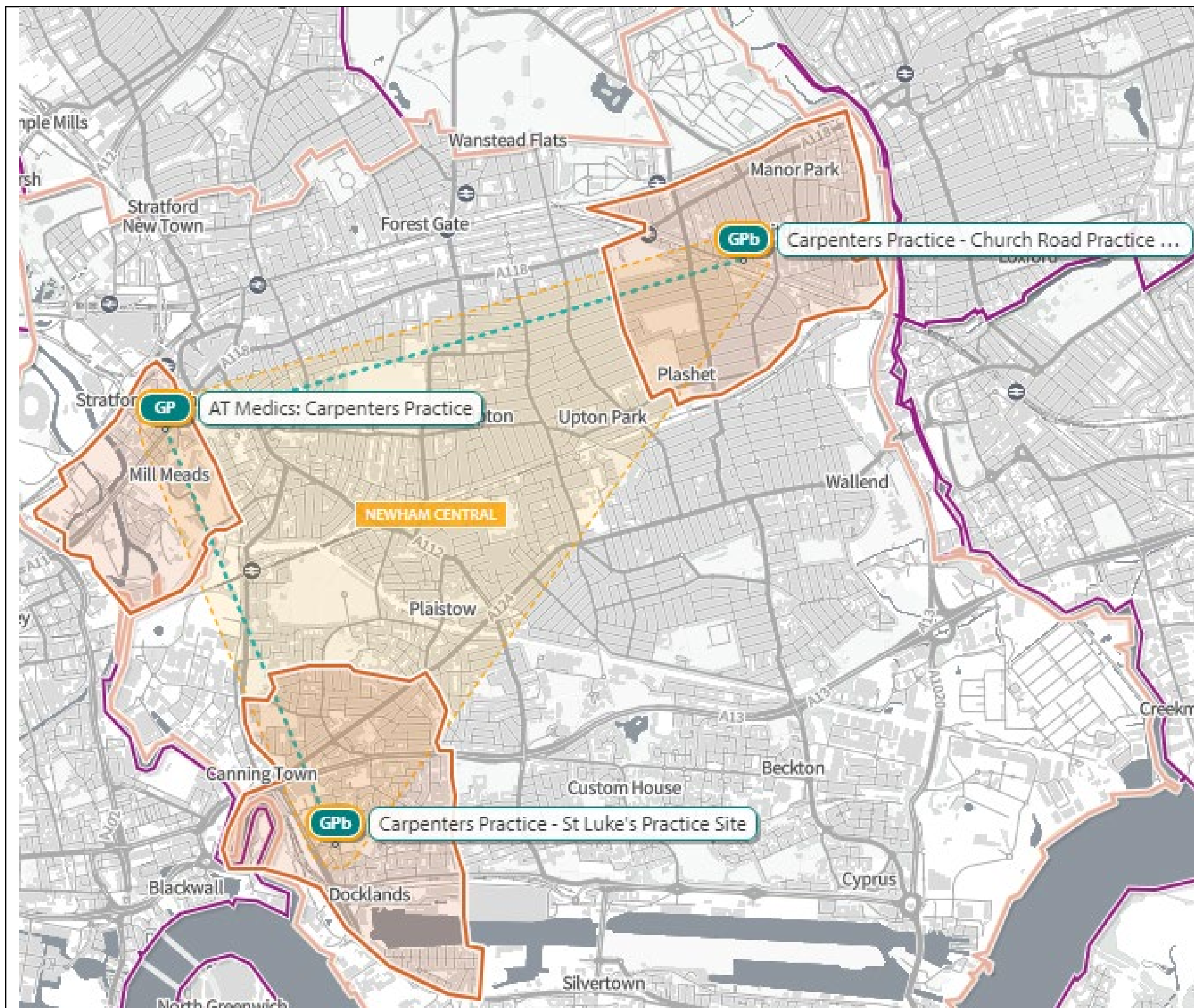
Action / recommendation	**Decision:** Approve extending the contract for a further five years until 30 June 2030.
Previous reporting	The report was discussed and the proposal to extend was endorsed at the Newham Local Fora on 20 June 2024.
Next steps/ onward reporting	Issue contract variation extension notice – August 2024 Monitor progress of improvement plan and review at the 24/25 contract review
Conflicts of interest	Any conflicts of interest to be managed in line with the Terms of Reference (ToR) of the Committee.
Strategic fit	Which of the ICS aims does this report align with? • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access
Impact on local people, health inequalities and sustainability	EQIA not required as no change to service provision.
Impact on finance, performance and quality	There are no financial, performance or quality implications
Risks	If suitable arrangements have not been confirmed within 9 months of the contract expiry date, continuity of patient care may be disrupted when the contract expires

North East London

GP Contract Strategic Commissioning Review Business Case

Place:	**PCN:**
Newham	Newham Central
Practice name:	**Practice code:**
Carpenters Practice	F84749
Raw list size (April 2024)	**Weighted list (April 2024)**
24983	23349.98
Current provider:	
AT Medics Ltd.	
Contract Start Date:	**Contract End date**
1 July 2020	30 June 2025
Contract Term Provision for Extension/Break Clause	
Option to extend to 30 June 2030 and further option to extend to 30 June 2035.	
Reason for contract review:	
Contract expires on 30 June 2025 and decision is required on whether to extend the contract further.	
Practice website:	
https://newhampractice.co.uk/	
Report Completed by:	

Benjamin Smith, Primary Care Commissioning Manager
Equality Impact Assessment Completed:
Not required as no change to service provision.
Summary of Recommendation:
Recommendation is to extend the contract for a further five years until 30 June 2030.
1.0 Contract Overview / History
1.1 In April 2013, Carpenters Practice was commissioned as an APMS contract. Lantern Health CIC were commissioned to provide primary medical care services under a single APMS contract for three failing practices (St Luke's Square; Church Road and Carpenters Road). The contract was originally issued for five years and was extended by a further two years in 2018 until 30 June 2020. This enabled the contract to be included as part of a procurement exercise. 1.2 Following the procurement exercise, AT Medics Ltd were awarded the contract, with a start date of 1 July 2020. This contract is due to expire on 30 June 2025. It has not been extended so far. There's an option to extend the contract to 30 June 2030, with a further option to extend to 30 June 2035. 1.3 AT Medics underwent a change of control in 2021 and a further change in December 2023, but they continue to be the contract holders. 1.4 There are no terms to be varied within the contract.
2.0 Practice Specific Information
2.1 Carpenters Practice operates over three sites across Newham, with two sites situated in areas of high population growth within Newham, Stratford & Mill Meads and Docklands. The practice operates in line with GMS/PMS core hours (Monday to Friday, 8am – 6.30pm (excluding bank holidays). All three sites are purpose built.



2.2 Premises occupied (purpose built, converted house etc)

Main Site Address:

Carpenters Practice - Stratford

236-252 High Street

London

E15 2JA

Branch Site Addresses:

Carpenters Practice – St Luke's

2 St. Luke's Square

London

E16 1HT

Carpenters Practice – Church Road

The Centre - 30 Church Road

London

E12 6AQ

2.3 Clinical workforce (Figure 2.0)

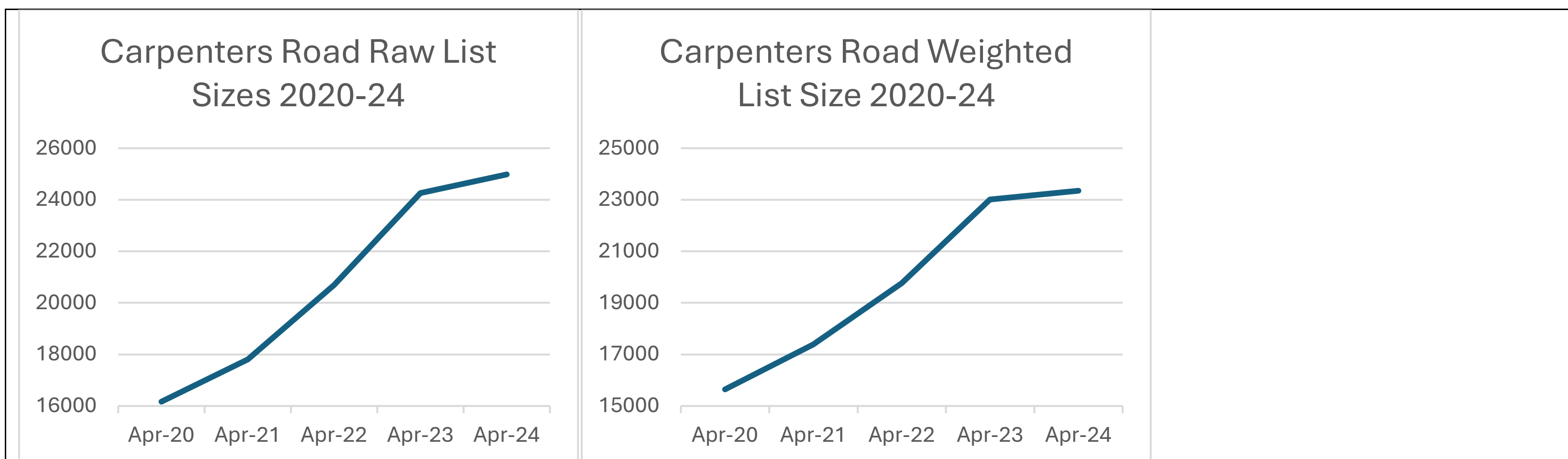
The clinical workforce at Carpenters practice is above the NEL ICB average for both GP and nursing staff. The GP FTE per 1000 registered patients is equal to the London and England average. The nurses FTE per 1000 registered patients is above the London average but below the England average.

Clinical workforce FTE - exc. Locums, trainees and apprentices							
Practice/Org	GP	Nurses	Direct Patient Care	GP FTE p1000	Nurse FTE p1000	DPC FTE p1000	Patients to GP FTE
CARPENTERS PRACTICE	5.8	3.9	9.4	0.2	0.2	0.4	4270
NEL ICB				0.3	0.1	0.2	2906
LONDON				0.4	0.1	0.2	2700
ENGLAND				0.4	0.3	0.3	2367

Data source: General Practice Workforce, 31 March 2024 – NHS England Digital

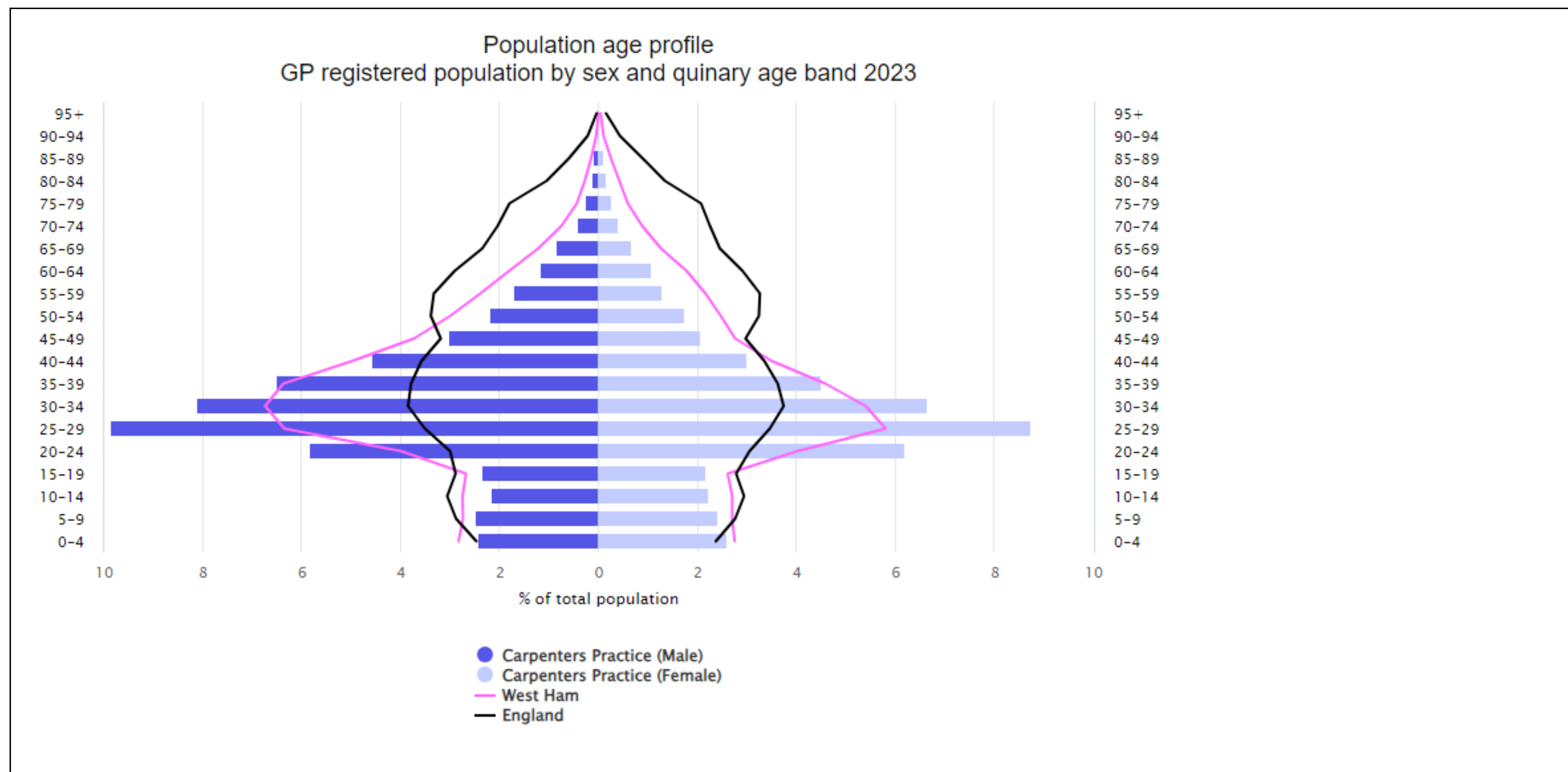
2.4 Patient List (Figure 3.0)

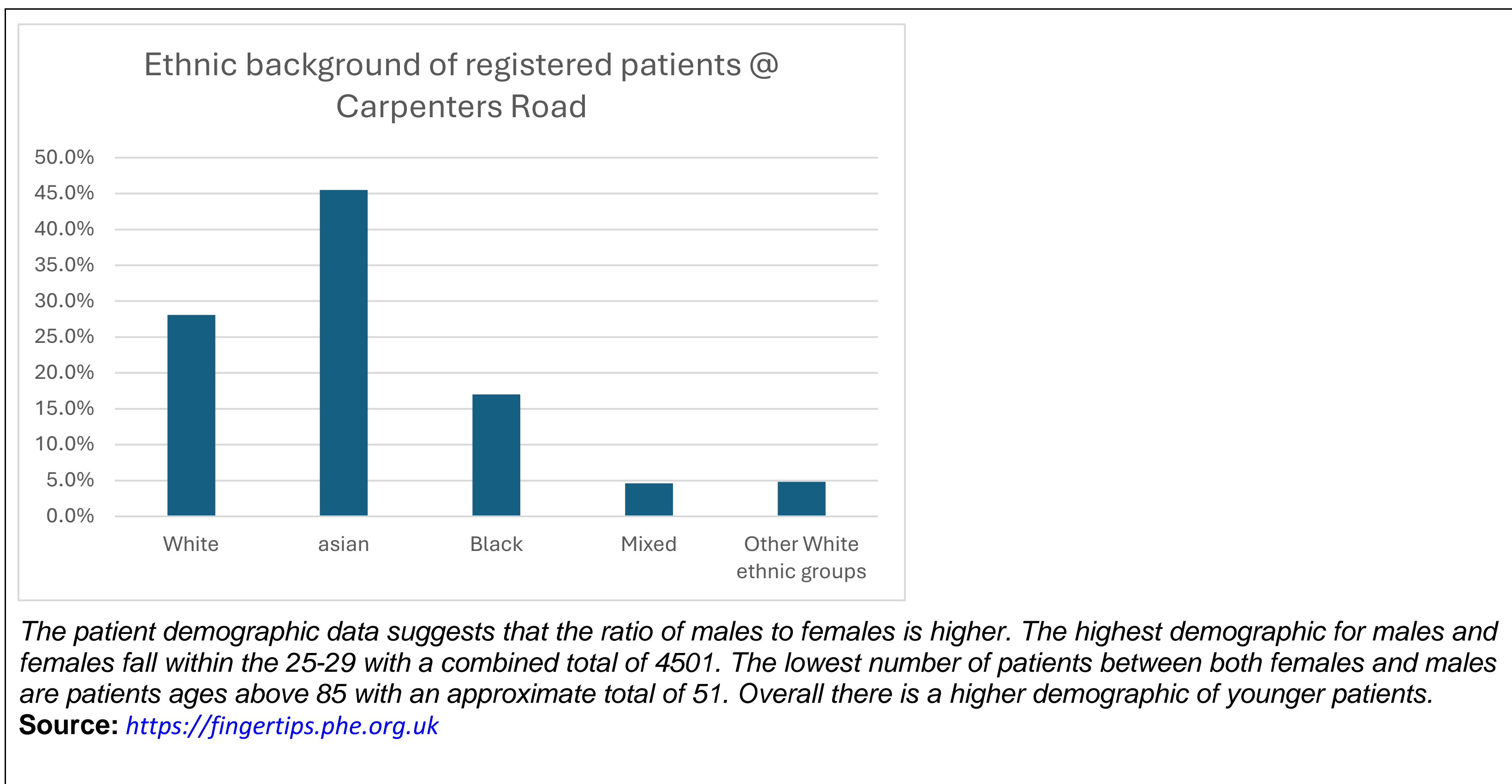
Date	Raw List Size
April 2024	24983
April 2023	24266
April 2022	20695
April 2021	17808
April 2020	16167



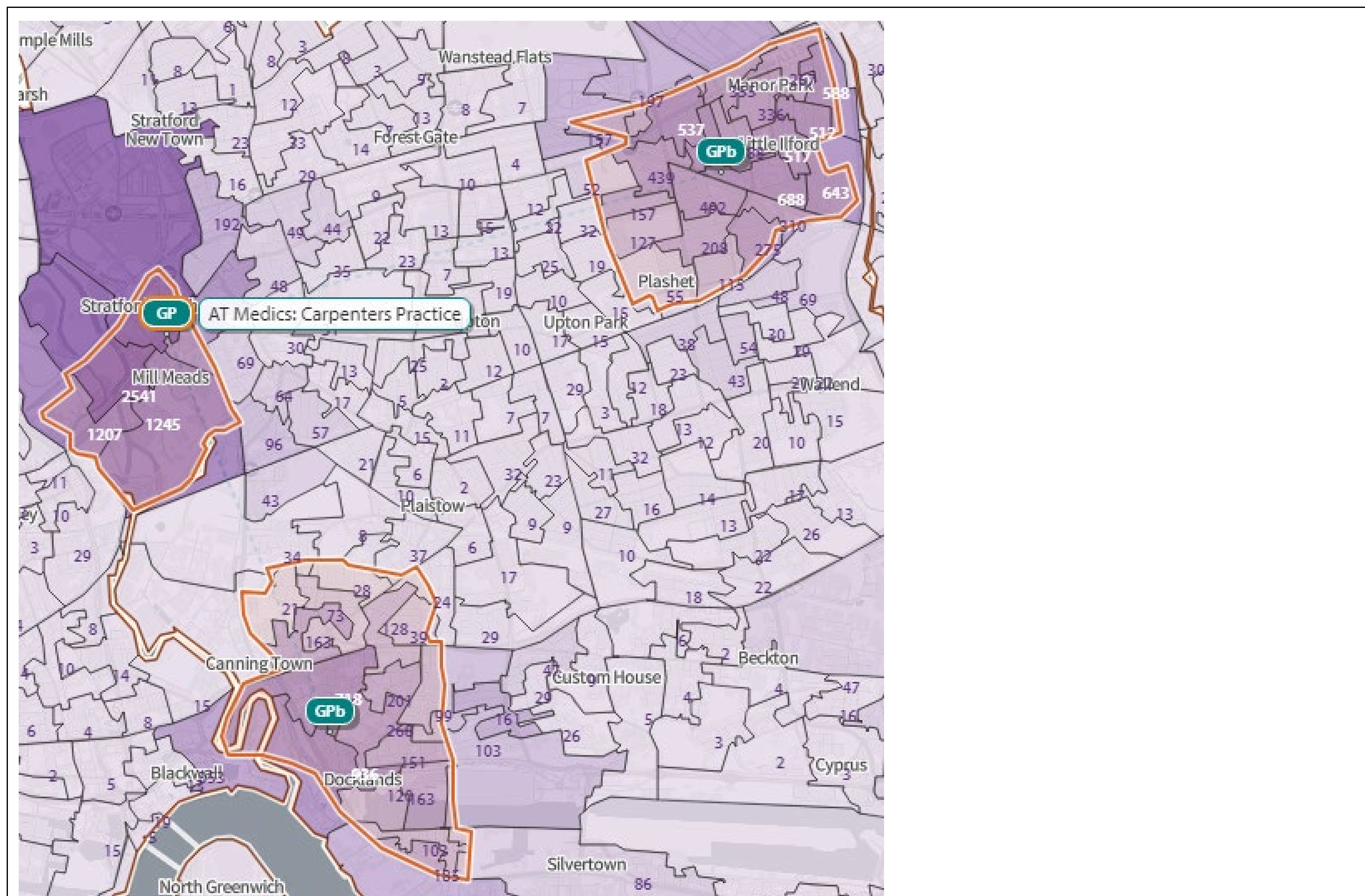
The registered patient list size has increased steadily over the last 5 year period. A slower increase in the year 2023 to 2024 can be seen. The increase in list size may have been directly impacted by the following practice closures- West Ham Medical Centre, Dr Lwin Surgery, Dr Abiola @ Lord Lister Health Centre, Dr Swedan @ Lord Lister Health Centre, Boleyn Road Practice, Esk Road Medical Centre, Summit practice and 2 branch sites closures at Sangam Surgery.

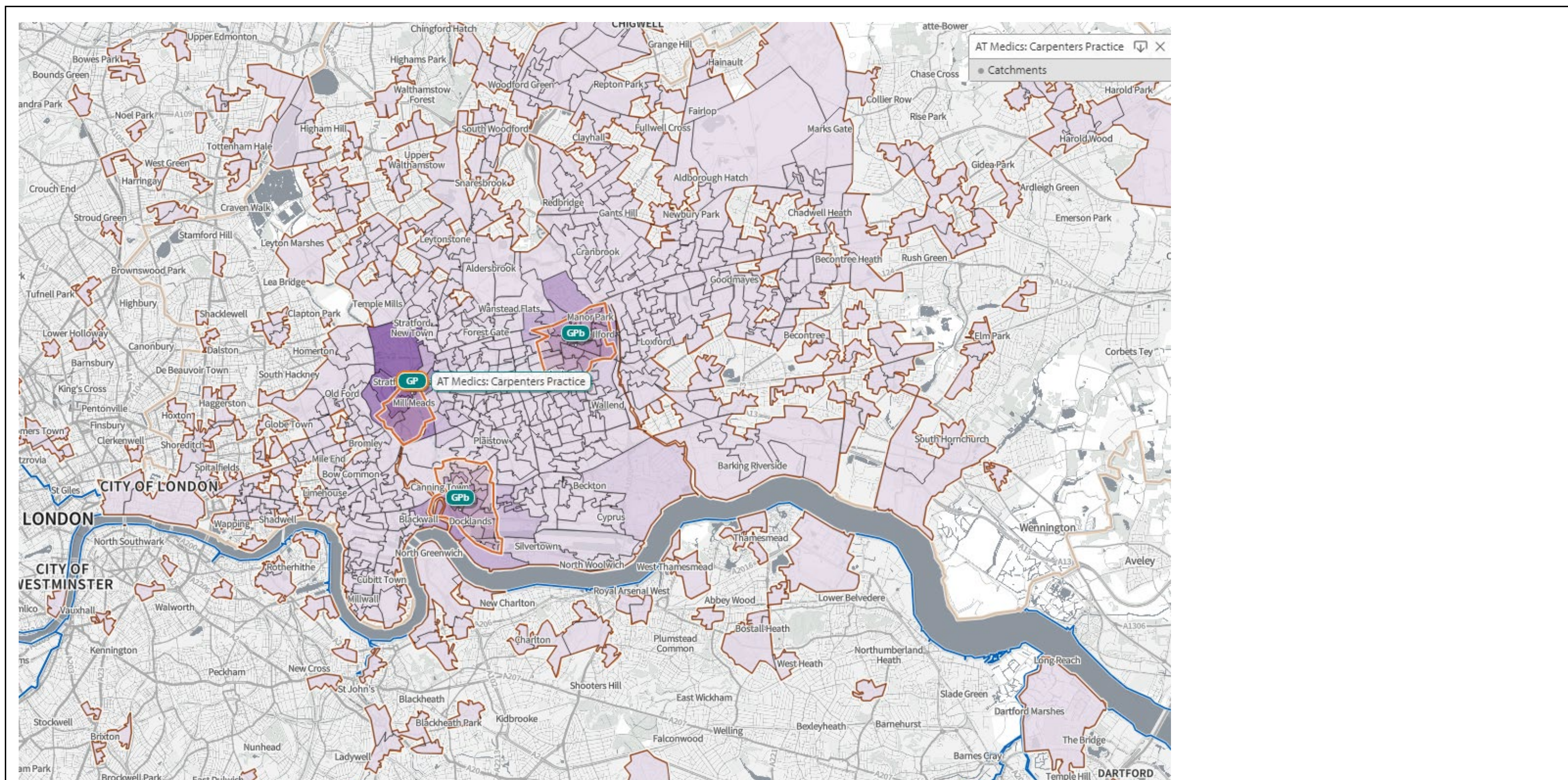
2.5 Patient demographics


Population age profile
GP registered population by sex and quinary age band 2023
95+
90-94
85-89
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
10 8 6 4 2 0 2 4 6 8 10
% of total population
Carpenters Practice (Male)
Carpenters Practice (Female)
West Ham
England



The patient demographic data suggests that the ratio of males to females is higher. The highest demographic for males and females fall within the 25-29 with a combined total of 4501. The lowest number of patients between both females and males are patients ages above 85 with an approximate total of 51. Overall there is a higher demographic of younger patients.
Source: *https://fingertips.phe.org.uk*


Wanstead Flats
Stratford New Town
Forest Gate
Manor Park
Little Ilford
Plashet
Upton Park
AT Medics: Carpenters Practice
Mill Meads
Plaistow
Canning Town
Custom House
Beckton
Blackwall
Docklands
Cyprus
Silvertown
North Greenwich



Source: https://app.shapeatlas.net/place/

Based on January 2024 figures, there is a total list size of 11775 registered patients who reside within the borough of Newham and 34 registered patients who reside outside the borough. 99.1% in borough and 0.9% out of borough.

3.0 Quality Performance - Compare performance (CEG data) against PCN, borough and national

if the practice is an outlier in any area, comment if this is being addressed by the practice e.g improvement plan in progress being monitored as part of the annual contract review:

3.1 QOF Performance

The practice has maintained good performance in QOF over the last few years. The practice has achieved higher than the borough average which can be seen in figure 3.0 below:

Figure 3.0 – QOF Achievement

Financial year	Practice Achievement	Newham Average	Variance
2022-23	580.24 out of 635 points	577.46	2.78 percentage points above
2021-22	581.00 out of 635 points	578.02	2.98 percentage points above
2020-21*	N/A	N/A	N/A

*Data unavailable due to the impact of COVID-19

Source: NHS Digital QOF Data

3.2 Childhood Immunisations 2023/24

In 2023-24 the uptake of childhood immunisations for this practice, particularly MMR was below the Newham average. The contractor has reported that some families are hesitant to vaccinate their children and decline the offer when invited to attend the surgery.

Multilingual GPs and other clinicians provide educational conversations for patients/families that decline and offer written materials in languages other than English. The practice works closely with mosques and other faith groups to build trust with patients and provide information about the benefits of childhood immunisations.

Patients becoming 12m	DTaP/IPV/Hib/HepB(%)	Men B(%)	PCV(%)	Rotavirus(%)
Carpenters Practice	87.5%	84.4%	89.1%	87.5%

NHS North East London

Newham Average	**88.1%**	**85.0%**	**91.4%**	**85.8%**

Patients becoming 24m	**DTaP/IPV/Hib/HepB (%)**	**MMR(%)**	**HiB/Men C (%)**	**PCV (Booster)(%)**
Carpenters Practice	88.9%	77.8%	81.0%	79.4%
Newham Average	**87.6%**	**81.2%**	**80.2%**	**79.8%**

Patients becoming 5 yrs	**DTaP/IPV/Hib/HepB(%)**	**MMR (Primary)(%)**	**DTaP/IPV (Booster)(%)**	**MMR (Booster)(%)**	**HiB/Men C(%)**
Carpenters Practice	84.5%	80.3%	66.2%	66.2%	84.5%
Newham Average	**89.4%**	**88.3%**	**81.1%**	**81.5%**	**87.7%**

(Source: CEG dashboard data 23-24)

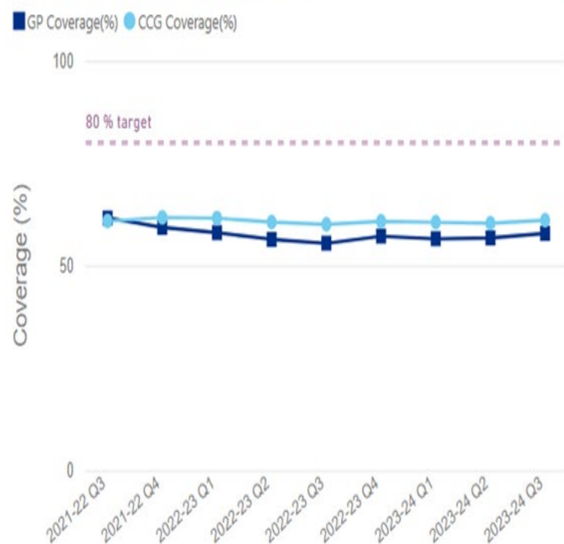
3.3 Flu – In 2023-24 the uptake of the seasonal flu vaccine was lower than the NEL average in most cohorts expect in some high -risk groups such as pregnant patients and children aged 2-3 years

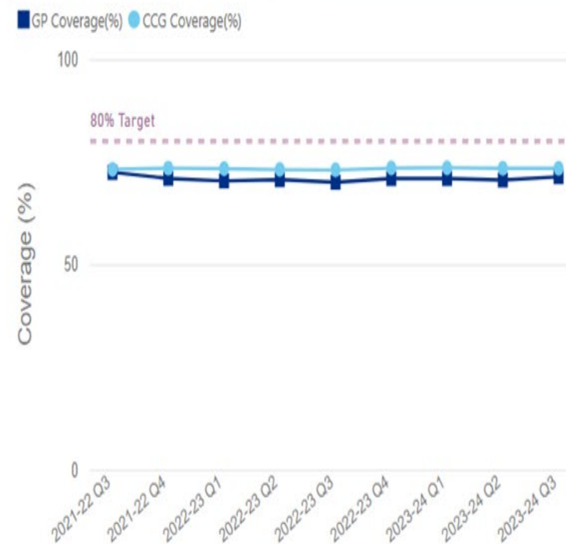
Cohort	Carpenters	NEL
1. Patients aged 65 and over (exc care home & housebound)	52%	64%
2. Patients living in residential or care home	44%	68%
4a. Patients aged 50-64 at clinical risk	49%	50%
5. Patients aged 18-49 yrs with clinical risk (exc housebound)	38%	32%
6a. Pregnant patients at clinical risk	64%	47%

6b. Healthy Pregnant Patients	34%	27%
8a. Children aged 2-3 at clinical risk	45%	45%
8b. Healthy Children aged 2-3 yrs	36%	24%

(Source: CEG dashboard data 23-24)

3.4 Cervical Screening – Carpenters practice achieved slightly lower than the NEL average for both age groups, however the coverage for ages 50 to 64 is higher than ages 25 to 49. In both age groups, coverage for both the practice and NEL are lower than the 80% national average.





(Source: Cervical Screening, NHS Digital)

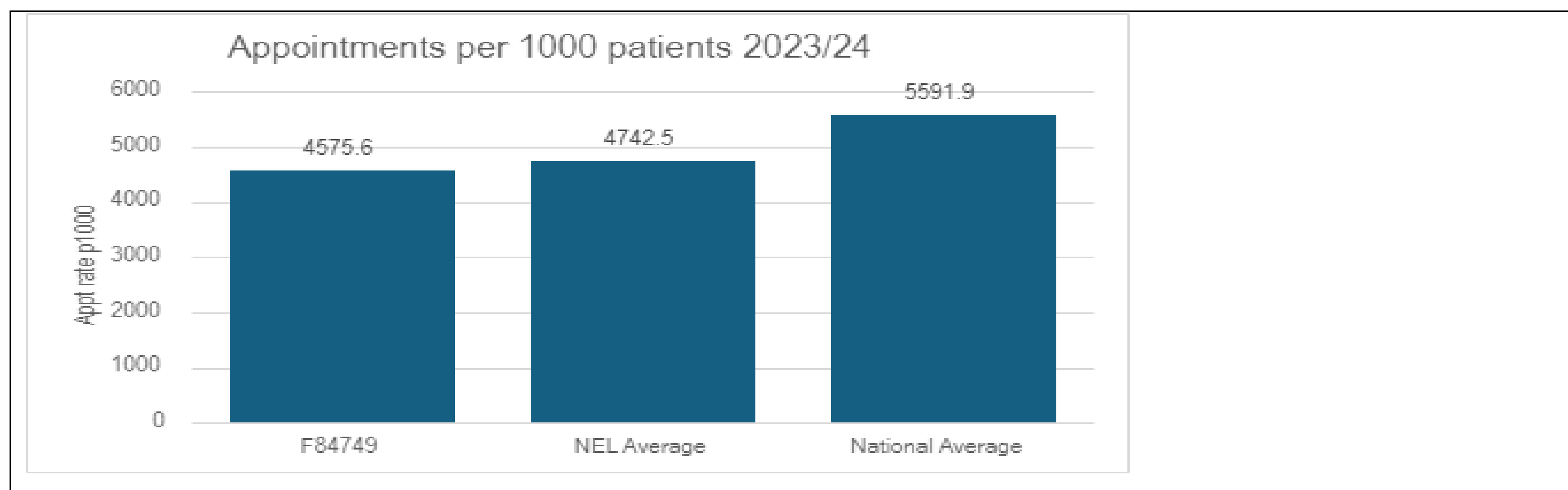
4.0 Service Delivery (Place to input this section)

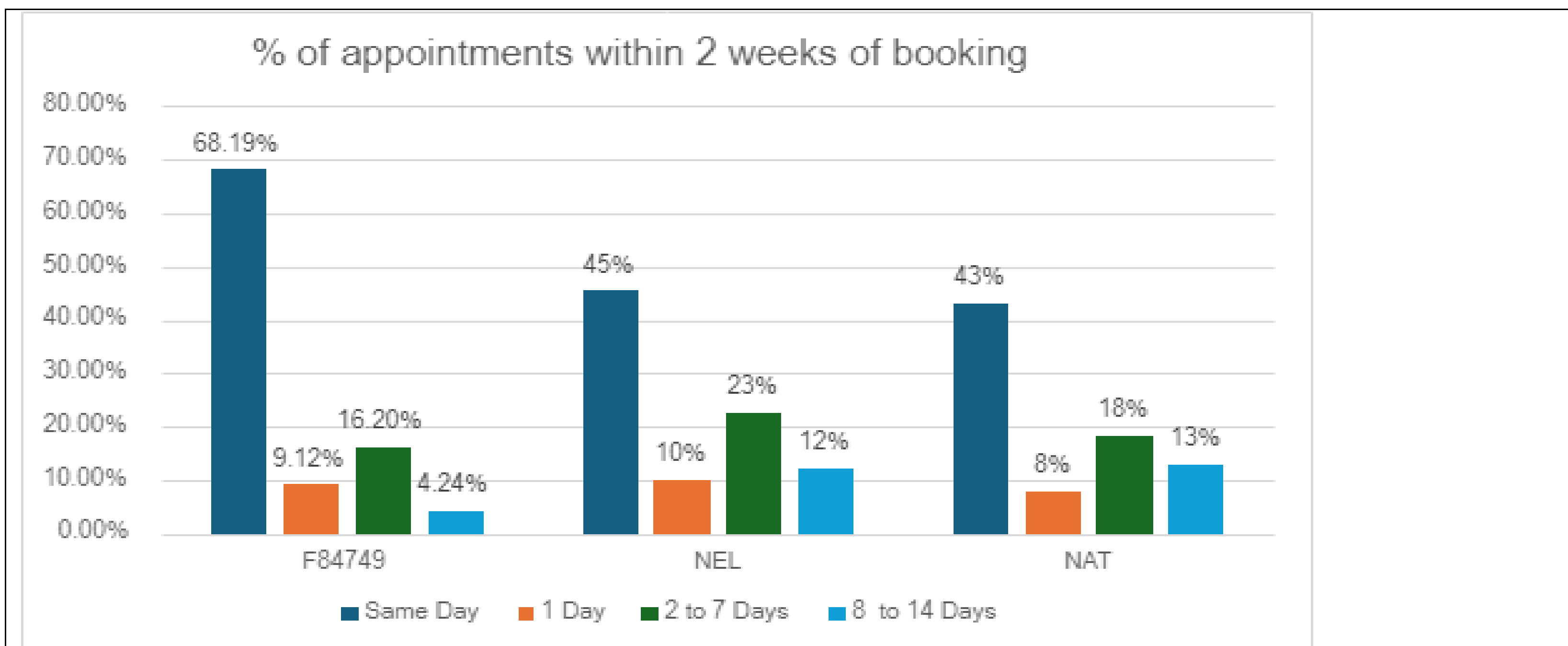
4.1 Access - In 2023-24 the practice delivered 4,576 appointments per 1000 patients (3.5% less) compared to the NEL average of 4,743 and national average of 5592.

98% of appointments took place within 2 weeks of booking compared to 90% in NEL average and 82% national average. NHSE operational planning guidance indicates that a minimum of 85% of GP appointments should take place within 2 weeks of booking.

Carpenters practice offered slightly fewer appointments per 1000 patients than the NEL average but a greater proportion of these take place within two weeks of booking and a significantly higher proportion of appointments take place on the same day compared to both the NEL and national average.

	Appt rate p1000	Same Day	1 Day	2 to 7 Days	8 to 14 Days
F84749/Carpenters Practice	4575.6	68.19%	9.12%	16.20%	4.24%
NEL Average	4742.5	45.50%	10.11%	22.60%	12.21%
National Average	5591.9	43%	8%	18%	13%


Appointments per 1000 patients 2023/24
Appt rate p1000
6000
5000
4000
3000
2000
1000
0
4575.6
4742.5
5591.9
F84749
NEL Average
National Average



(Source: Appointments in General Practice, NHS Digital)

4.2 In hours calls to NHS111 – In 2023/24 Carpenters practice rate of in hours calls to NHS111 is comparable to the PCN average and higher that the NEL average.

Carpenter	85
PCN	85
Newham	79
NEL	66

(Source: NEL BI – PC Dashboard Suite)

4.3 Pharmacy and Medicines Optimisation

The NHS Community Pharmacy Blood Pressure Check Service supports risk identification and prevention of cardiovascular disease (CVD).

Service	Period	Number of referrals-Practice	Number of referrals -PCN
Hypertension Case-finding NHS England » NHS Community Pharmacy Blood Pressure Check Service	November 2023 - May 2024	7	190
Ambulatory Blood Pressure Monitoring	November 2023 - May 2024	178	190
CPCS	March 2022- December 2023	2677	4,022
Pharmacy First NHS England » Pharmacy First	January	840	993

The practice has engaged with partners and stakeholders to implement these services. They continue to improve the uptake and referral rates.

The Prescribing Quality and Efficiency Scheme (PQES) is an initiative aimed at enhancing the quality, cost-effectiveness, and safety of prescribing and medicines optimisation within Primary Care.

Medicines Safety	Practice Output

To address the MHRA alert regarding the use of Valproate by women and girls, practices are asked to submit evidence of revieing patients on Valproate. If there are no patients on Valproate, another MHRA alert can be chosen to demonstrate implementation	Achieved
Opioid and Dependency Forming Medicines (DFM) prescribing clinical review	Achieved
Learning From Patient medicines-related safety events. Practices to report on prescribing errors/near misses via the Learning From Patient Safety Events (LFPSE) portal.	Achieved

Antimicrobial resistance (AMR) has been identified as one of the most pressing global challenges we face this century. In fact, the World Health Organisation (WHO) has declared AMR as one of the top 10 global public health threats, and AMR is listed on the UK Government's National Risk Register.

Practices are therefore asked to review their antimicrobial prescribing to ensure that this in line with local and national guidelines. Practices should aim to achieve the set targets for the antimicrobial prescribing metrics.

	Antibacterial items/STAR-PU position March 24 (12 months rolling data)	Proportion of co-amoxiclav, cephalosporin & quinolone items position March 24 (12 months rolling data)	Amoxicillin 500mg capsule: % of total items, 5 days (Quantity=15) March 24 (12 months rolling data)	OptimiseRx:
Target	≤0.871	≤10%	>40%	≥ 20% acceptance rate
Practice achievement	0.488	5.51%	43.36%	25.89%

4.4 KPIs

As this is an equalised contract (in-line with GMS/PMS) there are no KPI payments applicable to this contract.

4.5 Innovation

The contractor has implemented a digital transformation programme and introduced triage hubs to improve access and patient experience.

The contractor has appointed a new clinical director and six salaried GPs and reduced the number of GP locums to improve continuity of care and strengthen the team. The new model will be a ratio of 9:1, salaried GPs to GP locums.

5.0 Contract & Regulatory Compliance

5.1 The practice is registered with the CQC. Following an inspection in May 2021, Carpenters Practice was rated Inadequate but was subsequently rated Good overall and in every domain in July 2022 and at a follow up review in July 2023

the CQC found no evidence to reassess the rating. There are no compliance issues in relation to the yearly eDEC submissions by the practice.

5.2 AT Medics was served with a Breach Notice in May 2024 following an unauthorised change of control. This Notice was applicable to all APMS contracts held by AT Medics and was not exclusive to the Carpenters Practice.

5.3 The last annual contract review was for financial year 2022/23. The practice is working to address the areas highlighted where achievement is below the ICB average. The progress will be reviewed in the 24/25 contract review.

6.0 Premises and Estates

6.1 The practice is based across three sites. The Stratford and St Luke's sites are owned by NHS Property Services. The Church Road site is owned by Community Health Partnerships.

7.0 Patient Experience

7.1 Patient Participation Group (PPG)

The practice has an active PPG that meets quarterly. The last meeting was held on 7 March 2024 and eight people attended. the practices are using a variety of methods to help promote the PPG. Information about the PPG is also available on the practice website.

7.2 GP Patient Survey (GPPS)

The GPPS results for 2023 were below the ICB average for some of the key questions that were analysed (see figure 4.0 below) The Practice have undertaken their own practice patient survey in addition to the national patient survey and put an action plan in place to address areas of improvement :

Figure 4.0 – GPPS Results 2023

	Practice Result	ICB Result	Above / Below ICB Average
Describe their overall experience of this GP practice as good	55%	64%	Below

Satisfied with the general practice appointment times available	36%	51%	Below
Find it easy to get through to this GP practice by phone	41%	48%	Below

Source: GP Patient Survey

8.0 Contract Value

Carpenters Practice	**Price**
Global Sum price	£2,511,756.97
London Allowance	£54,462.94
Risk Premium	£116,749.88
Sub-total	**£2,682,969.80**
Less: OOH deduction (% of Global Sum & London Weighting)	-£ *121,895.45*
Total	**£2,561,074.35**

9.0 Options/ Preferred Option/Risks

	Pros	Cons	Risks	Mitigation
Option 1 – Do nothing	The contract will automatically terminate on 30 June 2025 with no provision for patient care			
Option 2 – Extend contract	No disruption to patient services – existing provider will continue to deliver primary medical services. There are no significant performance concerns in relation to the delivery of the practice contract, therefore no risk to patient safety. .	Some areas were identified where the practice could improve. i.e Results for some key patient survey questions were identified as performing below the NEL average	No improvement will be made The risk of a future deterioration of performance or financial instability following the change of ownership of AT Medics/Operose.	The practice improvement plan will be monitored in line with the annual contract review Performance and quality will be closely monitored through the contract management process
Option 3 – Terminate A new contractor may be able to achieve higher performance in the areas	A new contractor may be able to achieve higher performance in the areas highlighted for improvement	Disruption to patient services Additional costs will be incurred for an interim caretaking contract that would have to be put in place until the	Procuring a suitable provider with the capability to deliver patient services at scale	Market testing and ensuring a sufficient timeframe for procurement

highlighted for improvement **contract and tender new contract**		new contract is awarded		

Preferred Option:

The preferred option would be extending the contract for a further five years until 30 June 2030, which is option 2. This option carries the least amount of risk and minimises disruption to patient care.

10.0 Next steps

- Issue provider with contract variation for extension
- Continue with regular contract reviews with a particular focus on monitoring progress against the GP Patient Survey

NHS North East London

Primary Care Contracts Sub-committee

16 July 2024

Title of report	APMS Commissioning Intentions – Goodman's Field
Author	Abdul Rawkib, Primary Care Commissioning Manager, NEL ICB
Presented by	Abdul Rawkib, Primary Care Commissioning Manager, NEL ICB
Contact for further information	a.rawkib@nhs.net
Executive summary	The Goodman's Field Medical Practice APMS contract in Tower Hamlets has been managed by AT Medics since 2020. The contract provides a maximum term of 15 years with provision for 5-year break clauses throughout. The contract is approaching the expiry of its initial five-year term on 8 August 2025 and is subject to extension by mutual agreement for a further 5-year term pending its commissioning review. Contract performance is reviewed annually but a more comprehensive review has been undertaken in view of the commissioning options to be considered at the contract's five-year break-clause. The Strategic Commissioning Review presents an overview of contract performance and other factors to be considered in determining the future of the contract beyond the initial expiry date. Goodman's Field Medical Practice is delivering satisfactory performance across a range of indicators where performance is above the borough/ICB average notably in the Quality Outcomes Framework (QOF) with other areas identified for improvement which include flu vaccine uptake and the GP Patient Survey. Improving flu vaccine uptake is being addressed by initiatives to tackle vaccine hesitancy in the wider community and an improvement plan is in place to address issues identified as part of the GP Patient Survey. Overall, aside from the Breach Notice issued to AT Medics Limited for the unauthorised change of control which is applicable to all APMS contracts held by AT Medics, there are no significant concerns regarding contract delivery therefore, the preferred option is to extend the contract
Action / recommendation	The Committee is asked to approve the recommendation of extending the contract by a further five years until 8 August 2030.
Previous reporting	The report has been discussed and the proposal to extend supported at the local forum of the Tower Hamlets Primary Care Transformation Group
Next steps/ onward reporting	• Issue variation notice to extend the contract to 8 August 2030

	• Monitor and review progress on the improvement plan to address areas of underperformance as part of the 2024/5 contract review
Conflicts of interest	Any conflicts of interest to be managed in line with the Terms of Reference (ToR) of the Committee.
Strategic fit	Which of the ICS aims does this report align with? • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To support broader social and economic development
Impact on local people, health inequalities and sustainability	Extending this contract will ensure the continuity of primary medical services for patients and therefore will require no Equalities Impact Assessment (EIA), as there is no change to service provision.
Impact on finance, performance and quality	There are no financial, performance or quality implications
Risks	If suitable arrangements have not been confirmed within 9 months of the contract expiry date, continuity of patient care may be disrupted when the contract expires.
Appendices	Appendix 1 – Goodman's Field Strategic Review

NHS
North East London

GP Contract Strategic Commissioning Review Business Case

Place:	**PCN:**
Tower Hamlets	Tower Network
Practice name:	**Practice code:**
Goodman's Field Medical Practice	F84039
Raw list size:	**Weighted list:**
34,847 (1 April 2024)	31,109.02 (1 April 2024)
Current provider:	
AT Medics Limited	
Contract Start Date:	**Contract End date:**
9 August 2020	8 August 2025
Contract Term Provision for Extension/Break Clause:	
This contract was procured for a term of 15 years (5+5+5) with the option to extend until 8 August 2035.	
Reason for contract review:	
This contract is approaching its first five-year break clause, with the option to extend for a further five years until 8 August 2030.	
Practice website:	
https://eastlondongp.co.uk/	

Report Completed by:

Abdul Rawkib, Primary Care Commissioning Manager, NHS North East London
Rebecca Warren, Primary Care Delivery Manager, NHS North East London

Equality Impact Assessment Completed:

Not required as no change to service provision.

Summary of Recommendation:

Recommendation is to extend the contract for a further five years until 8 August 2030.

1.0 Contract Overview / History

1.1 AT Medics was the successful bidder in the 2019 Tower Hamlets CCG APMS procurement for East One Health practice. In addition to standard provisions and requirements of an APMS contract, the procurement also included:

(i) provision to merge the registered list of East One Health with the list of nearby Whitechapel Health Centre at that contract's expiry on 30 September 2024. The provider of the Whitechapel APMS contract was AT Medics.

(ii) requirement for the new provider to move from the existing East One premises (Deancross Street and Cable Street) to newly-built premises at Goodman's Fields in July 2021. It was expected that Whitechapel would also move from its premises in Hessel Street in 2021, so that the two practices would operate independently under two APMS contracts from Goodman's Fields.

Following the procurement, AT Medics and Tower Hamlets CCG mutually agreed that the Whitechapel APMS Contract would bring forward its expiry date from 30 September 2024 to be coterminous with the new East One Contract's commencement date (9 August 2020), and that the two patient lists would merge **prior** to the move from Deancross Street, Cable Street and Hessel Street to Goodman's Fields in July 2021.

A single APMS contract commencing 9 August 2020 was therefore established for services provided by AT Medics at **both** the following practices:

- East One Health (main premises at Deancross Street **and** branch premises at Cable Street)

- Whitechapel Health Centre (Hessel Street)

In September 2021 the practice which delivered services across three sites, consolidated all three sites in the relocation to the purpose-built Goodman's Field Health Centre at 11 Stable Walk, London, E1 8ZF. The practice was subsequently renamed the Goodman's Field Practice.

1.2 AT Medics underwent a change of control in 2021 and a further change in December 2023, but they continue to be the contract holders.

1.3. The contract is approaching its first five-year break clause.

2.0 Practice Specific Information

2.1 Goodman's Field Practice is in the Whitechapel ward. The practice is situated in a purpose-built health centre with modern facilities. The practice operates in line with GMS/PMS core hours (Monday to Friday, 8am – 6.30pm (excluding bank holidays).

2.2. The practice has a higher patient to GP FTE ratio than local, regional and national comparators. This is demonstrated in figure 1.0 and 2.0 below. The higher GP to patient ratio is mitigated by other direct patient care roles based at the practice i.e. nurses and clinical pharmacists.

Figure 1.0 - GP Workforce

Clinical workforce FTE - exc. Locums, trainees and apprentices							
Practice/Org	GP	Nurses	Direct Patient Care	GP FTE p1000	Nurse FTE p1000	DPC FTE p1000	Patients to GP FTE
GOODMAN'S FIELD HEALTH CENTRE	8.9	8	17.8	0.3	0.2	0.5	3902
NEL ICB				0.3	0.1	0.2	2906
LONDON				0.4	0.1	0.2	2700
ENGLAND				0.4	0.3	0.3	2367

Figure 2.0 - GP Workforce

Source: General Practice Workforce

2.3 The practice list size has grown significantly over the last three years. On average there has been approximately a 10% increase in list size per annum dating back to 2021. This is depicted in figure 3.0 below.
Quick list size growth was expected at this practice due to the residential development in the local area, as well as having a larger practice to be able to accommodate a larger list size.

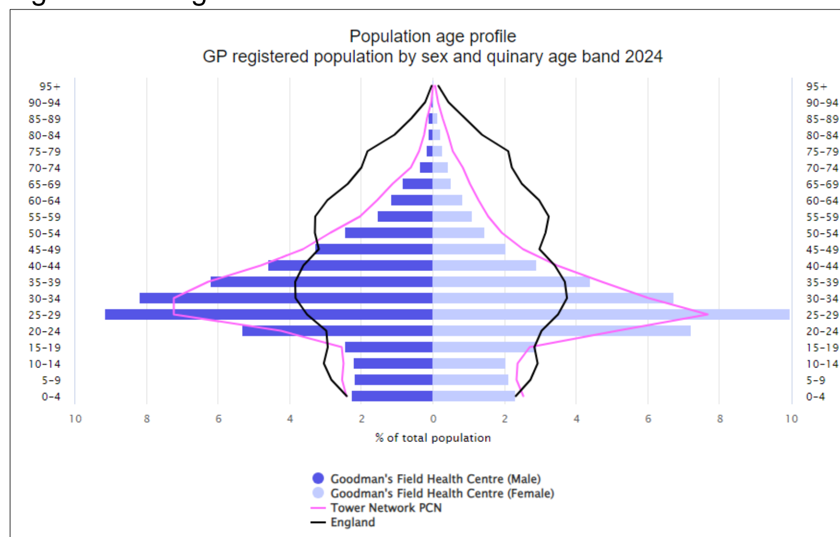
Figure 3.0 – Patient list size growth

Period	Raw List Size	Variation to Previous Year (count)	Variation to Previous Year (%)
Apr-24	34,847	2,302	7.1
Apr-23	32,545	3,007	10.2
Apr-22	29,538	3,110	11.8
Apr-21	26,428		

Source: PCSE list size data

2.4 The patient list mainly consists of the working age population and has a slightly higher ratio of males to females. A breakdown of the age categories can be seen in figure 4.0 below:

Figure 4.0 – Age breakdown



Source: National General Practice Profiles

3.0 Quality Performance - Compare performance (CEG data) against PCN, borough and national

3.1 QOF Performance

The practice has maintained good performance in QOF over the last few years. The practice has achieved higher than the borough average which can be seen in figure 5.0 below:

Figure 5.0 – QOF Achievement

Financial year	Practice Achievement	Tower Hamlets Average	Variance

2022-23	578.79 out of 635 points	576.24	2.55 percentage points above
2021-22	578.83 out of 635 points	576.20	2.63 percentage points above
2020-21*	N/A	N/A	N/A

*Data unavailable due to the impact of COVID-19
Source: NHS Digital QOF Data

3.2 Childhood Immunisations

The practice performance for childhood immunisations is comparable to the PCN average which can be seen in figure 6.0 below.

Figure 6.0 – Childhood Immunisations – 31 March 2024

CHILDHOOD IMMS 2023/24					**NHS Target - 95%**	
	F84039				**PCN Level**	
Patients turning 12m	**no.**	**%**			**no.**	**%**
DTaP/IPV/Hib/HepB	279	88.6			745	90.5

Men B	275	87.3			735	89.3
PCV	282	89.5			758	92.1
Rotavirus	269	85.4			708	86
Patients turning 24m	**no.**	**%**			**no.**	**%**
DTaP/IPV/Hib/HepB	271	86			773	88.9
MMR	259	82.2			723	83.1
HiB/Men C	259	82.2			725	83.3
PCV (booster)	258	81.9			721	82.9
Men B (booster)	259	82.2			731	84
Patients turning 5y	**no.**	**%**			**no.**	**%**
DTaP/IPV/Hib	264	88.6			757	90
MMR (primary)	271	90.9			757	90
DTaP/IPV (booster)	238	79.9			684	81.3
MMR (booster)	240	80.5			693	82.4
HiB/Men C	264	88.6			746	88.7

Source: CEG data

3.3 The practice flu performance has been comparable to the NEL average and in some areas above the NEL-wide average (see figure 7.0 below). Areas of low performance has been addressed through the annual contract review process and the practice do have an action plan in place to improve uptake.

Figure 7.0 – Flu Achievement

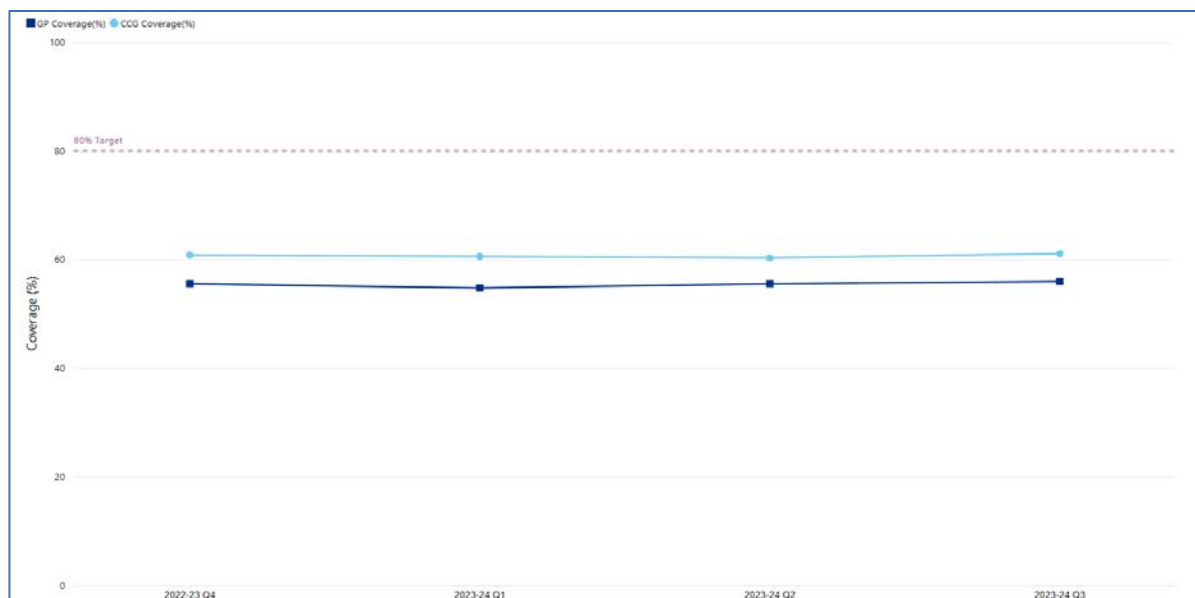
	F84039		NEL-wide		
09/2023- 04/2024	No.	%	No.	%	Target
1. Patients aged 65 and over (exc care home & housebound)	13,247	52%	3,201,263	56%	85%
2. Patients living in residential or care home	333	50%	105,625	62%	75%
3. Patients who are housebound (Age 65 or over or with clinical risk)	733	34%	211,133	57%	75%
4a. Patients aged 50-64 at clinical risk (exc housebound)	16,501	52%	1,413,433	42%	75%
5. Patients aged 18-49 at clinical risk (exc housebound)	19,180	34%	959,797	26%	75%
6a. Pregnant patients at clinical risk	337	51%	17,986	40%	75%

6b. Healthy Pregnant Patients	1,599	28%	93,060	24%	75%
7. Patients over 6 months and under 18 at clinical risk	111	7%	21,385	16%	70%
8a. Children aged 2-3 yrs at clinical risk	119	33%	22,561	44%	70%
8b. Healthy Children aged 2-3 yrs	3,229	19%	511,927	20%	70%
9a. Primary School Children at clinical risk	732	21%	85,807	30%	70%
9b. Healthy Primary School Children	7,538	14%	1,053,701	20%	70%
10a. Secondary School Children at clinical risk	331	13%	55,369	24%	70%
10b. Healthy Secondary School Children	2,474	9%	394,500	13%	70%
11. Carers	2,166	28%	177,293	24%	75%

Source: CEG data

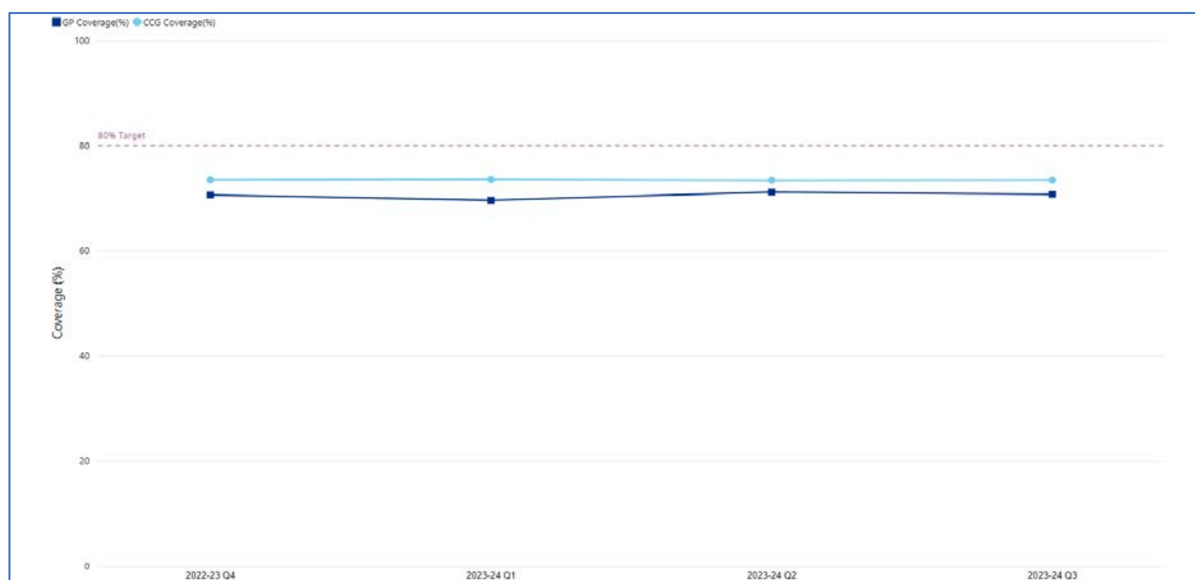
3.4 The practice performance for cervical screening is below the ICB average, however not regarded as a significant outlier. The practice is aware of the need for improvement and will be looking to make improvements in this area over the coming months.

Age Range 25-49		
GP Practice and CCG/Sub-ICB Coverage per quarter		
Date range	**GP coverage %**	**CCG coverage %**
2022-23 Q4	55.51	60.8
2023-24 Q1	54.73	60.56
2023-24 Q2	55.51	60.3
2023-24 Q3	55.96	61.05



Age Range 50-64
GP Practice and CCG/Sub-ICB Coverage per quarter

Date range	GP coverage %	CCG coverage %
2022-23 Q4	70.59	73.47
2023-24 Q1	69.57	73.53
2023-24 Q2	71.16	73.39
2023-24 Q3	70.72	73.43



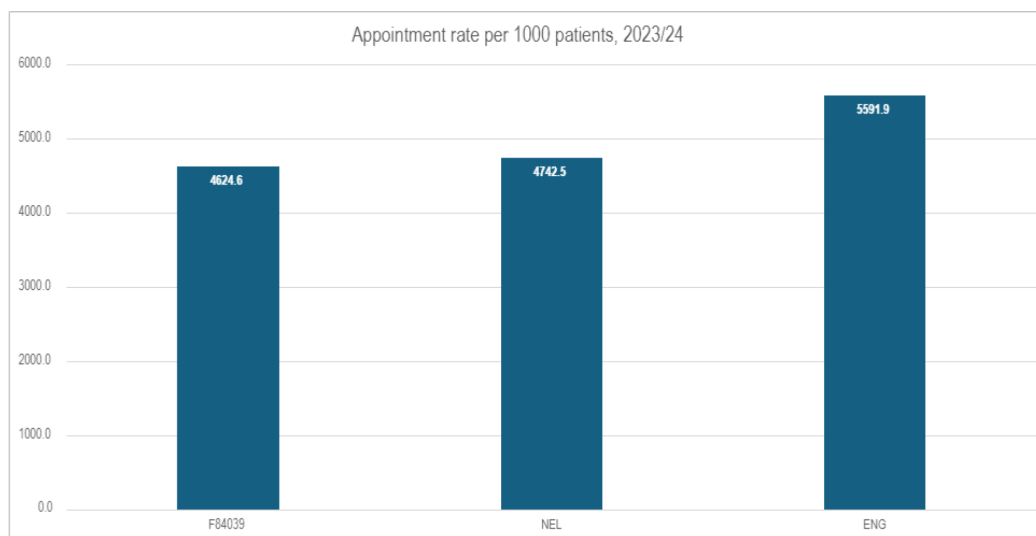
4.0 Service Delivery

4.1 Access

In 2023/24 the practice delivered 4624 appointments per 1000 registered patients. The NEL average was 4,743. The practice's same day, 1 day, 2 to 7 days, and 8 to 14 days appointment percentages are shown below:

NHS
North East London

ODS	Appt rate p1000	Same Day	1 Day	2 to 7 Days	8 to 14 Days
F84039 – Goodmans Field	4624.8	50.41%	13.12%	24.74%	8.47%
NEL Average	4742.5	45.50%	10.11%	22.60%	12.21%
National Average	5591.9	43%	8%	18%	13%



Although the practice offers a similar rate of appointments per 1000 patients than the NEL average, a greater proportion of these take place within two weeks of booking, particularly same day appointments compared to both the NEL and national average.

4.2 A&E / 111 Data

Summary of urgent care data has been provided below:

- Period: April 23 – March 24
- 2,779 in hour calls to 111
- 83 in hour calls per 1,000 patients – in line with Network average of 83.61
- (83.61 is the Network average, 69.52 is the Borough average, NEL average 66 calls per 1,000)

The practice in-hours calls to 111 is higher compared to the borough and NEL averages, however they are in line with the Network average. This is reflective of the the needs of the local population.

4.3 Prescribing Quality and Efficiency

Referral and engagement with Community Pharmacy referral services:

Service		Period	Number of referrals-Practice

Hypertension Case-finding [NHS England » NHS Community Pharmacy Blood Pressure Check Service]		November 2023 -May 2024	19
Ambulatory Blood Pressure Monitoring		November 2023 -May 2024	78
CPCS		March 2022-December 2023	823
Pharmacy First [NHS England » Pharmacy First]		January	200

The practice has engaged with partners and stakeholders to implement these services. They continue to improve the uptake and referral rates.

- As part of the Prescribing Quality and Efficiency Scheme 23/24, Goodman's Field Practice has submitted a self-declaration that the practice has met with the local community pharmacies/PCN community pharmacy lead, set up agenda for meeting and shared agreed action post meeting in relation to the local/national initiatives and utilising available clinical community pharmacy services.

- Based on available data, Goodman's Field Practice made 19 clinical blood pressure check referrals between April 2023 to December 2023 and 78 ambulatory blood pressure monitoring referrals between January to November 2023 to community pharmacies. There is currently no data available for Pharmacy First and this has only been launched in February 2024 and the dashboard is still currently under development.

- Goodman's Field practice has completed all required audits as part of the Prescribing Quality and Efficiency Scheme 23/24 and submitted relevant documents before the deadline 31st March 2024. The achievements for the indicators that require no submission is currently being renumerated against the prescribing data for 2023/2024 Q4 in comparison to baseline data 2022/2023 Q4.

NHS North East London

Medicines Safety	**Practice Output**
To address the MHRA alert regarding the use of Valproate by women and girls, practices are asked to submit evidence of revieing patients on Valproate. If there are no patients on Valproate, another MHRA alert can be chosen to demonstrate implementation	Achieved
Opioid and Dependency Forming Medicines (DFM) prescribing clinical review	Achieved
Learning From Patient medicines-related safety events. Practices to report on prescribing errors/near misses via the Learning From Patient Safety Events (LFPSE) portal.	Achieved

	Antibacterial items/STAR-PU position March 24 (12 months rolling data)	**Proportion of co-amoxiclav, cephalosporin & quinolone items position March 24 (12 months rolling data)**	**Amoxicillin 500mg capsule: % of total items, 5 days (Quantity=15) March 24 (12 months rolling data)**	**OptimiseRx:**
Target	≤0.871	≤10%	>40%	≥ 20% acceptance rate
Practice achievement	0.676	5.36%	42.58%	23.44%

North East London

4.4 KPIs

As this is an equalised contract (in-line with GMS/PMS) there are no KPI payments applicable to this contract.

4.5 Innovation

The practice has been utilising new technology to improve patient experience. For example, the practice has introduced a telephone call-back function. This innovative feature allows patients to request a callback from the practice, enabling them to remain in the queue without the need to wait on the phone for their call to be answered. The practice has also introduced health pods to allow patients to measure their height, weight, and blood pressure in order to improve the consultation process. The practice has also implemented Dr iQ, which is an online consultation service, although utilisation rates for this could be improved. The practice is continuing to raise the profile of online services and online registrations has increased by 10% in the last 12 months.

5.0 Contract & Regulatory Compliance

5.1 Following merger of the former APMS practices, the practice was registered with the CQC and at the point of registration the CQC stated that **"We checked this service was likely to be safe, effective, caring, responsive and well-led during registration."** A full CQC inspection has not been undertaken. There are no compliance issues in relation to the yearly eDEC submissions by the practice.

5.2 AT Medics were served with a Breach Notice in May 2024 following an unauthorised change of control. This Notice was applicable to all APMS contracts held by AT Medics and was not exclusive to Goodman's Field.

5.3 The last annual contract review for financial year 2022/23 was undertaken earlier this year. The practice is working to address the areas highlighted where achievement is below the ICB average. The progress will be reviewed in the 24/25 contract review.

6.0 Premises and Estates

6.1 The practice is situated in a purpose-built health centre with modern facilities. The practice has a lease arrangement in place with NHS Property Services (NHSPS).

7.0 Patient Experience

7.1 PPG

The practice has an active PPG which meets on a regular basis and is working to increase membership of the PPG.

7.2 GP Patient Survey (GPPS)

The GPPS results for 2023 were below the ICB average for some of the key questions that were analysed (see figure 8.0 below):

Figure 8.0 – GPPS Results 2023

	Practice Result	ICB Result	Above / Below ICB Average
Describe their overall experience of this GP practice as good	51%	64%	Below
Satisfied with the general practice appointment times available	38%	51%	Below
Find it easy to get through to this GP practice by phone	41%	48%	Below

Source: GP Patient Survey

The practice has put together an action plan to address the areas of low satisfaction rates and improvements should be recognised in the 2024 GPPS results. For instance, the practice has introduced the call-back option on the telephone system to reduce patients waiting for their calls to be answered. The practice has also expanded both the clinical and non-clinical team to deal with the increase in demand. A summary of the GPPS results has been included in Appendix A.

8.0 Contract Value

8.1. There are no KPI payments attached to this contract. The annual core contract price for this contract is £3,415,346 (indicative based on Q1 list size for 2024-25).

9.0 Options/ Preferred Option/Risks (e.g Contract extension; List Dispersal; appropriate PSR route)

	Pros	Cons	Risks	Mitigation
Option 1 – Do nothing	The contract will automatically terminate on 31 May with no provision for patient care			
Option 2 – Extend contract	• No disruption to patient services – existing provider will continue to deliver primary medical services.	Some areas were identified where the practice could improve. i.e Results for some key patient survey questions were identified as performing below the NEL average	No improvement will be made The risk of a future deterioration of performance or financial instability following the change of ownership of AT Medics/Operose.	The practice improvement plan will be monitored in line with the annual contract review Performance and quality will be closely monitored through the contract management process

Option 3 – Terminate contract and tender for a new contract	A new contractor may be able to achieve higher performance in the areas highlighted for improvement	Disruption to patient services Additional costs will be incurred for an interim caretaking contract that would have to be put in place until the new contract is awarded	Procuring a suitable provider with the capability to deliver patient services at scale to a list of over 34,000	Market testing and ensuring a sufficient timeframe for procurement

Preferred Option:

The preferred option would be extending the contract for a further five years until 8 August 2030, This option carries the least amount of risk and will not cause any disruption to patient services.

10.0 Next steps

- Issue provider with contract variation to extend to August 2030
- Continue with regular contract reviews with a particular focus on monitoring progress against the GP Patient Survey.

NHS
North East London

Primary Care Contracts sub-committee

16 July 2024

Title of report	Specialist support for the ongoing review of primary care business rates.
Author	Ian Clay, Deputy Director of Finance
Presented by	Ian Clay, Deputy Director of Finance
Contact for further information	Ian Clay, Deputy Director of Finance, ian.clay@nhs.net
Executive summary	NHS England, through its agent GL Hearn, undertakes cyclical reviews of assessed rateable value of primary care premises and appeals them with the Valuation Office Agency. This process can result in lower business rates for previous and future years. The associated refunds or reimbursements of business rates are paid into NHS England's designated bank account and then reconciled by GL Hearn before being allocated to either NHSE or the ICB based on whether the refund relates to pre or post delegation. A little while ago, the ICB failed to renew its contract with a company that had been providing the detailed administrative support for this ongoing process and we now need to re-start this work.
Action / recommendation	The sub committee is asked to: • Agree to restart the ongoing review of primary care business rates in line with national expectation and the need to secure the benefit of lower assessments.
Previous reporting	None.
Next steps/ onward reporting	If agreed, the next step would be to get approval through the Procurement Working Group for a direct award or to test the market.
Conflicts of interest	There are no conflicts of interests relating to this decision.
Strategic fit	Which of the ICS aims does this report align with? • To enhance productivity and value for money.
Impact on local people, health inequalities and sustainability	Through the active management of the review of reimbursable business rates we would be generating savings that can be reinvested into primary care services across NEL.
Has an Equalities Impact Assessment been carried out?	Not relevant to this proposal.
Impact on finance, performance and quality	There are no additional resource implications/revenue or capital costs arising from this report. The ongoing annual cost of £84k would be met from savings generated with the primary care rates budget.
Risks	No specific risks.

1.0 Introduction/ Context/ Background/ Purpose of the report

1.1 The ongoing process of reviewing rateable values involves a thorough analysis of the GL Hearn settlement data and close liaison with Local Authorities and Practices. Up until recently, the CCG and then the ICB had engaged Integrated Healthcare Properties (IHP) to support in the local delivery of this process to ensure that any payments related to rates recovery after the date of delegation are identified and recovered from NHSE. The service that the ICB now needs to re-start is not a duplication of the work commissioned nationally from GL Hearn, but is complementary and will support recovery from practices of any funds that have already been reimbursed to them and to support GL Hearn with the data collection for current and future rates appeals in line with VOA deadlines.

1.2 The Sub Committee is:

- asked to approve restarting the ongoing process of supporting the review of business rates and ensuring that funds owed to NEL ICB are recovered either from GP Practices or Local Authorities.

1.3 This proposal relates very directly to corporate objective around securing value for money and more specifically to ensuring that we minimise the level of reimbursable business rate payments across NEL.

2.0 Key messages

2.1 The following table shows the position in respect of the value of assessed historic business rate refunds that still need to be followed up across NEL at the point at which the ongoing support from IHP ceased earlier in 2023.

Rating Authority	Total Assessed savings (outstanding)	Outstanding GLH assessed savings **NHSE** 20/01 - 2014/15	Outstanding GLH assessed savings **ICB** 15/16 - 23/24
Barking & Dagenham	332,265.21	71,353.81	260,911.40
Hackney	1,218,921.00	530,124.84	688,796.16
Havering	112,588.47	64,796.25	47,792.22
Newham	331,175.82	159,261.15	171,914.67
Redbridge	398,374.52	164,197.20	234,177.32
Tower Hamlets	353,749.96	54,835.50	298,914.46
Waltham Forest	504,548.00	103,910.41	400,637.59
	3,251,622.98	**1,148,479.16**	**2,103,143.82**

The table shows that GL Hearn are still following up historic savings of £3.3M of which £2.1M is likely to relate to post delegation and therefore flow to the ICB (although the timing around receiving these funds depends upon collecting outstanding source documents and liaising with LA business rate teams and GP practices. It is this detailed administrative work that has ceased.

IHP are currently supporting a number of ICB's nationally with this work and the proposal here is that we restart this process within north east London as early as possible within 2024/25 to maximise the level of in year rebate benefit. The cost of the support would be £7,000 per month and would be ongoing and funded from rebate benefits.

3.0 Risks and mitigations

3.1 The key risk associated with this paper is that the cessation of the ongoing work will have led to a backlog in terms of gathering the source documents from Local Authorities and Practices that are required by GL Hearn in order to secure the identified financial benefits.

4.0 Conclusion / Recommendations

4.1 Members are asked to approve re-starting this ongoing process via the engagement of support from IHP at a cost of £84k per annum, subject to appropriate procurement processes having been undertaken.

5.0 End

Ian Clay, Deputy Director of Finance
21st May 2024

NHS North East London

Primary Care Contracts Sub Committee

16 July 2024

Title of report	North East London Integrated Care Board (the ICB) Policy for Management of Additional Roles Reimbursement Scheme (ARRS) Flexibility
Author	Fiona Erne
Presented by	Fiona Erne
Contact for further information	Fiona Erne, Deputy Director of Primary Care Development, f.erne@nhs.net
Executive summary	This paper asks the Committee to agree a process for approving requests to create locally approved ARRS roles across the ICB. As part of the process the Committee is asked to: • Agree a management assurance process led by the Primary Development Team that will ensure all proposals meet the ICB's People Standards for recruitment and that proponents have evaluated the job description against agenda for change. • Adopt powers to approve requests to new reimbursable Direct Patient Care roles that PCNs claim against their ARRS allocations. A new process is required following the release of the 2024-25 GP Contract Changes Guidance. This sets out revisions to the ARRS scheme that allows ICB autonomy to develop and reimburse new roles outside the national defined scheme from the national funding allocation.
Action / recommendation	The Board/Committee is asked to: • Agree a management assurance process led by the Primary Development Team that will ensure all proposals meet the ICB's People Standards for recruitment and that roles have been properly evaluated • Adopt powers to approve requests to approve new roles that can be claimed against the scheme within the ICB.
Previous reporting	Primary Care (PC) SMT Primary Care GP Provider Group Local LMC's Operational meeting LLMCs NHS NEL ICB

Next steps/ onward reporting	Place PC Transformation Boards PC Transformation and Enablement Group People and Culture committee
Conflicts of interest	As part of the process all applications to the committee will be managed and led by an ICB officer on behalf of the PCN (s) requesting approval for the new reimbursable role.
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The ARRS scheme allows local networks to develop new models of care based on a wider skill mix of roles and professionals which is tailored to the needs of the local population. Many of the ARRS roles can be offered to local residents and people training as Health Care Professionals in North East London (NEL). Primary Care Networks can fund roles in voluntary sector and other partner organisations who work within their network. As part of the assurance process applications to establish a new role must demonstrate: • A case for change that supports the need for the role in relation to population health • Adherence to the ICB's culture and values in relation to recruitment • That an equalities impact assessment has been undertaken in relation to the role • The role has been evaluated in line with Agenda for Change
Impact on finance, performance and quality	Posts approved under this scheme will be funded from the national ARRS funding allocation. This is a delegated budget with a nationally set ceiling for ICB's and Primary Care Networks (PCNS). There will be no impact on the ICB's finances as PCN's cannot claim above the nationally set ceiling.
Risks	There is a risk that if we do not establish an assurance process that PCNs may develop posts that are properly evaluated and which create distortions to the local job market and create inequity in primary care salaries.

Primary Care Directorate
Report to the Primary Care Contracts Sub Committee
July 2024

ICB Policy for Management of Additional Roles Reimbursement Scheme (ARRS) Flexibility

1.0 Introduction

1.1 This paper asks the Committee to agree a process for approving requests to create locally approved Direct Patient Care (DPC) roles funded under the ARRS scheme with the ICB. These new roles are intended to support and development Multi Disciplinary Team (MDT) working across PCN's.

1.2 As part of the process the Committee is asked to:

- Agree a management assurance process led by the Primary Development Team that will ensure all proposals meet the ICB's People Standards for recruitment and that roles have been properly evaluated

- Adopt powers to approve requests to approve new roles that can be claimed against the scheme within the ICB.

2.0 Background

2.1 A new process is required following the release of the 2024-25 GP Contract Changes Guidance. This sets out revisions to the ARRS scheme which confirms that recruitment of other direct patient care (non-nurse and non-doctor) MDT roles will be allowed if agreed with the ICB.

2.2 The ARRS scheme is part of the PCN Directed Enhanced Service offer to GP practices and is part of the delegated responsibilities the ICB holds for the management and administration of delegated Primary Care Medical Services Contracts. As such responsibility for approving new direct patient care (DPC) roles sits with the Primary Care Contracts Sub Committee

2.3 The ICB and each PCN has an annual ceiling allocation to fund reimbursements to PCN's for the cost of roles recruited under the scheme. In 2024-25 the ICB shall 60% of a ceiling allocation of £53.170m in our baseline. The additional 40% can be drawn down from the national allocation if or when the ICB utilises the baseline allocation.

2.4 The ICB processes and approves claims for individuals recruited under the scheme by PCN's. The claims team undertake assessments to ensure that PCN claims comply with the nationally agreed ARRS roles and job descriptions. Claims that do not comply are rejected.

2.5 All DPC roles included in the national scheme are graded against Agenda for Change pay scales and have been developed with appropriate professional service

and clinical expertise. This ensures equality of pay across primary care and partner services and maintains professional standards. Additionally, well developed role design and job descriptions ensure effective recruitment and retention of staff.

3.0 Proposed Process for Approving new DPC roles that can be reimbursed.

3.1 The flexibility in the contract changes guidance offers welcome opportunities to expand and develop network teams in order to support the expansion of MDT and implementation of Fuller principles as part of Integrated Neighbourhood Teams. However the ARRS scheme is part of the ICB's delegated responsibilities and we are required to ensure that any new reimbursable roles meet the following criteria:

- The proposed role has been developed in accordance with the ICB's and ICS's people and culture standards and values in relation to equality and WRES and as set out in the ICB's Job Description Template and statement of Values, see appendics.
- Have been evaluated against Agenda For Change pay scales
- Have been developed with appropriate management and clinical expertise
- Are required to meet the needs of the local population as part of a case for change

3.2 In order to facilitate and manager the development of new reimbursable roles a three stage process is proposed:

Stage 1: Local development of the case for change, job description and person specification

Stage 2: Assurance by the PC Development team

Stage 3: Approval by the PCCC of assured proposal

3.3 Stage 1 Local or Service Role Development

3.3.1 It is anticipated that most proposals will be developed locally at place by PCNs. However, it is also acknowledged that some proposals may arise as part of service and workforce development schemes. In either case the proponents will be required to develop a case for change for the role to be included in the scheme.

3.3.2 In the case of requests from a PCN, the local Head of Primary Care shall be responsible for submitting the request on behalf of the PCN to avoid conflicts of interest.

3.3.3 It is recommended that the proponents engage and seek input from the Primary Care Development Team, Local Training Hubs and professional leads at this stage.

3.3.4 The proponent shall be responsible for:

- developing the case for change and undertaking an Equalities Impact Assessment
- developing the Job Description using the ICB Template,
- securing managerial and professional input into the development of the job description and person specification
- consultation with the relevant Local Representative Committees.

3.3.5 The proponent is expected to request job evaluation and/ or present evidence it has been evaluated against agenda for change bandings. The request must state the evaluated banding.

3.3.6 The proponent should send completed Case for Change, job description, job evaluation outcome to the Primary Care Development Team for Assurance using the template in Appendix 1. Where appropriate the proponent should respond to any feedback or information requests from the Primary Care Development Team required as part of the assurance process.

3.4 Stage 2 Assurance

3.4.1 The Assurance process shall be managed by the Primary Care Development Team and undertaken by a sub-group of the Primary Care Enablement and Transformation Group composed of the following members:

- Deputy Director of PC Development
- Training Hub Programme Manager
- Relevant service, clinical or professional (unconflicted) lead
- Member of People and Culture Team

3.4.2 In order to expediate the approval process the sub group will be convened virtually by the Deputy Director of PC Development who will be responsible for:

- Preparing and circulating papers for the members
- Providing feedback and key lines of enquiry back to the proponent
- Notifying the proponent of the outcome
- Preparing papers for the PCCC to seek approval for assured posts.
- Undertaking any further consultation required for the PCCC

3.4.3 The sub group shall assess the request against the following ***Assurance Criteria:***

- The role is a Direct Patient Care role;
- The role is a non-medical and non-nursing role;
- The role is based in primary care;
- The Job description and person specification has been evaluated against agenda for change – this can be undertaken by NEL ICB (evaluation by another NHS organisation can be accepted)
- The Job description is complete, is readily understandable to potential applicants for the post and avoids ambiguity about responsibilities;
- The Person Specification sets out the required professional qualifications which do not exceed the minimum qualification specified by the awarding bodies;
- The Person Specification avoids discriminating against people who have qualified abroad and details skills, knowledge, abilities and experience as an alternative to qualifications;
- Confirmation that appropriate consultation has taken place. This may vary but should include:
    - Local or regional professional leads
    - LMCs
    - Service leads and local Place leadership (via local Primary Care Transformation boards and forums)

- ICB People leads – which can be facilitated via the ICB's
- Primary Care Enablement and Transformation Group
- Training Hubs

3.5 Stage 3 PCCC approval

3.5.1 The Deputy Head of PC Development shall prepare and submit requests for approval to the PCCC in a report that sets out the following the Case for Change and confirmation that the request meets the assurance criteria set out below:

3.5.2 The Deputy Head of PC Development shall inform the proponent of outcome.

3.5.3 Where a request is not approved the Deputy Director of PC Development shall provide details of why the PCCC refused the request and offer advice and guidance on alternative funding or recruitment options. Feedback should include details of how a PCN can appeal the decision under the dispute resolution process.

3.5.4 Where a request is approved the Deputy Director of PC Development shall notify the claims team and other stakeholders of that the role is now reimbursable via normal communication means. All approved reimbursable roles will be listed on the Training Hub Website alongside nationally reimbursable roles.

4.0 Risks and mitigations

4.1 There is a risk that roles will be developed without expert professional or managerial input to the person specification and job description. This inhibits recruitment and leads to unnecessary costs and may result in poor retention when recruitment occurs.

4.2 There is a risk that without evaluation there will inequity in pay resulting in a distorted job market within the system and reduced professional standards.

5.0 Consultation

5.1 As part of the development of this proposal we have engaged with and sought feedback from the following stakeholder and representative groups:

- Place Local Medical Committees
- Londonwide LMC
- The GP Provider Group
- Transformation Groups

5.2 Feedback from the LMC's and GP providers include the following asks and concerns

- GP Representatives and providers asked for assurance that only PCNs could access funding for posts.
  This has been confirmed as only PCNs can claim against the ARRS delegated budget.

- Londonwide LMC have asked for more clarity on the criteria for assuring posts have properly developed in line with NEL good practice and the ICB's values and standards.
  We have provided more detail on the information required to secure assurance in paragraph 3.4.3 and detailed the ICBs values and standards for people and culture in Appendix 1.

- We have been asked to confirm the definition of Direct Patient Care with NHSEI.
  This is in hand.

- We have been asked to ensure parity with other ICB areas in the development of this policy and new reimbursable roles.
  We have asked NHSEI London to support once for London work in this area.

- We have been asked whether it would be feasible to develop joint and integrated roles under this policy.
  We have confirmed this is possible provided the partner organisations contributed to the non-PC element. This recognises that the ARRS funding is part of the GP contract settlement.

6.0 Conclusion / Recommendations

The Committee is asked to approve this process and revise the Committee's existing terms of reference to extend responsibilities to include approval of new ARRS reimbursable DPC roles. Specifically the Committee is asked to:

- Agree a management assurance process led by the Primary Development Team that will ensure all proposals meet the ICB's People Standards for recruitment and that roles have been properly evaluated
- Adopt powers to approve requests to approve new roles that can be claimed against the scheme within the ICB.

6.0 Attachments

6.1 List appendices as:

- Appendix 1 ICB Statement of People and Culture Values
- Appendix 2 Request for New ARRS Reimbursable Role
- Appendix 3 NEL Job Description template – this includes details of the recruitment criteria used within NEL
- Appendix 4 NEL Job Evaluation forms

Fiona Erne
Deputy Director or Primary Care Development
13 June 2024

Appendix 1

North East London People Values

The NHS is founded on a set of principles and values that bind together the communities and people it serves and the staff who work for it. Building on the NHS values, our organisational values, launched in April 2024, are at the heart of and underpin everything we do, guiding how we work together to deliver the ICS vision and priorities and setting the ambition for the culture we aspire to.

Developed with staff across our organisation as well as being informed by evidence and best practice on the values, behaviours and cultures that create successful environments in health and care, the wider public sector and beyond, our values set out how **we will work with and for all the people of north east London to create meaningful improvements in health, wellbeing and equity.**

Ambitious – We strive for the best and make a difference by being innovative, courageous and bold

- We believe change is possible, are proactive and work together to take on challenges.
- We are committed and accountable, making decisions using a range of evidence and always knowing how our work contributes to our ambition and priorities.
- We foster an environment of learning and improvement, making space for new and creative ideas and empowering everyone to challenge the status quo.

Collaborative – We work together with local people and each other to find the best solutions

- We actively make and respond to opportunities to work together across our organisation and system to find the best solutions to shared goals.
- We build strong and meaningful connections, share knowledge and recognise that working in a system is complex, continually adapting to meet this challenge.
- We create environments where diverse ideas and perspectives are valued and contribute to solutions.

Inclusive – We are resolute in our pursuit of equity and equality, with mutual respect for all in everything we do

- We harness the power of our diversity and ensure that equity is meaningfully and visibly embedded in all that we do.

- We treat everyone with dignity, respect and fairness, speaking up and acting if this is not the case.
- We are open to change and encourage learning and meaningful conversation that helps achieve inclusion.

Kind – We are open, honest and kind to each other in all our work

- We develop trust by being open, honest, authentic and acting with integrity.
- We contribute to positive environments that support our health and wellbeing and take time to listen, understand, empathise and support one another.
- We appreciate each other and celebrate achievements across our system.

We are all responsible for bringing our organisational values to life, ensuring they drive our work and contribute to a culture and working environment in which we can all thrive and belong.

Our values will be embedded in a range of organisational policy, process and practice and will steer the ongoing development of the organisation over time.

Diversity and inclusion

In NHS North East London we wish to foster a work environment in which we continually develop our understanding of equality, diversity and inclusion, keeping our minds open and actively recognising and addressing our own potential biases.

Diversity is about recognising differences. It's acknowledging the benefit of having a range of perspectives in decision-making and the workforce being representative of our population. Inclusion is where people's differences are valued and used to enable everyone to thrive at work. An inclusive working environment is one in which everyone feels that they belong without having to conform, that their contribution matters and they are able to perform to their full potential, no matter their background, identity or circumstances.

As an organisation one of our main priorities is to create a more compassionate, collaborative and inclusive environment, some of the ways we aim to achieve this in our organisation are through staff networks which ate there to support colleagues, raise awareness, impact-assess decision making and enable innovative approaches to make our organisation stronger.

WRES

Workforce Race Equality Standard (WRES) is a set of agreed actions to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

What is the Workforce Race Equality Standard (WRES)?

WRES is a set of agreed actions to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations..

Appendix 2

Request for New ARRS Reimbursable DPC Role	
Proponent	[name, title, email]
On behalf of:	[list of PCNs] / [Service or Directorate]
Case for Change and	[to include details of strategic fit, population needs and why this role will support MDT working]
Impact on local people, health inequalities and sustainability	
Job Evaluation	[Confirm banding and attach outcome]
Consultation	[provide details of consultation and engagement undertaken as part of the Job design and development]
Professional Oversight	[provide details for profession, clinical and managerial, expertise used to develop the job description and specification

Appendix 3 – NEL Job Description Template

Job-Description-_-Person-Specification-

Appendix 4 – NEL Job Evaluation Forms

Job-Evaluation-Request-Form (4).docx

Job-Evaluation-Effort-and-Environment-

NHS North East London

Primary Care Contracts sub-committee

18 March 2024

Title of report	**Dental, Optometry & Pharmacy Update including 2024/25 Non-recurrent UDA commissioning proposal**
Author	Jeremy Wallman, Head of Primary Care Commissioning, Dentistry, Optometry and Pharmacy Kelly Nizzer, Regional Lead; Dentistry/Optometry Andrew Biggadike; Regional Lead, Acute and Specialised Dental Contracts
Presented by	Jeremy Wallman, Head of Primary Care Commissioning, Dentistry, Optometry and Pharmacy Jeremy Wallman, Head of Primary Care Commissioning, Dentistry, Optometry and Pharmacy Kelly Nizzer, Regional Lead; Dentistry/Optometry Andrew Biggadike; Regional Lead, Acute and Specialised Dental Contracts
Contact for further information	jeremy.wallman@nhs.net
Executive summary	Summary of the key points/messages in the report.
Action / recommendation	The primary care contracts sub-committee is asked to note the contents of the report and endorse the approach to commissioning additional dental activity during 2024/25.
Previous reporting	Commissioning Oversight Group (COG)
Next steps/ onward reporting	FPIC
Conflicts of interest	None
Strategic fit	To enhance productivity and value for money
Impact on local people, health inequalities and sustainability	To improve and stabilise the oral health of patients treated. To extend and increase the availability of NHS dentistry.
Impact on finance, performance and quality	As detailed in the report
Risks	On going risks, identified in the report. Under delivery of Primary Care contracts previously referenced

Primary, Secondary, Community and Specialist Dentistry

NEL ICB Update 2023/24 Q4

Primary Care

Primary Care performance at M12 increased in delivery during March as contractor's close treatments down in time for them to be counted towards their 2023/24 contract delivery requirement. The non-recurrent resource invested by the ICB during 2023/24 has meant that practices have been able to continue providing access to patients without being concerned with exhausting their contract activity before the year-end. This coupled with permitting practices to over perform on contracts by up to 10% has provided an overall contract delivery in NEL of 95.1%. The increase in contract delivery has reduced the potential 'claw-back', in respect of underperformance, to £4.7m from the Month 10 figure of £9.7m. Any overperformance payment paid to dental contracts will result in the 'claw-back' being reduced. All under/over performance payments will be reconciled during the period June – September 2024 with the resultant clawback being deducted from contracts between October 2024 – March 2025. Overperformance payments will be paid as a 'one-off' transaction in October 2024.

2023-24 Dental UDA Contract Activity Performance Analysis

ICB	UDA Performance Target	UDA Delivered – Reconciled 31/5/24	Expected UDA contract delivery (%) at M12	Actual % Delivered – Reconciled 31/5/24
NCL	2,007,952	1,882,839	92.6%	93.8%
NEL	2,714,147	2,619,426	95.1%	96.5%
NWL	3,247,542	3,125,553	95.3%	96.3%
SEL	2,792,728	2,631,721	94.5%	94.3%
SWL	1,899,873	1,807,615	93.5%	95.2%
	12,662,242	**12,067,153**	**94.2%**	**95.2%**

2023-24 Dental Finance Contract Performance Analysis

ICB	Under Performance Value £m	Over Performance Value £m	**Reconciled Underperformance Value 31/05/24** £m
NCL	*(5,734)*	2,056	*(3,679)*
NEL	*(7,125)*	2,435	*(4,689)*
NWL	*(6,821)*	2,402	*(4,419)*
SEL	*(6,627)*	1,632	*(4,995)*
SWL	*(5,349)*	1,517	*(3,832)*
	(31,657)	**10,042**	**(21,615)**

Secondary Care

As London North-West University Hospital, Guy's & St Thomas' and King's College all moved to new software, an exemption of PTL submissions was granted. It is hoped that from April onwards figures will be reliable enough to submit data. The absence of the two largest dental contracts and the fifth largest dental contract should be taken into consideration when viewing figures provided below. While the move to new software will have caused a reduction in productivity, GSTT and KCH were in a safe position to tolerate this.

There has been some slippage in the PTLs across London and this is due to multiple factors.

- Ongoing workforce pressures including short and long-term sickness, parental leave and long term vacancies continue to affect capacity.
- Increased access to primary care services, while a positive thing, increases the volume of referrals into SCS services, therefore increasing waiting times.
- Prioritisation of other treatments over dentistry, while appropriate, also affects recovery of certain specialties.

Due to the retention of medically simple paediatric patients by Community Dental Services (CDS) the mix of patients has altered for secondary care providers. Our neuroatypical paediatric patients often take longer to treat than neurotypical ones, meaning that productivity as defined by patient numbers will appear to reduce. Where six patients may have been seen per list previously, this number may have halved due to the complex needs of the patient and delays to treatment which have increased acuity. It must be considered that when contracted activity is monitored, a reduction in patient numbers does not necessarily equate to a reduction in clinical time and the associated overheads. Chelsea and Westminster, UCLH and Barts have all reported this trend. A workstream for the five largest dental providers to review this trend is already in motion. All findings and recommendations will be reported to the ICBs.

Barts is an outlier for patients waiting over 52 weeks and is in a challenging position for all dental specialties, mutual aid is being provided by GSTT, Homerton and St George's. The slow recovery of the Trust is across all services, not just dentistry.

Continued concern that there may be an increase in the number of patients from surrounding regions being referred into London. London has always been a net importer of patients but due to workforce issues there will be challenges in regions that may be less desirable to work in.

The Direct Award C process under the Provider Selection Regime (PSR) for L2 Endodontics has begun. Once completed, the same process will begin for L2 Oral Surgery (IMOS).

Procurement colleagues continue to learn about the challenges and pitfalls of PSR. As we move closer to the re-procurement of Community Dental Services, the process will be better understood.

Barts Health

Unfortunately, there is no sustained reduction in patients waiting over 65 weeks, currently there are 413, of which 149 do not have an appointment booked. The Trust is particularly affected by workforce shortages, the impact of industrial action and lack of access to theatres. There are high levels of sickness (long and short term), vacancies and parental leave at consultant level.

The Clinical Director for dentistry changed some time ago and the General Manage is due to change in a few of months. This will be an added pressure on services as their replacements get to grips with the department.

- **Oral Surgery**, 305 patients waiting over 65 weeks of which 72% have an appointment booked. 25 PAs are currently lost to long-term sickness and 10 PAs remain vacant. The 35 undelivered PAs are between maxillofacial and oral surgery clinicians. Oral surgery is a very challenging specialty at a national level but recovery at London level has been good. GSTT and Homerton are providing mutual aid for the longest waiters.
- **Restorative**, 13 patients over 65 weeks the majority of which are special care and therefore more complex. Of the 13, 10 have an appointment booked. The department is struggling with the consultant led triage for Level 2 Complexity Endodontic Services.
- **Paediatric**, 68 patients waiting over 65 weeks of which 30% have an appointment booked. The Trust has focussed on non-admitted paediatric patients while a consultant is on maternity leave. Once the consultant returns the focus will shift to admitted patients.
- **Orthodontic**, 19 patients over 65 weeks of which 32% have an appointment booked. Workforce continues to be highly challenging with the two new orthodontic trainees on maternity leave.
- **Dental Medicine**, 2 patients waiting over 65 weeks, both of which have appointments booked. All five patients have Bechet's disease for which Barts is a centre. The only clinical consultant is now on maternity leave. Academics have been asked to deliver clinical time and mutual aid is being investigated but does not look promising.
- **Maxillofacial**, 6 patients over 65 weeks of which 5 have appointments booked. Some maxillofacial patients will be sitting under the oral surgery PTL. St Georges are providing mutual aid for TMJ patients.

Barts Health							
Specialty	Admitted / Non-admitted	January		February		March	
		52-64 weeks	65 weeks and over	52-64 weeks	65 weeks and over	52-64 weeks	65 weeks and over
Oral Surgery	Admitted	102	111	85	117	87	105
	Non-admitted	510	238	531	253	611	200
Restorative	Admitted	13	9	16	6	19	6
	Non-admitted	39	7	51	6	50	7
Paediatric	Admitted	81	45	89	54	97	66
	Non-admitted	17	6	21	2	22	2
Orthodontic	Admitted	12	21	8	21	7	18
	Non-admitted	36	3	16	4	23	1
Dental Medicine	Admitted	0	0	0	0	0	0
	Non-admitted	2	5	7	2	9	2
Maxillofacial	Admitted	10	6	7	6	7	5
	Non-admitted	4	0	8	0	12	1
Total		826	451	839	471	944	413

Barking, Havering & Redbridge University Trust

Three patients waiting over 65 weeks.

- **Orthodontic**, 4 patients over 52 weeks, BHRUT is receiving an increasing number of referrals from outside London. Where possible referrals are rejected due to low complexity but those meeting criteria have to be accepted. There is limited provision for orthodontics in surrounding regions.
- **Maxillofacial**, 3 patients waiting over 65 weeks, none of which have an appointment booked. Theatre lists regularly cancelled for higher priority / profile cases.

Barking, Havering & Redbridge University Trust							
Specialty	Admitted / Non-admitted	January		February		March	
		41-51 weeks	52 weeks and over	41-51 weeks	52 weeks and over	41-51 weeks	52 weeks and over
Orthodontic	Admitted	1	0	0	0	0	0
	Non-admitted	11	2	6	4	17	4
Maxillofacial	Admitted	161	40	142	62	132	74
	Non-admitted	41	39	44	30	30	17
Total		214	81	192	96	179	95

Homerton University Hospital

No patients waiting over 65 weeks. Trust is assisting Barts with long waiting oral surgery patients.

- **Maxillofacial**, 2 patients waiting over 52 weeks, 1 with an appointment booked. Trust faces challenges with increasing referral numbers and the inability to match the overtime payments made by competing trusts.
- **Paediatric Maxillofacial**, 2 patients over 52 weeks, both with appointments booked.

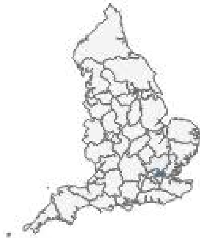
Homerton							
Specialty	Admitted / Non-admitted	January		February		March	
		41-51 weeks	52 weeks and over	41-51 weeks	52 weeks and over	41-51 weeks	52 weeks and over
Maxillofacial	Admitted	24	6	14	8	12	1
	Non-admitted	3	0	3	0	1	1
Paediatric Maxillofacial	Admitted	5	2	1	1	1	2
	Non-admitted	0	0	0	0	0	0
Total		32	8	18	9	14	4

ICB Secondary Dental Patient Flows - Provider Landing

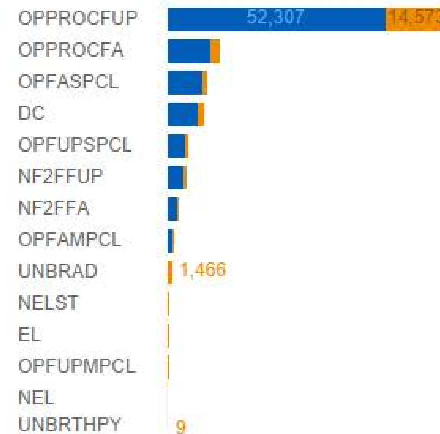
View Point: Host Provider

The map below displays Activity levels for NHS North East London Integrated Care Board providers, where patients accessing services within the ICB but are registered to a GP Practice outside of the ICB.

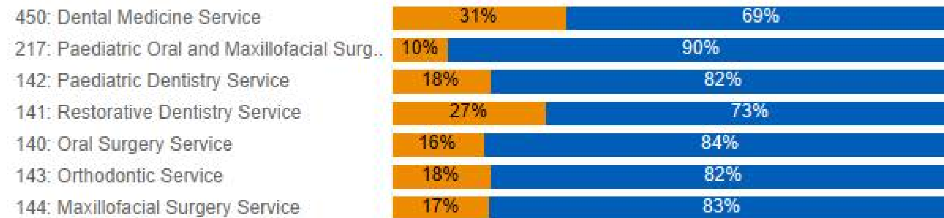
Total Provider flow for NHS North East London Integrated Care Board: All

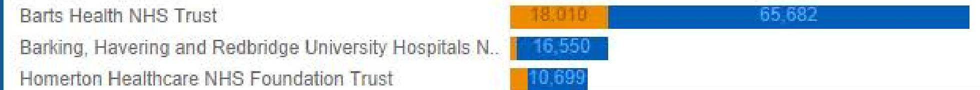


Attendance Type Summary



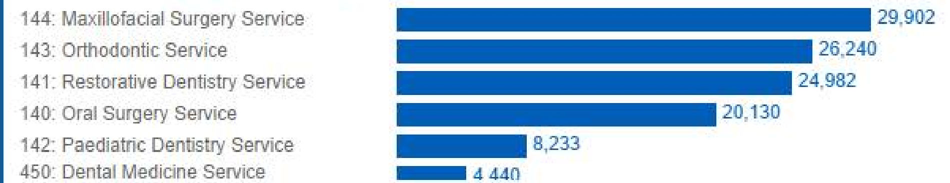
Percentage of activity undertaken for in area patients vs out of area patients



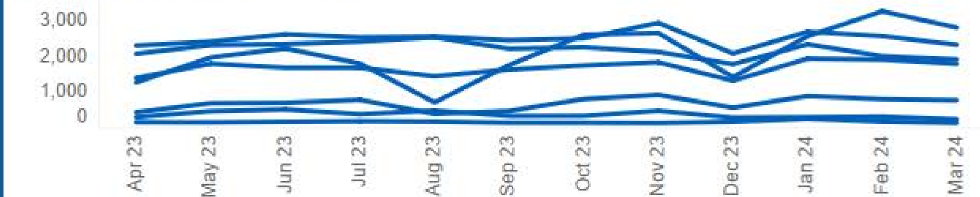


Treatment Function Code (TFC) for all Activity

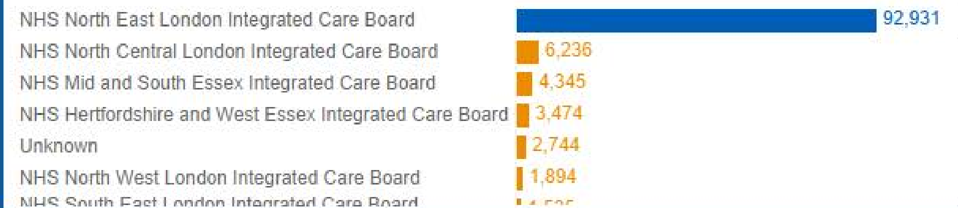
Select a TFC to highlight the monthly trend below



TFC Monthly Trend for all Activity



Patients coming into NHS North East London Integrated Care Board to Access Service



- 65, 682 NEL patient attendances at Barts, 16,550 NEL patient attendances at BHRUT, 10,699 NEL patient attendances at Homerton, 92,931 in total
- 6,239 attendances for NCL patients
- 4,345 attendances for Mid and South Essex patients
- 3,474 attendances for Hertfordshire and West Essex
- Total of 23,044 attendances for patients outside NEL ICB

ICB Secondary Dental Patient Flows - ICB of Patient

View Point: Patient's Resident ICB

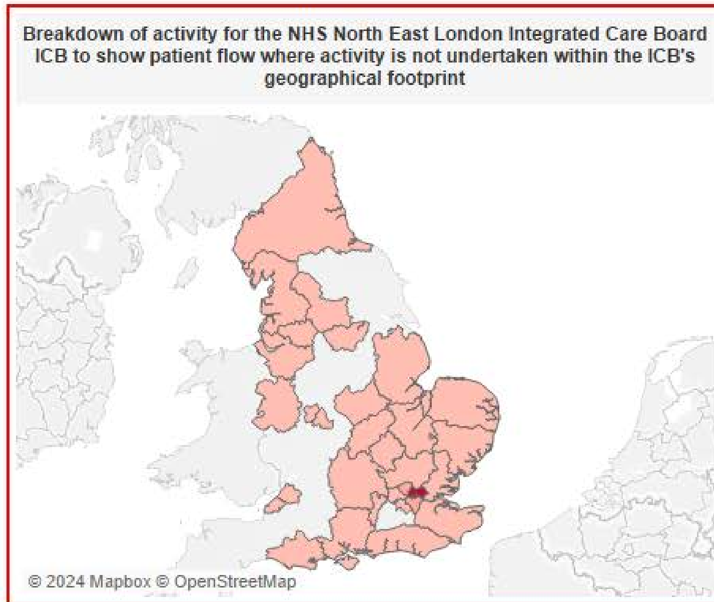
In Area | Out of Area

Activity undertaken for the NHS North East London Integrated Care Board ICB, for patients treated in the ICB

Total Number of Activity undertaken by NHS North East London Integrated Care Board	Total Activity within the NHS North East London Integrated Care Board	Total Activity for patients from the NHS North East London Integrated Care Board, treated in other ICB's
115,286	92,931	22,355

Percentage of activity within the NHS North East London Integrated Care Board

Breakdown of activity for the NHS North East London Integrated Care Board ICB to show patient flow where activity is not undertaken within the ICB's geographical footprint



Breakdown of total activity for patients from the NHS North East London Integrated Care Board, treated in other ICB's

ICB	Activity
NHS North East London Integrated Care Board	92,931
NHS South East London Integrated Care Board	10,872
NHS North Central London Integrated Care Board	10,168
NHS Mid and South Essex Integrated Care Board	408
NHS Hertfordshire and West Essex Integrated Care Board	342
NHS North West London Integrated Care Board	138
NHS Sussex Integrated Care Board	129
NHS South West London Integrated Care Board	108

Provider Summary for all NHS North East London Integrated Care Board Activity

Provider	Activity
Barts Health NHS Trust	65,682
Barking, Havering and Redbridge University Hospitals NHS Trust	16,550
Homerton Healthcare NHS Foundation Trust	10,699
Guy's and St Thomas' NHS Foundation Trust	9,668
University College London Hospitals NHS Foundation Trust	8,309
King's College Hospital NHS Foundation Trust	1,204
Great Ormond Street Hospital for Children NHS Foundation Trust	1,204

Due to KCH and GSTT implimenting Epic software, the figures below have limited accuracy

- 115,286 attendances for NEL patients
- 92,931 of which delivered in ICB (81%)
- 22,355 delivered in alternative ICBs (19%)
- 1,069 attendences provided by ICBs outside London Region

Community Dental Services

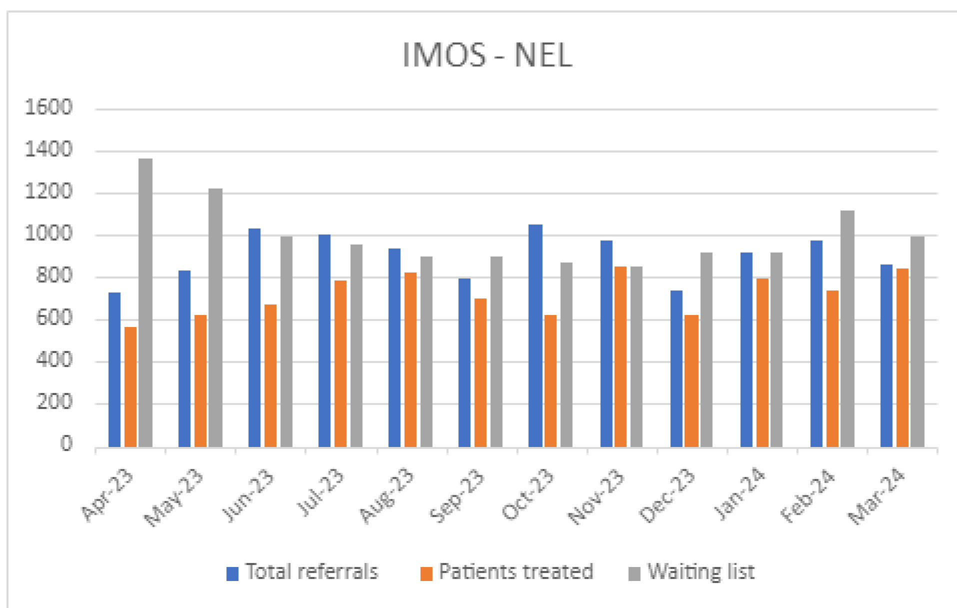
CDS serves the following patient groups, paediatric, special care, elderly and rough sleeping homeless and provides oral health promotion (OHP) on behalf of the local authorirties that commission it.

The CDS contract has a current expiry date of 31/03/2017. As revised commissioning guidance has now been issued, the direct award process preparation work will commence in 2024. Commissioners met with CDS providers, Dental Public Health Consultants, the Local Dental Network Chair and appropiate Managed Clinical Networks in Jauary 2024 to formulate a work plan, agree metrics with which to evidence satisfactory delivery and revise the service specification. This will be presented to ICBs for their comments and approval. It is hoped that the contracts can be awarded for a further 10 years and this can be agreed by the end of financial year 2025/26.

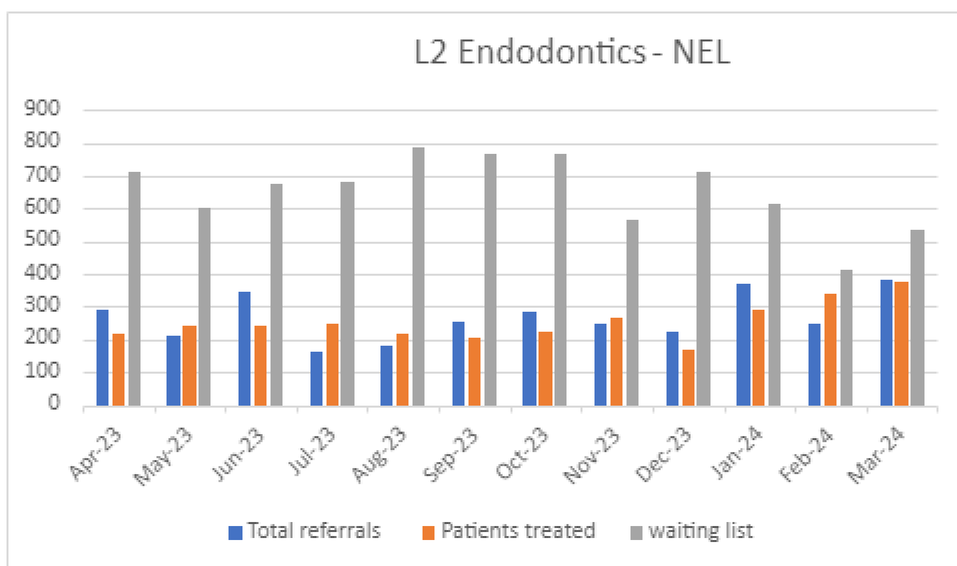
- Number of referrals increasing predominantly in paediatrics.
- Rising increase in the number of appointments offered for both adults and paeds.
- Increase in paeds GA, inhalation and intravenous sedation capacity and waiting lists steady.
- **Paediatrics**, increase in oral decay due to poor diet. Supervised brushing in schools delivered at full capacity. CDS continues to deliver paeds GA out of the dental GA suites at Barts.
- **Special care**, the Special care Dentistry Managed Clinical Network has begun an oral health needs asessment for this patient group.
- **Elderly** need additional services (which would require investment). Demand driven by deteriorationg oral helath in population though lack of nursing staff and therefore brushing of residents’ teeth.
- **Rough sleeping homeless** numbers have increased and their distribution across London has spread. Some outer boroughs are planning to create new services for this group.
- Additional OHP is required nationwide and there is renewed interest from local authorities will fund this. Commissioners and Dental Public Health Consultants are collaborating with LAs and ICBs to ensure evidence based OHP is implimented and complimentary to existing services. Caution is advised regarding the identification of oral health need and signposting to already strained services.

Intermediate Oral Surgery Services and Level 2 Complexity Endodontics

- Increase in demand for both services and workforce and funding is restricting capacity.
- To increase workforce we haveworked with Managed Clinical Networks, Local Accreditation Panels and the Office of the Chief Dental Officer to create accreditation of performers with conditions. While the number of accrediatations with conditions is small it is working well.
- Some regions have stopped accrediting entirely or have reduced the robustness of the process. London Region maintains its high standards in this process.
- There are challenges in the endodontic pathway and the Restorative MCN is reviewing possible temporary changes to alleviate pressure in the system.
- Current review into the movement of low complexity oral surgery patients into trusts undergraduate programmes as trainee dentists are not currently exposed to an appropriate volume of extractions prior to qualification.



Current waiting list for NEL ICB IMOS providers 991. As a service, IMOS is well balanced.

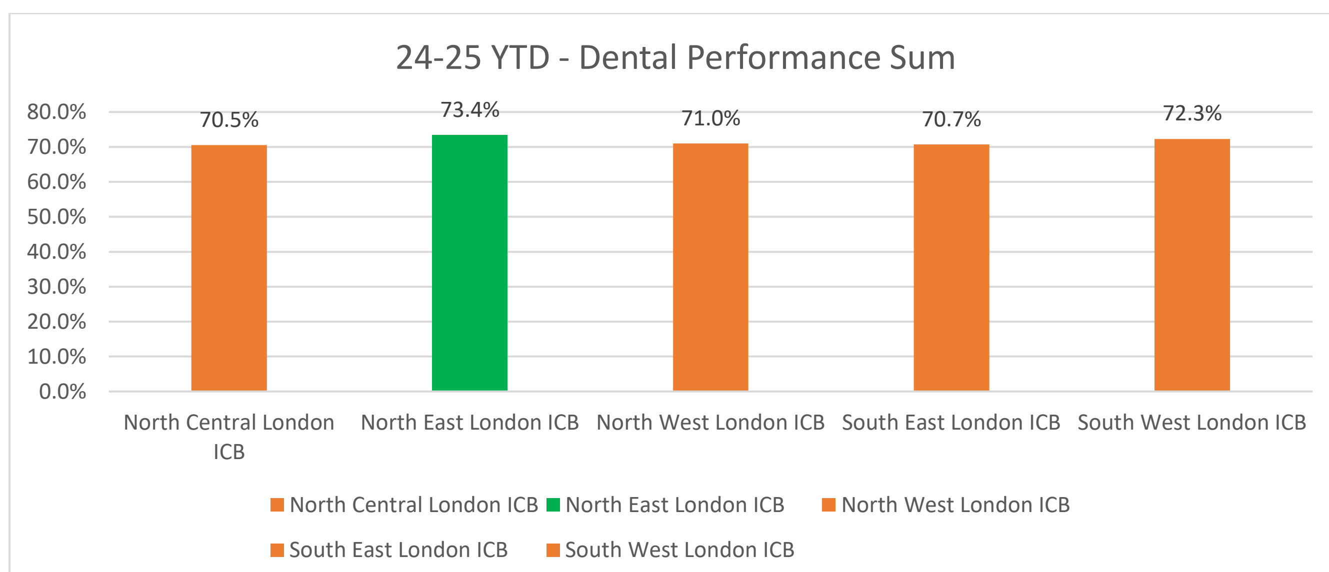


Current waiting list for NEL ICB L2 Endo providers 536. As a service, L2 Endo is well balanced.

Primary Care Dental Contract Delivery 2024/25 – M2

The early months of the contracting year within Primary Care Dentistry do not provide any real indication as to what the likely out turn on contract delivery will be, however for completeness please see the table below which provides an early indicator of dental activity and a very provisional forecast based on current activity. To note; NEL is continuing its trend as the highest performing ICB in the London Region

ICB	UDA Percentage Delivery @MO2	24/25 Projected UDA contract delivery based on MO2 activity	2023/24 Actual Delivery %
NCL	70.5%	88%	93.8%
NEL	*73.4%*	*92%*	*96.5%*
NWL	71.0%	89%	96.3%
SEL	70.7%	88%	94.3%
SWL	72.3%	90%	95.2%
London Wide	**71.6%**	**89%**	**95.2%**



Primary Care Dental Recovery Plan – Update

1. Introduction

The Governments Dental Recovery plan; [Faster, simpler and fairer: our plan to recover and reform NHS dentistry](), was published on 7th February 2024 and the key strategic commitments made in the plan are:

a) In 2024, significantly expand access so that everyone who needs to see a dentist will be able to. This will begin with measures to ensure those who have been unable to access care in the past 2 years will be able to do so - by offering a significant incentive to dentists to deliver this valuable NHS care. Introduction of mobile dental vans to take dentists and surgeries to isolated under-served communities.
b) Launch 'Smile for Life' - a major new focus on prevention and good oral health in young children, to be delivered via nurseries and other settings providing Start for Life services and promoted by Family Hubs. The introduction of dental outreach to primary schools in under-served areas in addition to taking forward a consultation on expanding fluoridation of water to the north-east of England - a highly effective public health measure.
c) Ramp up the level of dental provision in the medium and longer term by supporting and developing the whole dental workforce, increasing workforce capacity as committed to in the NHS Long Term Workforce Plan, reducing bureaucracy and setting the trajectory for longer-term reforms of the NHS dental contract.

2. Summary of Key NHS Commissioning Commitments

The significant NHS aspects of the plan in respect of dental commissioning are:

a) Increase in the minimum UDA value to £28.00.
ACTIONED
b) Introduction of a new patient premium for 2024/25. This will pay an additional £50 for a new patient receiving a band 2 or 3, and an extra £15 for a new patient receiving a Band 1 in addition to the funding the practice would already receive.
ACTIONED
c) Roll out of dental vans in certain underserved ICBs. This is focused on isolated rural and coastal communities *NOT APPLICABLE IN LONDON*
d) Introduction of a 'golden hello' scheme (£20k per dentists, split over 3 years, available for posts agreed by regions / ICBs to be priorities for access) to encourage dentists into under-served areas and supporting those practices with the lowest rates of payment for their work.
CURRENTLY BEING IMPLEMENTED; A maximum of 8 posts have been allocated to the London region, therefore following discussions with Public Health colleagues and using commissioning intelligence regarding areas where it is known that recruitment is challenging, the following areas have been prioritised with expressions of interest (EOIs) received, to date, as indicated in the table below

NCL	NEL	NWL	SEL	SWL	
Haringey	Tower Hamlets	Brent	Southwark	Croydon	Merton
1 -	2 -	0 -	1 -	1	0 -

Should EOIs not be forthcoming in the priority areas, additional boroughs over, and above, the initial list will be considered. A more detailed report on both this and the impact of the new patient premium will be provided at a future meeting.

Proposal	**Phase 2 - Improve access to Primary Care Dental Services across London through the investment of funds from the ICBs recurrent 'ring-fenced' dental allocation on a non-recurrent basis during 2024-25 with the potential to extend into 2025-26.**

Background

This paper sets out a proposal for increasing access as part of the ongoing recovery of dental services to pre-pandemic levels of activity. This proposal builds on existing measures already being implemented.

Previous papers have discussed national workforce issues which have contributed to contract terminations (contract hand backs) and requests to rebase (reduce) activity to manageable levels. £1.3m funds from terminated or rebased contracts has already been reinvested on a recurrent basis in April 2023 via local EOI processes within existing practices in priority areas as identified through a Public Health led Oral Health Needs Assessment (OHNA).

A further non-recurrent investment for 2023-24, (Phase 1) signed off by ICBs in August 2023, totalling £11.3m across London for the period Oct 2023 – Mar 2024 was implemented. This focused on areas where there was under delivery, but high need evidenced through a Public Health led Oral Health Needs Assessment.

ICB	No Practices	Total UDAs	Cost of UDAs*
NCL	44	68,450	£2,330,351.17
NEL	76	101,650	£3,361,097.59
NWL	84	103,400	£3,452,323.79
SEL	35	50,900	£1,679,700.00
SWL	4	13,000	£430,607.13
TOTAL	243	324,413	£11,254,079.69

Table 1; Summary of Non-Recurrent Primary Care Dental Investment 2023/24
** Indicates the gross investment before Patient Charges are deducted, reducing the overall cost of the initiative*

As a result of this initiative, aggregate dental contract delivery across London in 2023/24 reached 95.2% as demonstrated in Table 2 below. This delivery has resulted in London achieving the NHS target of returning general dentistry back to pre-pandemic levels of activity.

ICB	**UDA Performance Target**	**UDA Delivered – Reconciled 31/5/24**	Expected UDA contract delivery (%) at M12	Actual % Delivered – Reconciled 31/5/24
NCL	2,007,952	1,882,839	92.6%	93.8%
NEL	2,714,147	2,619,426	95.1%	96.5%
NWL	3,247,542	3,125,553	95.3%	96.3%
SEL	2,792,728	2,631,721	94.5%	94.3%
SWL	1,899,873	1,807,615	93.5%	95.2%
	12,662,242	**12,067,153**	**94.2%**	**95.2%**

Table 2; 2023-24 Primary Care Dental Contract Activity Performance Analysis

	London has a comprehensive provision of urgent dental care; which has now been successfully procured and now in place long term; however, patients can still experience difficulties in accessing routine care and treatment need has increased significantly due to the impact of the pandemic. Therefore, there is need to resource additional capacity to ensure more patients can be made dentally fit within a more reasonable timescale. Without this capacity in place, patients will increasingly seek urgent treatment as their oral health deteriorates.
Business / Service Need & Objectives	• To further increase access to dental services for those patients whose treatment has been delayed or where patients have been unable to access routine care. • To improve and stabilise the oral health of patients treated. • To secure additional services across London via existing providers and aligning the level of investment based on an Oral Health Needs Assessment. • To support and deliver against the Dental roadmap for Dentistry in London to improve dental access.
Strategic Case	To improve patient access to NHS dental care, through various commissioning approaches with a focus on addressing the oral health inequalities outlined in the NHS Long Term Plan.
Commercial Case	An informal but transparent allocation process is proposed based on suitability criteria to ensure practices applying to deliver non-recurrent activity have both, the capacity and capability to deliver in this financial year. Some practices that were not eligible for the funding last year now fit the criteria enabling them to see additional patients and thus, broadening the scope of practices who can be engaged in this initiative The expected level of activity awarded to any one existing provider will be around 1000 UDAS and is not expected to exceed 5,000 UDAs at an average unit UDA rate of £33. If there is underspend, further funds would be offered to practices that have capacity to deliver additional UDAs. This will enable the utilisation of funds from contracts which have under-performed to support improved access. This approach will complement formal procurements to secure provision of new services both for urgent and routine care. Extending this proposal to 2026 will ensure extended dental access in a significant number of practices for a 20-month period.
Financial Case	Funding is available from existing recurrent ICB dental budgets.
The Management Case	Intended timeframe for mobilisation is August 2024, pending provider confirmation of their capacity/capability and ICB sign off. This will allow practices to provide 8 months of additional access, however, sign off by mid-July will be required for this to be achievable. The proposal is supported by a Public Health led Oral Health Needs Assessment. Funding is available from the ICBs recurrent dental allocation. The allocation of non-recurrent activity in this financial year will enable the stabilisation of oral health for patients who have experienced delays or access to routine care.

	Risks will be minimised through an application process to ensure providers have a track record of delivery and have the additional capacity in terms of workforce, premises, and facilities. The award of non-recurrent additional activity is subject to normal Year End Reconciliation processes and breach / recoveries for under-delivery. Contract variations will be issued to successful applicants to formalise the allocation of additional activity and enable use of contractual levers where necessary. An evaluation to be undertaken when delivery data is available to demonstrate the value of the proposed reinvestment.
Timescales	To be able to provide 8 months of additional access during 2024/25, authorisation to proceed with this proposal will be required from ICBs by mid-July 2024. The initial scoping in respect of Phase 2 has already been completed by way of an advance expression of interest and therefore mobilisation of this can be swiftly progressed and contracts amended in keeping with a 1st August commencement.
Needs Assessment	The Oral Health Needs assessment for London is being updated, so although the offer will be made to all practices across the ICBs, priority will be given to the practices in the areas of highest need.
Experience of Non recurrent Commissioning	NHSE (National) allocated £7m, non-recurrently, to the London Region at very short notice in January 2021 for utilisation by the end of the financial year. Despite the extremely short timescale, the funds were allocated for an 8 week period, uptake in London was high and all practices managed to deliver the additional activity in addition to their contracted activity. Phase 1 of this work was completed successfully last year and activity shows an upward trajectory in respect of dental access for both new adults and children.

Financial Cost and Budget – Initial Scoping of EOIs received

<table>
<tr><td>Recommendation</td><td>
To approve a proportion of the recurrent unspent dental allocation to be utilised to increase dental access for the second half of the financial year 24/25 and where possible 25/26 noting that these funds are 'ring fenced' and can only be used for the commissioning of Dental Services.
ICBs are requested to respond by 12th July 2024, declaring the maximum amount of resource to be allocated, to enable the initiative to be mobilised by 1st August 2024.
Table 3, summarises the scoping exercise outcome and based on the EOIs received to date:
<table>
<tr><th>ICB</th><th>Number of applications</th><th>Total UDAs Applied For</th><th>Cost of UDAs applied for (@£33)</th></tr>
<tr><td>NCL</td><td>54</td><td>190,595</td><td>£6,289,635.00</td></tr>
<tr><td>NEL</td><td>91</td><td>296,053</td><td>£9,769,749.00</td></tr>
<tr><td>NWL</td><td>93</td><td>304,500</td><td>£10,048,500.00</td></tr>
<tr><td>SEL</td><td>43</td><td>77,400</td><td>£2,554,200.00</td></tr>
<tr><td>SWL</td><td>53</td><td>88,275</td><td>£2,913,075.00</td></tr>
<tr><td>LONDON</td><td>334</td><td>956,823</td><td>£31,575,159.00</td></tr>
</table>
As the volume of EOIs, in most cases, exceeds or exhausts the available funding available, they will be reviewed and reduced down by applying the following criteria:

Oral Health Needs Assessment
Review of 5-year performance and any outstanding contractual issues/disputes
Review IPCT visit outcomes
Reduce requested UDA volumes where necessary
Remove practices who have previously received funds where delivery has not been achieved.

</td></tr>
<tr><td>Approved by

(ICB NAME)</td><td></td></tr>
<tr><td>Funding amount approved for Phase 2</td><td></td></tr>
<tr><td>Date</td><td></td></tr>
</table>

Author: Kelly Nizzer, Regional Lead for Dentistry/Optometry, London DOP Commissiong Hub
Date: 28th June 2024

NHS North East London

Primary Care Contracts Sub-committee

16 July 2024

Title of report	Month 2 Primary Care Finance Report
Author	Rob Dickenson – Deputy Director of Finance
Presented by	Rob Dickenson – Deputy Director of Finance
Contact for further information	r.dickenson@nhs.net
Executive summary	• Summary of the 2024-25 budgets • Summary of the Month 2 reported financial position.
Action / recommendation	• Note the content of the report
Previous reporting	N/A
Next steps/ onward reporting	N/A
Conflicts of interest	No decisions required therefore no conflicts to manage
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money
Impact on local people, health inequalities and sustainability	Continual assessment of Value for Money (VfM) of current and future investments in order to reduce inequalities and provide a valuable service to the local people.
Has an Equalities Impact Assessment been carried out?	No
Impact on finance, performance and quality	Ongoing review of financial commitments against available resources. The total Primary Care budget, including Prescribing and DOPs is £994.7m. The Month 2 YTD position is break-even, in line with the recently submitted Operating Plan.
Risks	The main risks to the position are Prescribing, Demographic Growth, ARRS, estates developments and SDF.

1.0 Introduction/ Context/ Background/ Purpose of the report

1.1. This report provides the Primary Care Collaborative Sub-Committee with a summary of the Primary Care budgets for 2024-25 along with associated risks, at a high-level (NHS NEL). At the time of writing this report, the budgets had not fully been disaggregated to a place level.

1.2. The 2023-24 audit has now finished, and the accounts have been signed-off. The Primary Care position was signed off as per what was reflected in the last report.

1.3. The 2024-25 Operating Plan was submitted to NHSE in May. For Primary Care, this included an annual budget of c.£994.7m. This represents an increase of c.4% compared with 23-24 recurrent spend.

2.0 Annual Budget and Month 2 Financial Overview

2.1. At Month 2, NHS NEL reported a YTD break-even position (as per the following table) This is in line with NHSE expectations of delivering plan at this stage of the year, given that the plan has just been submitted. As highlighted in the previous report, however, the Operating Plan includes a significant amount of risk.

	Annual	YTD		
Month 2	**Budget**	**Budget**	**Actual**	**Variance**
Area of spend	£m	£m	£m	£m
Delegated Primary Medical Services	413.9	69.0	69.1	0.1
Prescribing	295.8	49.3	49.5	0.2
Other ICB Funded Primary Care Services	51.3	8.5	8.2	(0.3)
Total ICB Funded Primary Care Services	**347.1**	**57.8**	**57.7**	**(0.1)**
SDF and other PC allocations	5.1	0.8	0.8	0.0
Total Primary Care Position (excl. DOPs)	**766.1**	**127.7**	**127.7**	**(0.0)**
Delegated Dentistry, Optometry and Pharmacy (DOPs)	228.6	38.1	38.1	(0.0)
Total Primary Care Position (incl. DOPs)	**994.7**	**165.8**	**165.8**	**(0.0)**

2.2. The Delegated Primary Medical services budget remains the largest area of funding by far. The value is nationally calculated. Expenditure against this budget is predominantly influenced by national guidance.

2.3. This allocation has seen a recurrent increase of c.£13.5m of funding growth. The majority of this funding increase is utilised by funding the recurrent impact of demographic growth seen in 23-24, the core contractual price increases, and the anticipated demographic growth for the remainder of the financial year.

2.4. ICB Funded Primary Care, including Prescribing and SDF are reported as a net YTD underspend of c.£0.1m. Prescribing annual budget at £295.7m includes activity and price inflation. It also includes an efficiency target of c.£13.7m. The net result is flat cash compared to 23-24 outturn.

2.5. Dentistry, Optometry and Pharmacy (DOPs) are also nationally set allocations. There is always a time-lag in data provision (up to 2 months). We therefore do not currently have any in-year data. The YTD position is therefore to plan. Dental budgets are ring-fenced with any underspend due to be returned to NHSE.

2.6. More information is provided in subsequent sections of the paper.

3.0 Month 2 Detailed Financial Position

3.1. The Primary Care budgets are funded from four sources. The first is the Delegated Primary Medical Services (Co-Commissioning) allocation. The second is from the overall ICB baseline allocation. The third is the System Development Fund (SDF) which includes Primary Care Transformation (PCT) funds. The fourth is the Delegated Dentistry, Optometry and Pharmacy allocation.

3.2. Delegated Funding

3.2.1. At Month 2, the Delegated Primary Care position is a YTD overspend of c.£0.1m overspend. The table below provides a breakdown of the main categories of spend:

Month 2	Annual	YTD		
	Budget	Budget	YTD Actual	Variance
Spend Category	£m	£m	£m	£m
GMS/PMS/APMS Specific				
GP Contractual Service	249.6	41.6	41.6	0.0
Enhanced Services	2.0	0.3	0.3	0.0
Quality Outcomes Framework (QOF)	24.7	4.1	4.1	0.0
Premises Reimbursements	42.0	7.0	7.0	0.0
Other Administered Funds	3.5	0.6	0.6	0.0
Personally Administered Drugs	0.9	0.1	0.1	0.0
GMS/PMS/APMS Specific Total	**322.8**	**53.8**	**53.8**	**0.0**
Primary Care Networks (PCN)	74.8	12.5	12.5	0.0
Other	16.4	2.7	2.8	0.1
Total Delegated Primary Care Position	**413.9**	**69.0**	**69.1**	**0.1**

3.2.2. The annual budget/allocation is nationally calculated with the majority of spend being determined nationally.

3.2.3. The recurrent allocation received by NHSE has increased by c.£13.5m compared with last year, however our planning assumption are that this will be fully utilised by price, population, and activity increases that are outside the control of the ICB.

3.2.4. More than £9m will be utilised by core contractual price increases (nationally mandated), recurrent impacts of list size increases in 23-24, and estimated demographic growth through the rest of the year.

3.2.5. A further c.£2m will be utilised on Premises reimbursement. This is a combination of existing premises price inflation/revaluation, and practice relocations attracting increases in cost.

3.2.6. Network DES contracts (excluding ARRS) will increase by c.£1m, however this is more reflective of list size growth, as the majority of elements within the DES are more or less remaining at the same unit price.

3.2.7. The overall available ARRS funding (part of the Network DES) has increased by c.£1m up to c.£53.2m. The ICB have received c.£33.5m in the above quoted baseline allocation (This represents c.£0.6m of the increase) with a further c.£0.4m included in the centrally retained c.£19.7m.

3.2.8. There currently appears to be no affordability to retain any contingency budgets within Delegated, apart from Demographic Growth. All spend categories have been costed using national guidance, known contract criteria, and best assumptions. However some of the expenditure types are based upon activity, performance, and changes in patient numbers, which may present risks or opportunities as we go through the year. These variables will be continuously reviewed throughout the year in conjunction with other identified risks

3.3. ICB Baseline Funding (Incl. Prescribing and SDF)

3.3.1. At Month 2, the ICB Funded Primary Care position is c.£0.1m underspend. The table below provides a breakdown of the relative categories of spend.

	Annual	YTD		
Month 2	**Budget**	**Budget**	**Actual**	**Variance**
Spend Category	£m	£m	£m	£m
Prescribing	295.8	49.3	49.5	0.2
Oxygen	2.3	0.4	0.3	(0.1)
Out of hours	1.7	0.3	0.3	0.0
LES and Other	38.7	6.5	6.3	(0.2)
SDF - Primary Care Transformation	5.1	0.8	0.8	0.0
Access Hubs / Same Day Access	8.6	1.4	1.4	(0.1)
ICB Funded Primary Care Services	**352.1**	**58.7**	**58.6**	**(0.1)**

3.3.2. Prescribing budgets are clearly the most significant within this section. The budget has an in-built efficiency target of c.£13.7m, but despite that, it is still c.£7m above the recurrent outturn from 23-24.

3.3.3. The Prescribing data is always received 2 months in arrears, therefore we haven’t yet seen any data representing April or May 2024. As such we are relying upon the 23-24 data as a guide.

3.3.4. More information will be available at the next meeting once we start to see the actual in-year data but will also have information about the identification of opportunities and delivery against the efficiency target within the Prescribing budget.

3.4. Delegated Dentistry, Optometry and Pharmacy Services

3.4.1. The table below reflects the annual budget and month 2 financials associated with Dentistry, Optometry and Pharmacy services. Given the time lag in data for the new financial year, the position has been reported as break-even both YTD and FOT. By the time of the next meeting, there will be more data available to give a more meaningful position:

	Annual	YTD		
Month 2	**Budget**	**Budget**	**Actual**	**Variance**
Spend Category	£m	£m	£m	£m
Delegated Dental	165.0	27.5	27.5	0.0
Delegated Optometry	24.6	4.1	4.1	(0.0)
Delegated Pharmacy	38.0	6.3	6.3	(0.0)
Delegated Property Costs	1.0	0.2	0.2	0.0
DOPs Total	**228.6**	**38.1**	**38.1**	**0.0**

3.4.2. Similar to the Delegated Primary Medical Services budget, this is also a nationally calculated allocation.

3.4.3. The funding provided to the ICB in this allocation is c.£13m higher than 23-24 recurrent outturn, which represents c.6% increase.

3.4.4. The Dental budget of c.£165m is ringfenced. As such, any underspend in-year will be reclaimed by NHSE at some point towards the end of the year.

3.4.5. Pharmacy spend is anticipated to increase compared to the 23-24 outturn since the Pharmacy First service was introduced, however it's currently unclear as to the value of increase.

4.0 Risks

4.1. There are a number of inherent risks associated with the Primary Care budgets. Most of which have been covered in previous reports, but worth including again.

4.2. Demographic Growth

4.2.1. The opening Delegated budgets for the year have been set based upon the April 2024 core contractual payments, which are already based upon 1st April 2024 list sizes. This caters for c.£7.5m of the £9m referred to earlier in the report.

4.2.2. A budget has been set specifically for demographic growth (£1.48m). This is based upon an estimated level of demographic growth of c.1.21% for the remaining 3 quarters to 1st January 2025 (equates to c.1.7% per annum). This is in line with growth seen in the previous 12 months.

4.2.3. The next list size update will be available after 1st July (most likely mid-July) but given growth is never linear, this will not give a full indication of what is to come over the remainder of the year.

4.3. Additional Roles Reimbursement Scheme (ARRS)

4.3.1. The annual Delegated budgets for the year, as set by NHSE include c.63% of the total available funding for ARRS. This is consistent with previous years and requires evidence of spend by Networks in order to access any of the remaining c.37% being withheld by NHSE.

4.3.2. The total funding available for ARRS is increased this year to £53.2m (an increase of c.£1m in totality, or £0.22 per weighted patient). This represents less than 1% increase.

4.3.3. £33.5m is included within the baseline allocation received by the ICB, with a further £19.7m available by way of drawdown.

4.3.4. In 23-24 the forecast outturn was £46.6m out of a maximum £52.3m (c.89% utilisation). The full and final spend against 23-24 is not yet known due to a time lag of receiving final claims. We anticipate being able to share this information at the next meeting.

4.3.5. ARRS is shown as a risk for two reasons:

- For those networks already utilising 100% of their funding, an increase of less than 1% may not be financial viability, and they may have to re-look at their staff mix.
- Based on 23-24 available data, there are still some networks who are employing much fewer staff than in other areas. The risk here is that networks are not able to maximise the available funding which may have negative impacts on the patient population.

4.3.6. There is insufficient data at this stage to be able to reflect the likely utilisation of funding so far. We will bring this information to the next meeting.

4.4. Prescribing

4.4.1. As has been the case over the last 15-18 months, prescribing spend has seen an increase.

4.4.2. The annual budget has been set at with an increase compared to 23-24 levels, net of a £13.7m efficiency target. With no in-year data yet for 24-25 we don't yet know whether we will see the same pressures on the prescribing budget, however the main risks are price increase, volume increase, and/or under-delivery of efficiencies.

4.4.3. At the next meeting we will bring information about the efficiency programme and any early deliverables (it's likely that savings/cost reductions will be seen more in the second half of the year).

4.5. Estates Costs

4.5.1. Across NEL General Practice services are being provided by varying types of properties. There are a number of developments and changes to the property portfolio across NEL which will have an recurrent and non-recurrent impacts on ICB finances.

4.5.2. The 24-25 budgets currently assume c.£1m additional cost as a part year effect, with an estimated £2m full-year recurrent impact in 25-26.

5.0 Conclusion / Recommendations

5.1. The Primary Care Collaborative Sub-Committee is asked to note the content of the report.

Author: Rob Dickenson, Deputy Director of Finance
Date: 3rd July 2024

Appendix 1 – Total Primary Care annual budgets by Place

Spend Category	Annual Budget £m
Barking & Dagenham	45.6
City & Hackney	73.4
Havering	52.2
Newham	92.2
Redbridge	58.6
Tower Hamlets	78.0
Waltham Forest	63.0
Prescribing and other NEL-wide programmes	531.8
Total Primary Care Position	**994.7**

Appendix 2 – NEL Delegated annual budget by key spend category and by Place

	Annual Budget							
	Barking and Dagenham	Havering	Redbridge	Tower Hamlets	Newham	Waltham Forest	C&H	Total Place
Spend Category	£m	£m	£m	£m	£m	£m	£m	£m
GMS/PMS/APMS Specific								
GP Contractual Service	26.0	30.1	34.1	40.5	49.7	32.1	37.1	**249.6**
Enhanced Services	0.2	0.4	0.4	0.3	0.4	0.2	0.2	**2.0**
Quality Outcomes Framework (QOF)	2.6	3.6	3.9	3.4	4.7	3.3	3.3	**24.7**
Premises Reimbursements	4.9	4.3	3.4	8.4	7.7	5.0	8.4	**42.0**
Other Administered Funds	0.3	0.4	0.5	0.7	0.5	0.4	0.8	**3.5**
Personally Administered Drugs	0.0	0.2	0.1	0.1	0.2	0.1	0.1	**0.9**
GMS/PMS/APMS Specific Total	**34.0**	**38.9**	**42.3**	**53.3**	**63.1**	**41.1**	**50.0**	**322.8**
Primary Care Networks (PCN)	7.9	9.2	10.3	11.9	14.4	9.9	11.2	**74.8**
Other	1.6	1.6	2.9	0.0	5.2	3.6	1.5	**16.4**
Total Delegated Primary Care Position	**43.5**	**49.8**	**55.5**	**65.3**	**82.7**	**54.5**	**62.6**	**413.9**

- The ‘Other’ category predominantly covers Local Commissioning Intentions in each of the boroughs, such as the schemes funded by the recycling of PMS Premium a number of years ago, as well as services such as Care Home LIS, Phlebotomy, Homelessness, Interpreting and Practice Based Pro-active Care, to name a few.

Appendix 3 – ICB Funded by Place and NEL Central

	Annual Budget							
	Barking and Dagenham	Havering	Redbridge	Tower Hamlets	Newham	Waltham Forest	C&H	Total Place
Spend Category	£m	£m	£m	£m	£m	£m	£m	£m
Out of hours	0.0	0.0	0.0	0.0	1.4	0.0	0.3	**1.7**
LES and Other	1.2	1.5	1.6	11.3	6.1	6.7	10.4	**38.7**
Access Hubs / Same Day Access	1.0	1.0	1.5	1.6	1.5	1.8	0.1	**8.6**
ICB Funded Primary Care	**2.2**	**2.5**	**3.2**	**12.8**	**9.0**	**8.5**	**10.8**	**49.0**

- LES and Other Includes:
  - Specific LES/LIS schemes such as LTC and Safeguarding.
  - Community services such as Dermatology, Cardiology and ENT.
  - Other spends such as CEG contracts and PELC PTI Cover.

- There is significant variation in the value of services commissioned through LES and other contracts in each NEL Place, with Tower Hamlets commissioning the highest value (£11.3m) and Barking & Dagenham commissioning the lowest value (£1.2m). It is important to note that this only reflects services commissioned from Primary Care and a like-for-like comparison of contracts with all providers (including community and acute providers) would need to be completed for a true comparison to be made.
- Over time, detailed reviews will be required to fully compare and contrast services provided in each Place. This will need to include a thorough review of existing specifications and outcomes, in conjunction with the financial value of each contract.
- This review will need to take into account services commissioned from all providers not just Primary Care.

- The following budgets are accounted for at a NEL ICB level:
  - Prescribing - £295.8m
  - Oxygen - £2.3m
  - SDF – Primary Care Transformation (PCT) - £5.1m
    - This excludes any drawdown for Fellowships and Mentor funding

Appendix 4 – Funding per patient

	Barking And Dagenham	Havering	Redbridge	Tower Hamlets	Newham	Waltham Forest	City And Hackney	NHS NEL ICB
Delegated Funding (£ per WP)	£181.65	£174.50	£175.69	£177.04	£187.05	£179.48	£180.74	£179.83
Other PC Funding (£ per WP)	£9.01	£8.89	£9.98	£34.90	£20.14	£28.07	£31.24	£24.46
Total PC Funding (£ per WP)	£190.66	£183.40	£185.67	£211.94	£207.19	£207.55	£211.97	£432.14

- The price per patient across delegated funding ranges from £187.05 in Newham to £174.50 in Havering. The average price per patient across all NEL Places is £179.83. The limited variation in price per patient is due to the large value of contracts which are nationally determined and based upon the same unit rate. The small variation in price per patient is driven by elements which do not have the same unit rate or are not based upon Weighted Patients, for example premises costs.
- 'Other PC Funding' is everything other than Delegated, Prescribing and DOPs.
- There is greater variation in the price per patient in the 'other PC funding' category, ranging from £34.90 in Tower Hamlets to £8.89 in Havering. This significant variation will be driven by the additional services that have historically been commissioned from Primary Care in some Places. It is not possible to conclude from this analysis that there is inequity of service provision between Places because the same services may be commissioned from other providers (including community and acute providers).
- Further work is required to understand service provision in each Place and it is proposed that this analysis should be undertaken for particular population cohorts or clinical pathways (for example homelessness or diabetes). We will want to undertake this work in a collaborative and transparent way with clinical leaders from across the system helping to shape service specifications with consistent outcomes and value.
- It's also important to understand that some of the variation reflected in the above table is caused by provider performance levels (at place) not just variation in the services commissioned. For example, the LTC LIS is a consistent offer across the BHR places, but achievements and payments will not equate to the same £ per patient because of the cumulative delivery of practices against the service specification.
- Budgets are set on the basis of projected outturn (anticipated delivery and payment values) rather than the full potential budget. This enables full use of available budget on service provision rather than allocating budget against a service line which will deliver an underspend at the end of the financial year.

NHS North East London

NEL Primary Care Contracts Sub Committee

16 July 2024

Title of report	Primary Care Risk Register
Author	Alison Goodlad
Presented by	Deputy Director Primary Care
Contact for further information	alison.goodlad@nhs.net
Executive summary	• A full copy of the risk register is provided and a summary of the risks rated over 12 is outlined below. • A key risk to note is that of potential collective action by GPs (PC21). Any planned action is likely to take place from August, following the outcome of a ballot which is due to end on 29 July. Different practices may choose to take different actions from a list of 12 potential actions proposed by the BMA. The ICB is liaising closely with the LMC. The ICB to write to practices to try to understand what action they are likely to take. The potential Collective Action will be managed through to the existing NEL Industrial Action Fora.
Action / recommendation	The sub-committee is asked to note
Previous reporting	Primary Care Delivery Group/Primary Care Collaborative
Next steps/ onward reporting	
Conflicts of interest	Not applicable
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	N/A
Impact on finance, performance and quality	There are no additional resource implications/revenue or capital costs arising from this report
Risks	This paper notes the review and outlines the risks on the current NEL Primary Care Risk Register.

1.0 Highest rated risks

The full version of the risk version is attached. Nine risks are rated over 12. These are:

- The risk that the financial constraints will impact on our ability to invest and therefore limits our delivery of GP services – **20**
- The risk that the financial constraints will impact on our ability to invest and therefore limits our delivery of Dental services – **20**
- Primary Care Resilience and Sustainability Quality and financial vulnerability **- 16**
- Risk of limited or no access to routine NHS Dentistry – **15**
- Primary Care Workforce – Recruitment and Retention of GPs, nurses and other staff including ARRS staff – **15**
- GP Premises – Risk to sustainability and viability **- 12**
- That national requirements and measurements don't meet our local ambition and strategy – **12**
- Risk that the reduction in capacity within the NEL ICB primary care team will lead to insufficient support to primary care **- 12**
- Risk of potential planned collective action by GPs. **- 12**

Primary Care Risk Register

ID no.	Date raised	Area Raised by	Initial risk score	Corporate objective	Risk description	Previous rating	Current rating: Likelihood	Current rating: Impact	Current rating: Risk Score (1-25)	Target rating	Target completion date	Completed mitigating actions	Mitigating actions in progress	Risk owner	Action Owner	Responsible committee or group	Escalation required (Y/N)	Escalation Details	Updates/ comments	Close Down Status
PC01	13 March 2023	Primary Care Directorate	9	To tackle inequalities in outcomes, experience and access	There is a risk to primary care that lack of clarity around prioritisation processes and how/where funding and resources are allocated, will result in making investment decisions that don't align with local priorities by supporting primary care and improving population health, particularly where priorities might be conflicting eg NEL vs Place. Additionally,a lack of clarity around prioritisation could delay the allocation of resources effectively to deliver our priorities.	9	3	3	9	6	Sep-24		Ensure that the future prioritisation process and associated funding allocation to support any programme of work reflects the agreements set out in the Finance Strategy and principles and objectives of the ICS. Identifying and supporting informed discussions where priorities conflict. Prioritisation process to be transparent and supporting the allocation of resources. Review of 23/24 primary care budgets, as part of the Financial Recovery Process. Work being undertaken to firm up priorities and objectives and ensure alignment with place teams.	Sarah See	Sarah See	Primary Care Contracting Sub Committee	N			
PC19	20 December 2023	Primary Care Directorate	15	To tackle inequalities in outcomes, experience and access	There is an ongoing risk associated to the local population with limited, or no access, to routine NHS dentistry for both adults and children which will lead to a deterioration in the oral health of the population with wider consequences in terms of chronic health issues for adults and impact on children's education. There is significant eveidence to suggest that those in the most deprived groups are the most adversely affected.	15	4	5	15	12	Mar-25	Investment of £3.1m to deliver additional routine NHS dental access for the period Oct - 2023 - March 2024, signed off by the ICB in August 2023; Urgent Care Procurement completed, new permanent delivery in place from April 2024	Development of DOP specific provider groups; Inclusion of Dentistry as part of place based discussions within NEL. Ongoing work with Dental Public Health Consultants and LAs to formulate Oral Health approaches/strategies that can increase the opportunity for the population to access Oral Health advice and promote the delivery of 'supervised tooth brushing in schools and other community settings	Sarah See	Jane Lindo/ Jeremy Wallman	Primary Care Contracting Sub Committee and Commissiong Oversight Group (COG)	Y			
PC02	13 March 2023	Primary Care Directorate	12	Develop our NEL integrated care system	There is a risk to the development of primary care in NEL and the ability to meet the needs of the local people that national measures and requirements (often requested at short notice) do not align/meet our local ambition and are not consistent with our ICS strategy which will impact on our ability to develop comprehensive plans and strategies and/or impact on our resources and ability to deliver against local priorities. For example - national operating plan targets on GP appointment numbers, constraints on the ways that national investments can be spent	12	4	3	12	9	Sep-24			Sarah See	Jane Lindo	Primary Care Collaborative	N			
PC03	13 March 2023	Primary Care Directorate	6	To enhance productivity and value for money	There is risk that the lack of plans, operating models and structures will impact the ability of primary care to build relationships at Place, causing difficulty to engage and work collaboratively to deliver.	9	3	3	9	4	Sep-24	ICB structure released, consulted on and being put in place..	Ongoing development, led by CSTO, on future operating model.	Jo Moss	Sarah See	CSTO	N		risk incr to 9	
PC04	13 March 2023	Primary Care Directorate	12	To enhance productivity and value for money	There is a risk that the financial constraints will impact on existing GP Primary care services and investment in new services and that this will make an impact on local people. Risk that of inadequate investment in primary care services beyond core GMS/PMS, APMS services . There is a risk that disinvestment in primary care services destablises them and residents lose the accessibility and continuity provided by primary care. This could also lead to reputational risks for the ICB, particularly for the LIS equalisation programme that the ICB have committed to and has been delayed.	12	4	5	20	9	Mar-25		Prioritisation process to be transparent and support the allocation of resources. Phasing of workstreams. Business cases to demonstrate value and good outcomes and ability of primary care to react quickly, be acessible to the local population, have a strong impact and provide continuity of care. Ensure this is backed up with good data. Communication with stakeholders to manage expectations. Ensure maximum efficiencies and value for money and assess any opportunties to release funding to where efficiencies can be made. Use technology to maximise productivity. Review of 23/24 primary care budgets.	Sarah See	Sarah See	Primary Care Contracts Sub Committee	Y			
PC20	20 December 2023	Primary Care Directorate	20	To enhance productivity and value for money	There is a risk that the financial constraints will impact on investment in new dental services and that this will have an impact on local people's access to dentistry and the oral health of the local population. Risk that the available recurrent underspend in GDS is used as a contribution towards the ICBs FRP, therefore no scope to commission additional access. This could also become a reputational risk to the ICB we are unable to repeat additional investment during 24-25 or fund other OH schemes	20	4	5	20	9	Sep-25	Additional Investment secured, non-recurrently, in 23-24	Review spend in 24/25, and deliver viable proposal to re-invest recurrnt resource (unspent)	Sarah See	Jane Lindo/ Jeremy Wallman	Primary Care Contracts Sub Committee; FPIC, COG	Y			
PC05	13 March 2023	Primary Care Directorate	9	Develop our NEL integrated care system	There is a risk that PCNs are not yet mature enough/able to develop rapidly enough to work in an effective way with the Place Based Partnerships impacting on development and delivery of Transformation, especially where PCNs are the delivery vehicle for transformation e.g Fuller and neighbourhood model. Risk of variability in PCN maturity and lack of accountability.	9	3	3	9	6	Mar-25	CD Development Programmes Support from Federations OD Programmes Regular PCN meetings PCN Strategic Infrastructure planning at NEL level completed and plans shared with PCNs All PCNs have Capacity and Access Plans agreed.	Ongoing PCN development and OD work being undertaken at place. PCNs have put in place Capacity and Access Plans and have received funding for this in order to work collectively to address issues around access and patient experience and share good practice and reduce variation. Places teams working with PCNs to review progress. Local dashboard is being used to highlight any issues with PCNs. System wide strategy and approach to be developed around role of PCNs and Federations.	William Cunningham-Davis	Heads of Primary Care	Primary Care Collaborative	N			
PC07	13 March 2023	Primary Care Directorate	9	To enhance productivity and value for money	There is a risk that service pathways are fragmented and incompatible, not integrated and not effective due to services not working in a joined up way. This may result in services that do not deliver required outcomes eg the issue with Same day Access across the system where local people continue to go round the system with multiple contacts.	9	3	3	9	6	Sep-24	Completion of initial primary care goverance review.	Workstreams in place to address the various aspects of the Fuller Report. Representation from all parts of the systems involved and working in partnership, particularly at local place level. Goverance to be revisited in the light of the restructure and staffing capacity.	William Cunngham-Davis	Heads of Primary Care	Primary Care Collaborative	N			
PC08	13 March 2023	Primary Care Directorate	9	Develop our NEL integrated care system	There is a risk to primary care, in terms of ICB support and timely and acurate payments, caused by lack of investment in training and reduction to ICB staffing budgets, resulting in an insufficient amount of primary care staff with the right skills to support delivery. Primary Care depends on specialist skills and knowledge and there is a risk of being able to recuit and ensure sucession planning for the future. There is also the risk of loss of clinical leadership due to loss of funding for Clinical Lead roles. Finally, there is the risk that if the culture and OD is not mature enough, this will impact on the ability to work in a matrix way to support the development of primary care.	9	4	3	12	6	Sep-24	Primary Care Team Away Day planned for Dec 23 to focus on priorities, objectives and ways of working	OD Programmes in place to ICB staff in Primary Care Commissioning and Improvement and Place Based Teams. Prioritisation of workload, ensure staff are clear on roles and priorities. Ensure all staff have clear objectives and appraisals, automation of functions where appropriate, to free up capacity.	Sarah See	Sarah See	CSTO	N		The previous PC08 (primary care staff training), PC010 staff reduction and PC11 - staff restructure have been consolidated as one risk	
PC09	13 March 2023	Primary Care Directorate	9	To improve outcomes in population health and healthcare	There is a risk that the quality and variation of coding in practices is not of a sufficient standard and will result in loss of income for GP practices and the inability of the ICB to effectively monitor impact/outcomes or planning, which risks investing in services that are not delivering the required outcome.	9	3	3	9	6	Apr-23	All PCNs have produced plans to improve accuracy of recording in appt books as part of their capacity and access improvement plans	An incentive scheme has been developed to encourage practices to adopt standardised methods of clinical coding. As part of their Capacity and Access Improvement Plans, practices will be required to produce plans to improve acuracy of recording in appointment books.	William Cunningham-Davis	Heads of Primary Care	Primary Care Contracts Sub Committee	N			
PC12	13 March 2023	Primary Care Directorate	16	Deliver High quality service for patients	The resilience, sustainability and viability of general practice and Primary Care is at risk due to reduced workforce, increased demand, quality issues and financial pressures which could result in morale deteriorating, premises becoming unaffordable/unviable and practices closing which will affect the ability of the wider Primary care system to deliver the Transformation required.	16	4	4	16	9	Mar-25	Surge planning guidance in place that can be applied by local systems to support their business continuity and preparedness plans. Expanded locum bank in place Additional access and capacity funding has been made available to PCNs. CPCS in place and well established.	Work is being undertaken to roll out cloud based telephony, increase the take up of online consultations, develop ehubs and move towards implementation of 'modern general practice'. This will help to improve efficiency and release capacity. Work is ongoing to ensure practices make optimal use of the CPCS and Pharmacy First to be rolled out. Suport offers through the Primary Care Recovery Plan to suport practices in managing demand and capacity. Support being given to practices identified as being most at risk, through SDF Resilence, workforce and Digital funding.	Sarah See	Deputy Directors of Primary Care	Primary Care Contracts Sub Committee	Y		Risk increased to 16	

ID no.	Date raised	Area Raised by	Initial risk score	Corporate objective	Risk description	Previous rating	Current rating			Target rating	Target completion date	Completed mitigating actions	Mitigating actions in progress	Risk owner	Action Owner	Responsible committee or group	Escalation required (Y/N)	Escalation Details	Updates/ comments	Close Down Status
							Likelihood	Impact	Risk Score (1-25)											
PC13	13 March 2023	Primary Care Directorate	15	To tackle inequalities in outcomes, experience and access	Workforce risks. The risk that PCNs are not able to fully recruit to ARRS roles, and ensure that these are sustainable. There are also a number of GPs and nurses nearing the age of retirement and low GP and nurse patient ratios in most parts of NEL. There is a risk that workforce initiatives do not match the scale of the problem where recruitment and retention continues to be a challenge, leading to a continual reduction in capacity relative to growth and demand.	15	3	5	15	9	Mar-25	CD Development Programmes Support from Federations OD Programmes Regular PCN meetings PCN Strategic Infrastructure planning at NEL level completed and plans shared with PCNs Work taking place with the training hubs	NEL-wide GP Flexible Pools expanded GP Spin Programme continues GPN training and recruitment programme NEL Professional Development Framework Nursing - continued development and enhanced CPD GPN fellowships HCA training programme Hyper local plans in place to tackle areas of greatest workforce challenge.	Sarah See	Fiona Erne	Primary Care Collaborative	Y			
PC14	05-May-23	Primary Care Directorate	8	Develop our NEL integrated care system	Implementation of the contract changes/access recovery plans in 23/24 – Risk of capacity in the ICB primary care teams and general practice to deliver, Risk of buy-in and reception of changes by general practice and reputational risk.	8	2	4	8	4	Mar-24	Programme Plan for Access Recovery Plan in place with workstreams covering digital, interface, pharmacy, implementation of modern general practice etc	Task and Finish Group meeting regularly to oversee the implementation of the contract changes, with representation from central and place based primary care, digital, comms and Equip. Other Task and Finish Groups covering different workstreams such as Interface, prospective records access and direct referrals	Sarah See	Alison Goodlad	Primary Care Contracts Sub Committee	N			
PC18	30-Oct-23	Primary Care Directorate	12	Deliver High quality service for patients	GP Premises: The risk to the viability and sustainability of general practice and ability to provide patient care. Particular risk areas are in relation to service debt variability and practice debt and the impact on pratice viability, Planned increase in rents at NELFT properties, quality of property management and the impact on service provision and patient care, rent review backlog and impact on ICB finance, variation in support given to practices when relocating and having significant premises developments and moving to a standard NEL offer	12	3	4	12	8	Mar-25		Estates Steering Group set up to ensure robust oversight and management of the primary care estates premises budgets and ensure long term financial viability and resilience of practices in relation to premises costs and resolve issues relating to aged debt, appropriateness of service charge costs and quality of property maintenance. 4 workstreams have been establised.: 1. Service charge variability. 2. Quality of property management 3. Rent review backlog 4. Standardisation of NEL offer to practices going through relocation or other development	Sarah See	William Cunningham-Davies	Primary Care Delivery Group	Y			
PC21	20-Apr-24	Primary Care Directorate	12	To enhance productivity and value for money	Risk of Potential planned action: BMA letter dated18 April alerted ICB colleagues to the significant risk to the system, which may potentially ensue from any subsequent planned action following a BMA referendum regarding the the 24/25 contract in which 99% of those GPs that took part rejected the contract changes. This could result in restricted access to primary medical services, subsequent impact on 111 and urgent care and impact on the ICB's financial position if GPs choose not engage with activiites to reduce prescribing spend.	N/A	3	4	12	8	Sep-24	Stakeholder comms sent out to help them to understand context and plan where possible, any mitigating actions. Modelling usign GPAD data undertaken to understand impact on NEL, should practices provdie a max of 25 appts per day per GP. Furher local analysis may be undertaken if necessary.	Any planned action is likely to take place from August, following the outcome of a ballot which is due to end on 29 July. Different pratices may choose to take different actions from a list of 12 potential actions. ICB liaising closely with the LMC. ICB to write to practices to try to understand what action thye are likely to take. Londonwide meetings to commence. The potential Collective Action wil lbe managed through to teh existing NEL Industrial Action Fora.	Sarah See	William Cunningham-Davies	Primary Care Contracts Sub Committee	Y			

NHS North East London

NEL Primary Care Contracts Sub Committee

16 July 2024

Title of report	Expressions of Interest for CVD Pilots for Dental and Optometry Practices
Author	Fiona Erne Alison Goodlad
Presented by	For information only
Contact for further information	Fiona Erne, Deputy Director of Primary Care Development, f.erne@nhs.net
Executive summary	The purpose of this paper is to provide the NEL Primary Care Contracts sub committee with an update on the Expressions of Interest submitted to NHSEI by the ICB to partake in pilots to provide blood pressure monitoring and AF monitoring in Dental and Optometry Practices. These were submitted to NHSEI at the end of May 2024. Following submission it was confirmed that NEL ICB was successful in the bid to partake in the Dental Pilot.
Action / recommendation	This item is for information only
Previous reporting	None
Next steps/ onward reporting	A task and finish group has been established to develop and implement a delivery plan.
Conflicts of interest	None known
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The EOI is aimed at improving access to testing and monitoring for people who may not have frequent contact with their GP practice.
Impact on finance, performance and quality	Funding has been allocated to the ICB by NHSEI for the pilot. The EOI included costs to manage and evaluate the programme.
Risks	Dental and optometry services provide services to people from outside the system. There is no registration or requirement to live in the system. The task and finish group will be limiting the offer to local residents.

Expression of Interest (EoI) Template for CVD Prevention case finding funding

This template should be used to submit Expressions of Interest to the CVD Prevention National Team.
• ICS CVD leads are asked to develop EOIs for implementation of dental and/or Dental hypertension case finding pilots. • Proposals should be developed by ICS CVD leads in collaboration with dental and/or Dental clinical and management colleagues. • The **closing date for EOI's is close of play 24th May 2024**, please return bids to the clinical policy unit england.clinicalpolicy@nhs.net • The NHS England CVD Prevention National Team will review proposals received by this date and notify systems of approved schemes by 7th June 2024.
1. Bid details
Name of submitter: Fiona Erne **Email address of submitter**: f.erne@nhs.net **Name of ICB**: North East London **Name of region:** London **Named point of contact**: Fiona Erne **Email address of point of contact**: f.erne@nhs.net **Named senior sponsor**: Sarah See **Email address of senior sponsor:** sarahsee@nhs.net **Finance contact:** Rob Dickenson **Cost centre:** Primary Care (1 *point)* (1 *point)*
2. Description of local need for hypertension and/or AF case finding
Description of bidding area, and population within area who aim to be covered by this intervention. North East London (NEL) is a unique, diverse, vibrant and thriving part of London with a rapidly growing population of over two million people, living across seven boroughs and the City of London. We are rich in history, culture and deep-rooted connections with strong and resilient communities. Despite this, local people experience significant health inequalities. We have one of the fastest growing populations in England with pockets of deprivation across our patch. We have a high demand for urgent and emergency care, and we continue to have long waiting lists for planned care. Despite the challenges, we have some great assets in NEL including our workforce and our primary care service providers. These present us with opportunities to do things differently, moving away from treatment towards a greater focus on prevention, working collaboratively and improving productivity to address the needs of our population. We are well placed to improve access to primary care by introducing new ways to access health screening without having to make a GP appointment. As part of this bid, NEL will build on our commitment to making every contact count (MECC) by offering checks in local opticians to people at risk of developing CVD who live in deprived areas and who may not otherwise be in regular contact with a GP. In NEL we have over 260 GP practices and 350+ Community Pharmacies that come together to form 47 Primary Care Networks. There are 205 Dental practices across NEL. *(2 points, suggest approx. 200 words)*

Description of current hypertension and/or AF case finding rate for the population, and population characteristics.

NEL monitors hypertension case finding and management via practice dashboards which are shared with practices and commissioners on a regular basis. The latest data for April is provided below.

NEL Hypertension Practice Data – April 2024

Total List Size	2,449,889
Hypertension Register	262,132
% list size	10.70%
Hypertension and BP (last 12m)	230,013
% Hypertension Register	87.75%
Hypertension and BP < 140/90 (Patients aged under 80) < 150/90 (Aged 80 and over) (last 12m)	168,477
% Hypertension Register	64.27%

This data shows that 262,132 (10.7%) of all patients (all ages) registered with a GP practice in NEL are on the hypertension register), and of those 230,013 (87.75%), have hypertension and BP measured in the last 12 months - BUT it is estimated that the true prevalence of high blood pressure in NEL may be 20.2% of the 16-95+ age group (PHE, 2020). This means half of the population with Hypertension may be unaware that they have it, and so are not taking steps to control their blood pressure and reduce risk of cardiovascular disease.

NEL joint forward plan 2024 - acknowledged that we need to Improve detection of undiagnosed hypertension and ensure those with hypertension are controlled to target – by 2029 80% of expected numbers with hypertension are detected and 80% of people with high blood pressure are treated to target.

In NEL there is a very clear association between premature mortality from CVD and levels of deprivation. The most deprived areas have more than twice the rate of premature deaths compared to the least deprived areas. 2021/22 figures showed for every 1 unit increase in deprivation, the premature mortality rate increases by approximately 11 deaths per 100,000 population.

Data on deprivation and CVD and hypertension is provided below:

JSNA 2022	*Deprivation data*					
	***Q1** (most deprived)*	***Q2***	***Q3***	***Q4***	***Q5** (least deprived)*	
Total Population	***20.20%***	***21.40%***	***22.20%***	***19.70%***	***16.50%***	
Hypertension Register	***21.00%***	***20.70%***	***20.50%***	***19.70%***	***18.10%***	
CVD	***20.80%***	***20.90%***	***21.10%***	***19.40%***	***17.80%***	
	Recorded ethnicity					
	White	***Asian / Asian British***	***Black / Black British***	***Mixed***	***Other Ethnic Group***	*Not Stated*
Total Population	***46.70%***	***29.30%***	***13.00%***	***3.40%***	***6.10%***	***1.40%***
Hypertension Register	***46.90%***	***26.80%***	***19.90%***	***2.00%***	***3.70%***	***0.60%***

CVD	52.10%	35.30%	7.60%	1.20%	3.10%	0.60%

(2 points, suggest approx. 200 words)

Clear rationale of the unmet need for hypertension (and/or AF) case finding in the area. Describe a rationale for communities and/or geographies in scope of the proposal and the expected impact on CVD prevention outcomes for the scheme. Include predicted size of population impact with data e.g. CVD Prevent or other locally collected data.

Cardiovascular disease (CVD) is one of the leading causes of premature death in NEL and in England. Hypertension is the biggest risk factor for CVD and is one of the top five risk factors for all premature death and disability.

For many conditions there are low recorded prevalence rates, while at the same time, most NEL places have a higher Standardised Mortality Ratio for those under 75 (SMR<75) – a measure of premature deaths in a population – compared to the England average. Whilst some of this may be due to the age profile of our population, there may be significant unmet health and care need in our communities that is not being identified or effectively met by our current service offers.

Patients from more deprived backgrounds and those with Asian ethnicity are more likely to smoke (CVDPrevent). People from the Asian, black, and 'other' ethnic groups were less likely to be physically active than the national average (Active Lives Survey, 2024). Over 50% of our population comes from a BME background.

NEL also has a higher proportion of adults who are physically inactive compared to London and England. Those that are physically inactive are also more likely to have high blood pressure. There are a wide range of risk factors for high blood pressure, including a range of lifestyle factors (smoking, excessive alcohol, excess salt, unhealthy diet, obesity, physical inactivity)

In NEL there is a very clear association between premature mortality from CVD and levels of deprivation. The most deprived areas have more than twice the rate of premature deaths compared to the least deprived areas. 2021/22 figures showed for every 1 unit increase in deprivation, the premature mortality rate increases by approximately 11 deaths per 100,000 population.

A cross-sectional cohort study published in 2023 which investigated health inequalities related to ethnicity, sex, age, and socioeconomic status in the monitoring, treatment, and control of blood pressure in a cohort of adult patients with hypertension in 5 NEL places concluded that individuals of black ethnicity and younger people are less likely to have controlled hypertension and may warrant targeted interventions

Dental Practices are accessible in most high streets and communities across NEL presenting a great opportunity for conversations with individuals around health and wellbeing. The pilot will aim to onboard c 10+ practices in the more deprived areas of NEL, particularly those areas where patients are most at risk and there are high rates of undiagnosed people with infrequent contact with other NHS services.

We shall work with our local PH, Place and Dental leaders to target and promote this service in our most deprived areas. This will build on the work we have already delivered to develop and test the London specification. As part of the pilot, we shall support and encourage working across the primary care services within local PC network and neighbourhood footprints. The target population for promotion and development of this service will be those living in areas of high deprivation and where practice data shows the high divergence from the OPG target of 80% for patients who are treated to age-appropriate threshold.

The pilot is part of a strategy to increase detection to 68% in pilot areas which could prevent up to 90 heart events per year as well as other acute conditions.

(4 points, suggest approx. 400 words)

3. Planning, engagement, and preparedness

System engagement – what engagement has taken place for this project across the system with providers, commissioners, and other system/ community organisations? (please include senior buy in, service or clinical buy in, PPV representatives and a named executive and/or regional sponsor)

We regularly meet with representatives from our local representative committees, and we have established provider groups for each of the four primary care services. These meet on a regular basis and are a forum for our providers to discuss the challenges and opportunities for their respective services in NEL. It will be through local forums that we shall discuss the opportunities to be part of the pilot and where we will feedback the findings during and after the pilot. These conversations will then be fed into to our Primary Care Collaborative for further direction.

NEL also has seven place partnerships with their own transformation board and forums where this opportunity is being discussed with our colleagues in Health and Social care, including patient representatives and public health leaders. It is at place that we actively involve our local community and patient representatives in developing and improving our local services. It is our intention to involve the local community and voluntary sector through our existing arrangements in the development, implementation and delivery of the scheme.

The EOI is supported by our LDC, Provider Groups and Primary Care Collaborative and the following leadership is in place to lead the scheme.

Service Leads
Sarah See - Managing Director of Primary Care
Charlotte Stone - System Programme Director for Long Term Conditions (LTCs) and Specialised Services
Clinical Leads
Dr Christopher Carvalho - Cardiovascular Clinical Lead
Ben Molyneaux - Associate Medical Director
Executive:
Dr Jagan John
Jo Moss - CSTO

(2 points, suggest approx. 200 words)

How will this pilot be used to reduce inequality in the area? Please include data in your answer

As part of this pilot development and implementation NEL intends to target and onboard Dental practices in areas where the local population are most at risk of CVD and where the prevalence of hypertension and AF are the highest, using data identified within our CVD strategy. This has confirmed that:

- Prevalence of hypertension was highest in the 85+ group where over 70% of the population were on the hypertension QOF register.
- Females had slightly higher prevalence of hypertension (14.1%) than males (12.7%)
- Those of black ethnicity (21.3%) were much more likely to be on the hypertension register compared to other ethnicities
- Barking & Dagenham, Havering, Redbridge and Waltham Forest all have prevalence of hypertension higher than the NEL average

Our NEL CVD prevention strategy has used QRisk diagnostic metrics to calculate whether an individual is at risk of developing CVD in the next 10 years and this will be used to further refine the criteria for targeting and selecting practices which will include: • Dental practices serving communities with high levels of deprivation • Those in areas with high prevalence rates • Areas with large black and south east Asian populations or other ethnic minorities who don't regularly interact with GP services. This will include areas with large asylum seeker populations and other inclusion groups. *(2 points, suggest approx. 200 words)*
How people with lived experience of CVD and/or hypertension be involved in the project? Building on the expertise within our communication and engagement department, staff across NEL are provided with the skills and knowledge to listen and act upon feedback from local people. This helps to ensure that participation and co-production is part of the culture and individual staff development of the ICS. We are transitioning our CVD clinical network into a improvement network with a focus on Hypertension. As part of the transition we are widening our membership to include people with lived experience and charities and voluntary organisations representation We have also utilised knowledge gathered via: • Working with charities, voluntary organisations and residents with lived in experience meaningful participation within our wider CVD and LTC projects, including work being held at schools and local communities regarding heart health • Gathered insight by using the NEL Community Insight System, commissioned from our local Healthwatch, using a wide range of existing and bespoke insight from local people. We have previously used this to gather insight on prevention and stroke services with residents who have had a stroke, a risk of having one due to CVD or people who are carers • Working with the Citizens' Panel consists of more than 2,500 residents living in NEL and was created as another way to listen to our diverse population. • Incorporate learning and knowledge from the Big Conversation which included 56 focus groups and 450 people attending community events which highlighted MEC and also person-centred approach to health and care *(2 points, suggest approx. 200 words)*
Implementation planning – please describe the service you plan to implement. Please describe a blueprint for implementation in the bidding area. How will you make and embed a highly effective operational pathway? How will you monitor the extent to which this pathway is being used and the benefits to patients that the pathway is delivering? Are there clear review points to assess the effectiveness of the pilot as it progresses? **Governance** NEL will embed a programme workstream to have oversight of the pilots and who shall be accountable to our Primary Care leadership via our PC Delivery Group and PC Collaborative. The Programme shall also report into the LTC team governance who will be represented within the programme board. The board will have a SRO, Clinical lead, provider representatives, PC and LTC commissioners and a project manager. The programme will be supported by our PC PMO. A clear programme plan with defined milestones will be developed to deliver the pilots in line with the national timetable. Key elements of the programme shall be the development of an overall programme plan and deliverables by the end of June 2024 that shall include the following:

1. **Engagement and Comms plan**
- Aimed at onboarding practices in areas that would benefit from the scheme and engagement with the key local stakeholders such as GPs, PCNs and local community pharmacies.
- A patient inclusion and engagement plan to ensure local people and users have voice in the development and roll out of the scheme. This will build on the insights already gained from the testing of the service in NEL.

2. **Delivery and Implementation**
- NEL will appoint a project manager for the pilots who will be responsible for supporting this pilot and if successful the Dental Practice Pilot.
- On notification that the pilot is successful, NEL will put in place the Programme Board by mid June who shall agree the programme plan and process for selecting practices by the end of June 2024.
- Put in place local agreements based on the pilot specifications with participating practices.
- The Programme Board will review and refine the existing pathways developed during the previous testing of this service in NEL.

3. **Monitoring and review**
- In NEL we already have dashboards to monitor case finding that can be used to baseline and monitor activity. These are part of our Clinical Effectiveness Group (CEG) Dashboards.
- The PM and PMO shall produce regular reports based on the agreed monitoring metrics for the Programme, PC Delivery Board, LTC Team, PC collaborative and NHSEI. These shall also be shared with the Provider Groups (Dental, Pharmacy and GP).
- We are proposing to establish a network peer group for the participants where they can meet with local GPs and community pharmacists to discuss the pilot and the impact on local uptake.
- Reports shall also be made available and shared with the NHSEI team.

4. **Training, Education and Development**
- NEL ICB will work with our local Training Hubs to develop a training package to support the pilots.
- NEL ICB and our Training Hub will develop learning materials from the pilot that can be used to expand and develop this scheme via our local forums.

5. **Evaluation**
- An evaluation plan will be agreed as part of the programme initiation.
- This will baseline the agreed metrics for evaluation (see below)
- We would like to appoint a Fellow from within our clinical workforce who can evaluate the pilot and review

(4 points, suggest approx. 400 words)

Funding- please provide a breakdown of how funding will be used. This could include, but may not be limited to; equipment, training, incentivisation, and evaluation costs. This should be explicitly and closely linked to the proposed implementation blueprint described above.

	Dental		
	Number	Cost	Total
Equipment			£ 5,000
Practice Training Fees	10	£ 200	£ 2,000
Integrated working	10	£ 200	£ 2,000
Incentive Fees			£ 33,000
Direct Service Costs			**£ 42,000**
Management and Evaluation			£ 8,000

The ICB shall contain costs for equipment within the ceiling allocated by NHSEI, building on existing investment.

In line with the specification already implemented in NEL we shall offer a one-off fee of £200 to support participants to cover out of practice expenses for attendance for both the Health Care champion and the governance lead at a London Dental Commissioning Hub hosted training event for this service.

The ICB also wants to support engagement and learning across the PC services delivering this in local neighbourhoods. This will facilitate closer working and shared learning and support, a QI approach to development of the service and the local patient pathway. To this end a further one-off fee of £200 will be available to support dental staff to attend local PCN meetings about this service with local GPs and Community Pharmacists. Fees will be paid on confirmed attendance.

We have based the fees and incentives on those already used in NEL pilots. Dental practices providing this service will be eligible for the following payment structure:

Payments will be made in 4 stages
Stage 1 – Month 1-3
Stage 2 – Month 4-6
Stage 3 – Month 7-9
Stage 4 – Month 9-12.

A maximum payment of

- £700 for each stage for BP tests for a minimum of 50 tests per stage
- £300 for each stage for AF tests for a minimum of 30 tests

To qualify for the maximum payment, the following requirements will need to be met by the dental practice. In the event the dental practice does not qualify for the maximum payment for any stage, a volume adjusted payment will be made depending on the number of BP and AF tests performed.

The ICB shall monitor activity on a quarterly basis to ensure that incentives are being fully utilised and the patient benefit maximised. This includes supporting practices to improve uptake and where appropriate and affordable to reinvest slippage. The ICB aims to target c2000 patients under this scheme.

The ICB has identified resources to support delivery, implementation, and evaluation of this pilot. These will be used in conjunction with the ICB existing programme resources to fund minimal project management support and an evaluator.

(4 points, suggest approx. 400 words)

Please describe the main barriers or risks you are likely to encounter implementing this service. How do you plan to mitigate these and what support mechanisms will you use if the project does not go to plan?

Risk	Mitigation
There is a risk that users of services may not be resident or registered with NEL GP practices which means we cannot locally track or benefit from impact.	As part of our selection process we shall encourage and promote applications from practices whose patients are predominantly resident in NEL
There is risk that the pilot may identify suitable patients who are at risk but who do not have a GP and may not be able to address their health risk.	NEL has embedded Pharmacy First and pharmacy based BPM across all areas which we offer patients access to BP monitoring. We shall also develop materials to support patient registration with a local GP practices (including online registration) as part of this pathway
There is a risk that uptake may be low in some practices or that staff may need additional support to enable implementation	As part of our Pharmacy 1st and the testing of the service we have developed facilitation support that can be offered to local participants including local GPs and pharmacies. This will be used to unblock issues and address low uptake. We shall offer support with establishing NHS.net email addresses and use of any software that will enable communication with GP practices such as Pharma Outcomes

(2 points, suggest approx. 200 words)

How do you plan to carry out local evaluation of the project? Please include proposed outcome metrics, method of assessment, review points, and how this will support sustainability of this intervention once the pilot has been completed.

The ICB shall appoint an evaluator utilising part of the pilot funding and some existing research funding as part of a wider evaluation to make progress towards the NHS Long-term Plan CVD ambitions.

As such the evaluation will look at practice level improvements in the pilot areas against the following metrics using our existing CEG dashboards on a **quarterly basis:**

- % patients with hypertension who are treated to age-appropriate threshold on a quarterly basis
- % patients with AF are treated with anticoagulation therapy
- No of patients who have received checks in the local pilot service
- Referrals to GP practices and community pharmacy
- Outputs from our user feedback section in the event records

The relevant programme boards take action to ensure that the pilots are achieving planned targets and meeting relevant milestones. In addition, the evaluation will meet and engage with service providers, local network leads and users to gain insight into their experience of the service.

A final evaluation report will be prepared at the end of the pilot period that shall out findings and make recommendations to inform improvements and changes to deliver the LTP. The ICB will also look at ways to improve and enable communication and information sharing across the four PC pillars.

Expression of Interest (EoI) Template for CVD Prevention case finding funding

This template should be used to submit Expressions of Interest to the CVD Prevention National Team.
• ICS CVD leads are asked to develop EOIs for implementation of dental and/or optometry hypertension case finding pilots. • Proposals should be developed by ICS CVD leads in collaboration with dental and/or optometry clinical and management colleagues. • The **closing date for EOI's is close of play 24th May 2024**, please return bids to the clinical policy unit england.clinicalpolicy@nhs.net • The NHS England CVD Prevention National Team will review proposals received by this date and notify systems of approved schemes by 7th June 2024.
1. Bid details
Name of submitter: Fiona Erne **Email address of submitter**: f.erne@nhs.net **Name of ICB**: North East London **Name of region:** **London** **Named point of contact**: Fiona Erne **Email address of point of contact**: f.erne@nhs.net **Named senior sponsor**: Sarah See **Email address of senior sponsor:** sarahsee@nhs.net **Finance contact:** Rob Dickenson **Cost centre:** Primary Care (1 *point)* (1 *point)*
2. Description of local need for hypertension and/or AF case finding
Description of bidding area, and population within area who aim to be covered by this intervention. North East London (NEL) is a unique, diverse, vibrant and thriving part of London with a rapidly growing population of over two million people, living across seven boroughs and the City of London. We are rich in history, culture and deep-rooted connections with strong and resilient communities. Despite this, local people experience significant health inequalities. We have one of the fastest growing populations in England with pockets of deprivation across our patch. We have a high demand for urgent and emergency care, and we continue to have long waiting lists for planned care. Despite the challenges, we have some great assets in NEL including our workforce and our primary care service providers. These present us with opportunities to do things differently, moving away from treatment towards a greater focus on prevention, working collaboratively and improving productivity to address the needs of our population. We are well placed to improve access to primary care by introducing new ways to access health screening without having to make a GP appointment. As part of this bid, NEL will build on our commitment to making every contact count (MECC) by offering checks in local opticians to people at risk of developing CVD who live in deprived areas and who may not otherwise be in regular contact with a GP. In NEL we have over 260 GP practices and 350+ Community Pharmacies that come together to form 47 Primary Care Networks. There are 224 optometry practices across NEL. *(2 points, suggest approx. 200 words)*

Description of current hypertension and/or AF case finding rate for the population, and population characteristics.

NEL monitors hypertension case finding and management via practice dashboards which are shared with practices and commissioners on a regular basis. The latest data for April is provided below.

NEL Hypertension Practice Data – April 2024

Total List Size	2,449,889
Hypertension Register	262,132
% list size	10.70%
Hypertension and BP (last 12m)	230,013
% Hypertension Register	87.75%
Hypertension and BP (last 12m) < 140/90 (Patients aged under 80) < 150/90 (Aged 80 and over)	168,477
% Hypertension Register	64.27%

This data shows that 262,132 (10.7%) of all patients (all ages) registered with a GP practice in NEL are on the hypertension register), and of those 230,013 (87.75%), have hypertension and BP measured in the last 12 months - BUT it is estimated that the true prevalence of high blood pressure in NEL may be 20.2% of the 16-95+ age group (PHE, 2020). This means half of the population with Hypertension may be unaware that they have it, and so are not taking steps to control their blood pressure and reduce risk of cardiovascular disease

NEL joint forward plan 2024 - acknowledged that we need to Improve detection of undiagnosed hypertension and ensure those with hypertension are controlled to target – by 2029 80% of expected numbers with hypertension are detected and 80% of people with high blood pressure are treated to target.

In NEL there is a very clear association between premature mortality from CVD and levels of deprivation. The most deprived areas have more than twice the rate of premature deaths compared to the least deprived areas. 2021/22 figures showed for every 1 unit increase in deprivation, the premature mortality rate increases by approximately 11 deaths per 100,000 population.

Data on deprivation and CVD and hypertension is provided below:

JSNA 2022	***Deprivation data***					
	***Q1** (most deprived)*	***Q2***	***Q3***	***Q4***	***Q5** (least deprived)*	
Total Population	***20.20%***	***21.40%***	***22.20%***	***19.70%***	***16.50%***	
Hypertension Register	***21.00%***	***20.70%***	***20.50%***	***19.70%***	***18.10%***	
CVD	***20.80%***	***20.90%***	***21.10%***	***19.40%***	***17.80%***	
	Recorded ethnicity					
	White	***Asian / Asian British***	***Black / Black British***	***Mixed***	***Other Ethnic Group***	*Not Stated*
Total Population	***46.70%***	***29.30%***	***13.00%***	***3.40%***	***6.10%***	***1.40%***
Hypertension Register	***46.90%***	***26.80%***	***19.90%***	***2.00%***	***3.70%***	***0.60%***
CVD	***52.10%***	***35.30%***	***7.60%***	***1.20%***	***3.10%***	***0.60%***

(2 points, suggest approx. 200 words)

Clear rationale of the unmet need for hypertension (and/or AF) case finding in the area. Describe a rationale for communities and/or geographies in scope of the proposal and the expected impact on CVD prevention outcomes for the scheme. Include predicted size of population impact with data e.g. CVD Prevent or other locally collected data.

Cardiovascular disease (CVD) is one of the leading causes of premature death in NEL and in England. Hypertension is the biggest risk factor for CVD and is one of the top five risk factors for all premature death and disability.

For many conditions there are low recorded prevalence rates, while at the same time, most NEL places have a higher Standardised Mortality Ratio for those under 75 (SMR<75) – a measure of premature deaths in a population – compared to the England average. Whilst some of this may be due to the age profile of our population, there may be significant unmet health and care need in our communities that is not being identified or effectively met by our current service offers.

Patients from more deprived backgrounds and those with Asian ethnicity are more likely to smoke (CVDPrevent). People from the Asian, black, and 'other' ethnic groups were less likely to be physically active than the national average (Active Lives Survey, 2024). Over 50% of our population comes from a BME background.

NEL also has a higher proportion of adults who are physically inactive compared to London and England. Those that are physically inactive are also more likely to have high blood pressure. There are a wide range of risk factors for high blood pressure, including a range of lifestyle factors (smoking, excessive alcohol, excess salt, unhealthy diet, obesity, physical inactivity)

In NEL there is a very clear association between premature mortality from CVD and levels of deprivation. The most deprived areas have more than twice the rate of premature deaths compared to the least deprived areas. 2021/22 figures showed for every 1 unit increase in deprivation, the premature mortality rate increases by approximately 11 deaths per 100,000 population.

A cross-sectional cohort study published in 2023 which investigated health inequalities related to ethnicity, sex, age, and socioeconomic status in the monitoring, treatment, and control of blood pressure in a cohort of adult patients with hypertension in 5 NEL places concluded that individuals of black ethnicity and younger people are less likely to have controlled hypertension and may warrant targeted interventions

Opticians are accessible in most high streets and communities across NEL presenting a great opportunity for conversations with individuals around health and wellbeing. The pilot will aim to onboard c 10+ practices in the more deprived areas of NEL, particularly those areas where patients are most at risk and there are high rates of undiagnosed people with infrequent contact with other NHS services.

We shall work with our local PH, place and Optometry leaders to target and promote this service in our most deprived areas. This will build on the work we have already delivered to develop and test the London specification. As part of the pilot we shall support and encourage working across the primary care services within local PC network and neighbourhood footprints. The target population for promotion and development of this service will be those living in areas of high deprivation and where practice data shows the high divergence from the OPG target of 80% for patients who are treated to age-appropriate threshold.

The pilot is part of a strategy to increase detection to 68% in pilot areas which could prevent up to 90 heart events per year as well as other acute conditions.

(4 points, suggest approx. 400 words)

3. Planning, engagement, and preparedness

System engagement – what engagement has taken place for this project across the system with providers, commissioners, and other system/ community organisations? (please include senior buy in, service or clinical buy in, PPV representatives and a named executive and/or regional sponsor)

We regularly meet with representatives from our local representative committees, and we have established provider groups for each of the four primary care services. These meet on a regular basis and are a forum for our providers to discuss the challenges and opportunities for their respective services in NEL. It will be through local forums that we shall discuss the opportunities to be part of the pilot and where we will feedback the findings during and after the pilot. These conversations will then be fed into to our Primary Care Collaborative for further direction.

NEL also has seven place partnerships with their own transformation board and forums where this opportunity is being discussed with our colleagues in Health and Social care, including patient representatives and public health leaders. It is at place that we actively involve our local community and patient representatives in developing and improving our local services. It is our intention to involve the local community and voluntary sector through our existing arrangements in the development, implementation and delivery of the scheme.

The EOI is supported by our LOC, Optometry Provider Group and Primary Care Collaborative and the following leadership is in place to lead the scheme.

Service Leads
Sarah See - Managing Director of Primary Care
Charlotte Stone - System Programme Director for Long Term Conditions (LTCs) and Specialised Services
Clinical Leads
Dr Christopher Carvalho - Cardiovascular Clinical Lead
Ben Molyneaux - Associate Medical Director
Executive:
Dr Jagan John
Jo Moss - CSTO

(2 points, suggest approx. 200 words)

How will this pilot be used to reduce inequality in the area? Please include data in your answer

As part of this pilot development and implementation NEL intends to target and onboard optometry practices in areas where the local population are most at risk of CVD and where the prevalence of hypertension and AF are the highest, using data identified within our CVD strategy. This has confirmed that:

- Prevalence of hypertension was highest in the 85+ group where over 70% of the population were on the hypertension QOF register.
- Females had slightly higher prevalence of hypertension (14.1%) than males (12.7%)
- Those of black ethnicity (21.3%) were much more likely to be on the hypertension register compared to other ethnicities
- Barking & Dagenham, Havering, Redbridge and Waltham Forest all have prevalence of hypertension higher than the NEL average

Our NEL CVD prevention strategy has used QRisk diagnostic metrics to calculate whether an individual is at risk of developing CVD in the next 10 years and this will be used to further refine the criteria for targeting and selecting practices which will include:

- Optometry practices serving communities with high levels of deprivation
- Those in areas with high prevalence rates

- Areas with large black and south east Asian populations or other ethnic minorities who don't regularly interact with GP services. This will include areas with large asylum seeker populations and other inclusion groups.

(2 points, suggest approx. 200 words)

How people with lived experience of CVD and/or hypertension be involved in the project?

Building on the expertise within our communication and engagement department, staff across NEL are provided with the skills and knowledge to listen and act upon feedback from local people. This helps to ensure that participation and co-production is part of the culture and individual staff development of the ICS.

We are transitioning our CVD clinical network into a improvement network with a focus on Hypertension. As part of the transition we are widening our membership to include people with lived experience and charities and voluntary organisations representation

We have also utilised knowledge gathered via:

- Working with charities, voluntary organisations and residents with lived in experience meaningful participation within our wider CVD and LTC projects, including work being held at schools and local communities regarding heart health
- Gathered insight by using the NEL Community Insight System, commissioned from our local Healthwatch, using a wide range of existing and bespoke insight from local people. We have previously used this to gather insight on prevention and stroke services with residents who have had a stroke, a risk of having one due to CVD or people who are carers
- Working with the Citizens' Panel consists of more than 2,500 residents living in NEL and was created as another way to listen to our diverse population.
- Incorporate learning and knowledge from the Big Conversation which included 56 focus groups and 450 people attending community events which highlighted MEC and also person-centred approach to health and care

(2 points, suggest approx. 200 words)

Implementation planning – please describe the service you plan to implement. Please describe a blueprint for implementation in the bidding area. How will you make and embed a highly effective operational pathway? How will you monitor the extent to which this pathway is being used and the benefits to patients that the pathway is delivering? Are there clear review points to assess the effectiveness of the pilot as it progresses?

Governance

NEL will embed a programme workstream to have oversight of the pilots and who shall be accountable to our Primary Care leadership via our PC Delivery Group and PC Collaborative. The Programme shall also report into the LTC team governance who will be represented within the programme board. The board will have a SRO, Clinical lead, provider representatives, PC and LTC commissioners and a project manager. The programme will be supported by our PC PMO. A clear programme plan with defined milestones will be developed to deliver the pilots in line with the national timetable. Key elements of the programme shall be the development of an overall programme plan and deliverables by the end of June 2024 that shall include the following:

1. **Engagement and Comms plan**

- Aimed at onboarding practices in areas that would benefit from the scheme and engagement with the key local stakeholders such as GPs, PCNs and local community pharmacies.
- A patient inclusion and engagement plan to ensure local people and users have voice in the development and roll out of the scheme. This will build on the insights already gained from the testing of the service in NEL.

2. **Delivery and Implementation**

- NEL will appoint a project manager for the pilots who will be responsible for supporting this pilot and if successful the Dental Practice Pilot.
- On notification that the pilot is successful, NEL will put in place the Programme Board by mid June who shall agree the programme plan and process for selecting practices by the end of June 2024.
- Put in place local agreements based on the pilot specifications with participating practices.
- The Programme Board will review and refine the existing pathways developed during the previous testing of this service in NEL.

3. **Monitoring and review**

- In NEL we already have dashboards to monitor case finding that can be used to baseline and monitor activity. These are part of our Clinical Effectiveness Group (CEG) Dashboards.
- The PM and PMO shall produce regular reports based on the agreed monitoring metrics for the Programme, PC Delivery Board, LTC Team, PC collaborative and NHSEI. These shall also be shared with the Provider Groups (Optometry, Pharmacy and GP).
- We are proposing to establish a network peer group for the participants where they can meet with local GPs and community pharmacists to discuss the pilot and the impact on local uptake.
- Reports shall also be made available and shared with the NHSEI team.

4. **Training, Education and Development**

- NEL ICB will work with our local Training Hubs to develop a training package to support the pilots.
- NEL ICB and our Training Hub will develop learning materials from the pilot that can be used to expand and develop this scheme via our local forums.

5. **Evaluation**

- An evaluation plan will be agreed as part of the programme initiation.
- This will baseline the agreed metrics for evaluation (see below)
- We would like to appoint a Fellow from within our clinical workforce who can evaluate the pilot and review

(4 points, suggest approx. 400 words)

Funding- please provide a breakdown of how funding will be used. This could include, but may not be limited to; equipment, training, incentivisation, and evaluation costs. This should be explicitly and closely linked to the proposed implementation blueprint described above.

	Optometry		
	Number	Cost	Total
Equipment			£ 5,000
Practice Training Fees	11	£ 200	£ 2,200
Integrated working	11	£ 200	£ 2,200
Incentive Fees			£ 40,000
Direct Service Costs			**£ 49,400**
Management and Evaluation			£ 10,600

The ICB shall contain costs for equipment within the ceiling allocated by NHSEI, building on existing investment.

In line with the specification already implemented in NEL we shall offer a one-off fee of £200 to support participants to cover out of practice expenses for attendance for both the Health Care champion and the governance lead at a London Optometry Commissioning Hub hosted training event for this service.

The ICB also wants to support engagement and learning across the PC services delivering this in local neighbourhoods. This will facilitate closer working and shared learning and support, a QI approach to development of the service and the local patient pathway. To this end a further one-off fee of £200 will be available to support optometrists to attend local PCN meetings about this service with local GPs and Community Pharmacists. Fees will be paid on confirmed attendance.

We have based the fees and incentives on those already used in NEL pilots. Ophthalmic practices providing this service will be eligible for the following payment structure:

Payments will be made in 4 stages
Stage 1 – Month 1-3
Stage 2 – Month 4-6
Stage 3 – Month 7-9
Stage 4 – Month 9-12.

A maximum payment of

- £700 for each stage for BP tests for a minimum of 50 tests per stage
- £300 for each stage for AF tests for a minimum of 30 tests

To qualify for the maximum payment, the following requirements will need to be met by the ophthalmic practice. In the event the ophthalmic practice does not qualify for the maximum payment for any stage, a volume adjusted payment will be made depending on the number of BP and AF tests performed.

The ICB shall monitor activity on a quarterly basis to ensure that incentives are being fully utilised and the patient benefit maximised. This includes supporting practices to improve uptake and where appropriate and affordable to reinvest slippage. The ICB aims to target c2000 patients under this scheme.

The ICB has identified resources to support delivery, implementation, and evaluation of this pilot. These will be used in conjunction with the ICB existing programme resources to fund minimal project management support and an evaluator.

(4 points, suggest approx. 400 words)

Please describe the main barriers or risks you are likely to encounter implementing this service. How do you plan to mitigate these and what support mechanisms will you use if the project does not go to plan?

Risk	Mitigation
There is a risk that users of services may not be resident or registered with NEL GP practices which means we cannot locally track or benefit from impact.	As part of our selection process we shall encourage and promote applications from practices whose patients are predominantly resident in NEL
There is risk that the pilot may identify suitable patients who are at risk but who do not have a GP and may not be able to address their health risk.	NEL has embedded Pharmacy First and pharmacy based BPM across all areas which we offer patients access to BP monitoring. We shall also develop materials to support patient registration with a local GP practices (including online registration) as part of this pathway

There is a risk that uptake may be low in some practices or that staff may need additional support to enable implementation	As part of our Pharmacy 1st and the testing of the service we have developed facilitation support that can be offered to local participants including local GPs and pharmacies. This will be used to unblock issues and address low uptake. We shall offer support with establishing NHS.net email addresses and use of any software that will enable communication with GP practices such as Pharma Outcomes

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How do you plan to carry out local evaluation of the project? Please include proposed outcome metrics, method of assessment, review points, and how this will support sustainability of this intervention once the pilot has been completed.

The ICB shall appoint an evaluator utilising part of the pilot funding and some existing research funding as part of a wider evaluation to make progress towards the NHS Long-term Plan CVD ambitions.

As such the evaluation will look at practice level improvements in the pilot areas against the following metrics using our existing CEG dashboards on a **quarterly basis:**

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- No of patients who have received checks in the local pilot service
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- Outputs from our user feedback section in the event records

The relevant programme boards take action to ensure that the pilots are achieving planned targets and meeting relevant milestones. In addition, the evaluation will meet and engage with service providers, local network leads and users to gain insight into their experience of the service.

A final evaluation report will be prepared at the end of the pilot period that shall out findings and make recommendations to inform improvements and changes to deliver the LTP. The ICB will also look at ways to improve and enable communication and information sharing across the four PC pillars.