

## Primary Care Contracts Sub-Committee

8 July 2025; 13:00 - 14:15

Venue: FO1, 4<sup>th</sup> Floor, Unex Tower, Station Road, Stratford

### AGENDA

	Item	Time	Lead	Attached/ verbal	Action required
<b>1.0</b>	<b>Welcome, introductions and apologies</b>	13:00	Chair	Verbal	Note
1.1.	Declaration of conflicts of interest			Attached	Note
1.2.	Minutes of the meeting held on 13 May 2025			Attached	Approve
1.3.	Matters arising and actions log			Attached	Note
<b>2.0</b>	<b>Questions from members of the public</b>	13:05	Chair	Verbal	Note
<b>3.0</b>	<b>ICB operating model update</b>	13:20	Sarah See	Verbal	Note
<b>4.0</b>	<b>Dental Update 2024/25</b>	13:25	Jeremy Wallman	Attached	Note
<b>5.0</b>	<b>Operating plan submission detailed action plan to NHSE</b>	13:35	Dan Hodgson	Attached	Note
<b>6.0</b>	<b>APMS Strategic Commissioning Intentions</b>	13:45	Benjamin Smith		
6.1.	- Lucus Avenue (Newham)			Attached	Approve
6.2.	- Loxford (Redbridge)			Attached	Approve
6.3.	- Newham Transitional (Newham)			Attached	Approve
<b>7.0</b>	<b>GP Contract changes implementation</b>	13:55	Dan Hodgson	Verbal	Note
<b>8.0</b>	<b>Primary care finance report</b>	14:00	Rob Dickenson	Attached	Note
<b>9.0</b>	<b>Primary care risk report</b>	14:05	Daniel Hodgson	Attached	Note
<b>10.0</b>	<b>Any other business</b>	14:10	Chair	Verbal	Note
<b>Items for information only</b>					
<b>11.0</b>	<b>GP contracts update report</b>			Attached	Info only
<b>Date of next meeting: 9 September 2025</b>					

- Declared Interests as at 24/06/2025

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 Commissioning	Primary care contracts sub-committee	Indirect Interest	Northamptonshire NHS Foundation Trust	Sister is Mental Health Practitioner	2022-01-08	ONGOING	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	GP Practice in Waltham Forest	Registered patient	0097-06-01	ONGOING	
Benjamin Molyneux	Associate Medical Director, NHS North East London	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	ONGOING	
			Financial Interest	Princess Alexandra Hospital Trust	Non-executive director of the Trust	0202-03-10	ONGOING	
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 Collaborative sub-committee Primary care contracts sub-committee	Non-Financial Professional Interest	Royal College of Nursing (RCN)	Professional membership	2020-01-01	ONGOING	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Group B Strep Support (GBSS)	Director and Trustee	2020-01-01	ONGOING	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Royal College of Midwives (RCM)	Professional membership	1994-01-01	ONGOING	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Nursing & Midwifery Council (NMC)	Professional membership	1992-01-01	ONGOING	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Homerton Hospital	Midwife (honorary contract)	2015-01-01	ONGOING	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Clinical Senate	Member	2017-01-01	ONGOING	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	ONGOING	

			Non-Financial Professional Interest	British Medical Association	I am a member of the organisation.	2022-07-01	ONGOING	
			Non-Financial Professional Interest	Royal College of Psychiatrists	Fellow of the College	2022-07-01	ONGOING	
			Non-Financial Professional Interest	Medical Defence Union	Member	2022-07-01	ONGOING	
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 Collaborative sub-committee Primary care contracts sub-committee	Non-Financial Professional Interest	General Medical Council	Member	2022-07-01	ONGOING	
			Non-Financial Personal Interest	Stonewall	Member	2022-07-01	ONGOING	
			Non-Financial Personal Interest	National Opera Studio	Trustee on the Board	2023-08-01	ONGOING	
			Non-Financial Professional Interest	University of East London	Health Fellowship	2024-10-01	ONGOING	
			Non-Financial Professional Interest	Greater London Authority	Appointed to the Mayoral Cultural Leadership Board	2025-02-27	ONGOING	
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	ONGOING	
			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	ONGOING	
			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	2016-12-21	ONGOING	

					provide services outside the NHS GOS contract.			
			Non-Financial Personal Interest	Primary Care Optometrist	I am a practicing optometrist in primary care in the NE London area.	2002-04-01	ONGOING	
			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	ONGOING	
			Sponsorship	Merck Sharp Dohme	Gave a talk on : Vaccine Confidence in Ethnic Minority Communities: A Discussion' to MSD staff as part of MSD Black History Month activities, by request of the MSD diversity and inclusion group. The webinar took place on 19 October 2022. Payment was £840 for the 60 minute session. I took half a day annual leave in order to do this.	2022-10-19	2022-10-19	
			Sponsorship	PM Healthcare	I contributed to a High Cost Medicines Optimisation Group educational event (webinar) for pharmacy professionals on 18 January 2023.	2023-01-18	2023-01-18	

					<p>The webinar was produced by PM Healthcare, and sponsored by Abbvie. I had no conversations with Abbvie. Title of my session was 'Managing the immunotherapy/specialist medicines interface as patients move from secondary to primary care'. I also sat on a panel discussion/Q&amp;A with other speakers from the NHS. Payment for my time was £1000. I booked AL for this.</p>			
Raliat Onatade	Chief Pharmacist and Director of Medicines and Pharmacy	Clinical Advisory Group Pharmacy Provider Group Primary care contracts sub-committee	Indirect Interest	Roche	<p>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</p>	2002-10-24	0202-11-15	

					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).			
			Sponsorship	PM Healthcare	I was a member of a panel with three other ICB Chief Pharmacists - title of the discussion was 'Driving Successful Market Entry in the Modern NHS'. Attendees were pharmaceutical industry Market Access Executives (several different companies), looking for insights as to the best way to engage with ICBs, the role of pharmacy teams, and barriers and enablers to collaboration. The meeting was hosted by PM Healthcare. Honoraria offered was £500 and I attended in my own time (evening).	2024-08-21	2024-08-21	
			Financial Interest	PM Healthcare	Invited to take part in a panel discussion at a forum on 18/09/24 - ICB/ICS Development and Medicines Strategy Forum, hosted by PM Healthcare. Also on the panel will be two other ICB Chief Pharmacists. Topic for discussion is 'Progress to date	2024-09-17	2024-12-31	

					in ICB Pharmacy and the challenges ahead'. Audience is NHS staff, mainly pharmacy and medicines optimisation colleagues. Some sessions on the day are sponsored by pharma (not the panel I will be on). Honorarium offered is Â£250. I would have attended this forum even if I were not on a panel, but I have booked annual leave.			
			Financial Interest	General Pharmaceutical Council	As from 1 April 2025, I have taken up post as a member of Council of the pharmacy professional regulator. This is a paid role. The appointment is for a three-year term in the first instance.	2025-04-01	ONGOING	
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	ONGOING	Declarations to be made at the beginning of meetings
			Indirect Interest	Old Church Surgery (Chingford)	Niece works for GP practice	2022-06-05	ONGOING	Declarations to be made at the beginning of meetings

- Nil Interests Declared as of 24/06/2025

Name	Position/Relationship with ICB	Committees	Declared Interest
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.
Abdul Rawkib	Senior Primary Care Commissioning Manager	Primary care contracts sub-committee	Indicated No Conflicts To Declare.

Rob Dickenson	Deputy Director of Finance - Primary Care and London Services	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.
Daniele Serdoz	Assistant director of Primary care for Londonwide LMCs	Primary Care Collaborative sub-committee Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Daniel Hodgson	Head of Primary Care partnership Development	Primary Care Collaborative sub-committee Primary care contracts sub-committee	Indicated No Conflicts To Declare.
William Dawson	Primary Care Independent clinician	Primary care contracts sub-committee	Indicated No Conflicts To Declare.

**DRAFT**  
**Minutes of the Primary Care Contracts Sub-Committee**  
**Held on 13 May 2025; 13:00-14:00;**  
**via MS Teams**

<b>Members:</b>	
Dr William Dawson (WD)	Primary Care Independent Clinician - Chair
Amy Wilkinson (AW)	Hackney Place Director, representing NEL Place Based Partnerships
Dr Paul Gilluley (PG)	Chief Medical Officer, NHS NEL
Sarah See (SSe)	Managing Director of Primary Care, NHS NEL
Robert Nicholls (RN)	Director of Nursing & Safeguarding - For Diane Jones
Rob Dickenson (RD)	Deputy Director of Finance – Primary Care and London Services, NHS NEL – For Henry Black
<b>Attendees:</b>	
Daniele Serdoz (DS)	Assistant Director of Primary Care, Londonwide LMC
Jignasa Joshi (JJ)	NEL Integrated Care System Optometry Lead
Tam Bekele (TB)	East London and City Local Dental Committee
Dalveer Johal (DJ)	Chief Operating Officer, Community Pharmacy NEL
Alison Goodlad (AG)	Deputy Director of Primary Care, NHS NEL
William Cunningham-Davis (WCD)	Director of Primary Care Delivery, NHS NEL
Anthony Curtis (AC)	Senior Primary Care Commissioning Manager, NHS NEL
Benjamin Smith (BS)	Senior Primary Care Commissioning Manager, NHS NEL
Gohar Choudhury (GC)	Head of Primary Care Commissioning, NHS NEL
Jeremy Wallman (JW)	Head of Primary Care Commissioning, Dentistry, Optometry and Pharmacy
Daniel Hodgson (DH)	Head of Primary Care Partnership Development, NHS NEL
Keeley Chaplin (KC)	Governance Systems Lead, NHS NEL (minutes)
Kelly Nizzer (KN)	Regional Lead, Primary Care Dentistry/Optometry – item 3
<b>Apologies:</b>	
Henry Black (HB)	Chief Finance and Performance Officer, NHS NEL
Ahmet Koray (AK)	Director of Finance, NHS NEL
Ben Molyneux (BM)	Associate Medical Director for Primary Care, NHS NEL
Diane Jones (DJ)	Chief Nursing Officer, NHS NEL
Dr Asif Imran (AI)	BDH Local Medical Committee

Item No.	Item title	Action
<b>1.0</b>	<b>Welcome, introductions and apologies</b>	
	<p>The Chair welcomed everyone to the meeting.</p> <p>Apologies were noted as above.</p> <p>On behalf of the members, the Chair announced the retirement of Tony Curtis and thanked him for his valued contributions to primary care during his career including writing many reports and being responsible for overseeing many changes such as procuring new practices, mergers and dispersals.</p>	

1.1	<p><b>Declaration of conflicts of interest</b></p> <p>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.</p> <p>No additional conflicts were declared.</p> <p>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.</p>	
	<p><u>Vice Chair</u></p> <p>It was proposed that Sarah See will take up the Vice Chair role. The sub-committee agreed without any objection.</p>	
1.2	<p><b>Minutes of the meetings held on 18 March 2025 and 9 April 2025</b></p> <p>The minutes of the meeting held on 18 March 2025, and the minutes of the extraordinary meeting held on 9 April 2025 were accepted as accurate records.</p>	
1.3	<p><b>Matters arising/action log</b></p> <p>Members agreed to close all completed actions except for:</p> <p>ACT015: Translation and Interpreting services for Optometry – JW clarified that the process remains the same and practices can engage an interpreter of their choice and seek reimbursement. However there are anomalies in the payment process for the different contract groups and that clear communications will be developed and sent out. This action will remain open.</p> <p>ACT013: The update is on the agenda and action can be closed.</p>	
<b>2.0</b>	<p><b>Questions from members of the public</b></p> <p>There were no questions submitted by members of the public.</p>	
<b>3.0</b>	<p><b>Dental Update 2024/25</b></p> <p>JW provided sub-committee members with an update on primary, secondary, community and specialist dentistry performance based on month 12 data (Q4 Acute secondary care data):</p> <ul style="list-style-type: none"> <li>• NHS North East London (NEL) is performing well with a forecast of just under 98% for 2024-2025. Additional investment and a new patient premium both contributed to the positive performance in dental services.</li> <li>• There is very little clawback potential due to the high level of commissioned activity delivery by contractors.</li> <li>• There will be proposals around additional activity for providers in the upcoming year, aiming to maintain and improve performance levels.</li> <li>• NHS NEL remains top in London and all London ICBs are performing higher than national.</li> <li>• There will be more detail on secondary care activity in the next meeting's report.</li> </ul> <p>The primary care contracts sub-committee <b>noted</b> the contents of the report.</p>	

	<p><u>2025/26 Dental commissioning proposal</u></p> <p>JW and Kelly Nizzer (KN) discussed proposals for reinvesting in dental activity over three years (on a 2+1 basis) aiming to maintain the current level of access and improve dental services across London.</p> <ul style="list-style-type: none"> <li>• London has gone beyond the operating plan target to return to pre-pandemic levels. Procurement rules preclude us from investing permanently.</li> <li>• An oral health needs assessment undertaken by Public Health colleagues may be able to identify areas of highest need to target investment.</li> <li>• The proposal touches on operating plan targets but also relate to urgent care. As performance is high, London ICBs are not required to commission any more urgent dental care so these funds can be made available to commission additional general dental access.</li> <li>• The criteria for funding will mean practices must meet certain conditions such as meeting targets and demonstrating capacity to deliver additional services. Funding may not be made available until August or September once the criteria has been checked and signed off.</li> <li>• There is a need to address orthodontic waiting times and a report proposing a primary care waiting list initiative will be presented to the next meeting.</li> </ul> <p>Members <b>endorsed</b> the approach to commissioning additional dental activity (non-recurrently under a 2+1 agreement) during 2025/26 and potential to allocate resource on orthodontic waiting lists.</p>	
<p><b>4.0</b></p>	<p><b>Ecclesbourne Practice Remedial Notice (Waltham Forest)</b></p>	
	<p>Benjamin Smith (BS) provided an update on the practice:</p> <ul style="list-style-type: none"> <li>• The sub-committee had approved a remedial notice to be sent to the practice, which has two sites, in January due to a CQC rating of 'requires improvement' and 'inadequate' in the safety domain. The practice had until 1 March to complete a final submission and this was reviewed by subject matter experts.</li> <li>• Despite some improvements made, all the requirements of the notice were not satisfied and the recommendation is to award a further remedial notice.</li> <li>• ICB officers will meet with the practice each month until their next submission date of 31 July to address outstanding issues and improve patient safety.</li> </ul> <p>The sub-committee raised the following key points:</p> <ul style="list-style-type: none"> <li>• The LMC raised concerns about the ICB's process and delays in responding to queries raised by the practice such as the method of sharing evidence. The LMC did not support the issuance of a further remedial notice.</li> <li>• There is a commitment to patients to ensure the practice is safe and that safety can be clearly demonstrated.</li> <li>• There is a collaborative approach to support the practice in meeting the required standards.</li> </ul> <p><b>Action:</b> It was agreed that a learning session will be held to review the process and communication issues for both commissioner and the practice to review what went well and what improvements can be made.</p>	<p>PC Team</p>

	The primary care contracts sub-committee <b>approved</b> the awarding of a further Remedial Notice to Ecclesbourne Practice.	
<b>5.0</b>	<b>Primary Care Finance Report</b>	
	<p>RD presented the finance report, noting a year-end overspend of £9.1m, primarily due to prescribing costs. Other key areas highlighted were:</p> <ul style="list-style-type: none"> <li>• The largest area of overspend was prescribing, with a reported figure of £13.8m, driven by increasing trends towards the end of the year.</li> <li>• NHS England provided substantial non-recurrent allocations at year-end to support ICBs with reported pressures, including prescribing costs.</li> <li>• The delegated primary care position has an overspend of £2.1m, mainly relating to premises reimbursements, exceeding trends and expected uplifts.</li> <li>• The final Operating Plan has been submitted to NHSE and now waiting for this to be signed off. The budget setting process for 2025/26 is being finalised.</li> </ul> <p>The primary care contracts sub-committee <b>noted</b> the report.</p>	
<b>6.0</b>	<b>Any other business</b>	
6.1	Model ICB Blueprint	
	<p>SSE provided an overview of the model ICB blueprint, recently published. It proposes primary care contracting will remain with the ICB but shift primary care transformation to a neighbourhood provider.</p> <p>The ICB has until the end May 2025 to respond with costed proposals for the implementation of the blueprint, and there will be ongoing work to define the future model for the current directorate. It is not yet clear how long it will take to transition to a provider model.</p> <p><b>Action:</b> KC to circulate the published model ICB blueprint to members.</p> <p>The primary care contracts sub-committee <b>noted</b> the verbal update.</p>	KC
<b>7.0</b>	<b>Items for information only</b>	
7.1	Primary care risk report	
	Presented for information only.	
	<b>Date of next meeting – 8 July 2025</b>	

Primary Care Contracts Sub-Committee – Actions Log

OPEN ACTIONS					
Action ref:	Date of meeting	Action required	Lead	When	Status
ACT015	09/04/25	<p><b>3.0 Translation and Interpretation service for general practice</b> SSE to discuss translation service provision for community DOPs with Jeremy Wallman</p> <p><b>Update 05/25:</b> JW clarified that the process remains the same and practices can engage an interpreter of their choice and seek reimbursement. However there are anomalies in the payment process for the different contract groups and that clear communications will be developed and sent out. This action will remain open.</p>	SSE	<p><del>05/25</del></p> <p>07/25</p>	Action completed: SSE confirmed with JW that DOPs have access to translation and interpretation service. JW will arrange reminder communications of the available services to community DOPs including the LOC and LDC.
ACT016	13/05/25	<p><b>Ecclesbourne Practice Remedial Notice (Waltham Forest)</b> It was agreed that a learning session will be held to review the process and communication issues for both commissioner and the practice to review what went well and what improvements can be made</p>	Primary care team	09/25	Submission due in July 2025 after which the learning event can be held.
ACT017	13/05/25	<p><b>Model ICB Blueprint</b> Circulate the published model ICB blueprint to members.</p>	KC	07/25	Circulated 14/5 and action completed. <b>Request to close</b>

## Primary Care Contracts sub-committee

8 July 2025

<b>Title of report</b>	<b>Dental Update 2024/25</b> M12b Primary Care/Q4 Acute Secondary Care including 2025/26 Dental commissioning proposals
<b>Author</b>	Jeremy Wallman, Head of Primary Care Commissioning, Dentistry, Optometry and Pharmacy Andrew Biggadike, Regional Lead, Acute and Specialised Dental Contracts
<b>Presented by</b>	Jeremy Wallman, Head of Primary Care Commissioning, Dentistry, Optometry and Pharmacy
<b>Contact for further information</b>	<a href="mailto:jeremy.wallman@nhs.net">jeremy.wallman@nhs.net</a>
<b>Executive summary</b>	Summary of the key points/messages in the report.
<b>Action / recommendation</b>	The primary care contracts sub-committee is asked to note the contents of the report.
<b>Previous reporting</b>	Commissioning Oversight Group (COG)
<b>Next steps/ onward reporting</b>	FPIC
<b>Conflicts of interest</b>	None
<b>Strategic fit</b>	To enhance productivity and value for money
<b>Impact on local people, health inequalities and sustainability</b>	To improve and stabilise the oral health of patients treated. To extend and increase the availability of NHS dentistry.
<b>Impact on finance, performance and quality</b>	As detailed in the report
<b>Risks</b>	Ongoing Risks, identified in the report. Under delivery of Primary Care contracts previously referenced

# Primary, Secondary, Community and Specialist Dentistry NEL ICB Update 2024/25 - M12/Q4

## General Update

The provisional 2024/25-year end data demonstrate an exceptional high level of performance against primary care (GDS) contracted levels of activity and across London this translates into just under a 2.5% increase on the 2023/24 delivery. The GDS contract delivery across NEL GDS during 2023/24 came in at 96.5% which was a considerable achievement, however this has been surpassed in 2024/25 with a provisional delivery figure of 98.1%. Therefore, from a value for money perspective, the ICB can demonstrate that it is getting an excellent return in respect of the level of activity delivered in comparison to the amount that has been commissioned. This ultimately results in a very low value in respect of resource to be clawed back in respect of underperformance.

Whilst London is the best performing region in England, it is worth noting that NEL's performance has been enhanced by the commissioning of additional activity in the past two years, which has been supplemented by the New Patient Premium (NPP). The combination of these factors contributes significantly to the sustained and improved delivery of dental activity across the ICB and for this to be maintained, additional activity is being implemented again, particularly given that the NPP has been discontinued which removes some of the incentive associated with seeing new patients. New patients are key to driving up activity for dental practices with NHS contracts which has the associated benefit to the ICB of reducing the number of complaints received from residents having trouble in accessing NHS dental care.

Investing in additional primary care dental activity increases access to routine care for patients. Due to the way the GDS contract works, many providers are delivering on their existing contracted activity and without additional investment they will simply decline to see new patients on the basis they will not be paid to do so. The knock-on impact is that patients will seek care elsewhere and whilst there is a comprehensive urgent care offer service in place across London, this does not prevent patients seeking help via general practice both in and out of hours or accident and emergency departments, none of which are suitable for dealing with dental problems. This represents additional cost to the system and exacerbates waiting times needlessly.

ICB	Contracted UDAs	UDA Delivered to date	UDA % Delivery	24/25 Expected UDA delivery based on M12b data	2023/24 Actual Delivery %
				FOT	
				FYE	
North-Central London	1,897,137	1,853,794	97.7%	97.7%	93.8%
<b>North-East London</b>	<b>2,421,373</b>	<b>2,375,659</b>	<b>98.1%</b>	<b>98.1%</b>	<b>96.5%</b>
North-West London	3,086,086	3,041,745	98.6%	98.6%	96.3%
South-East London	2,704,286	2,636,488	97.5%	97.5%	94.3%
South-West London	1,810,421	1,727,806	95.4%	95.4%	95.2%
<b>London Wide</b>	<b>11,919,303</b>	<b>11,635,494</b>	<b>97.62%</b>	<b>97.62%</b>	<b>95.23%</b>

There are significant waiting lists for orthodontic patients (a national issue), partly driven by the pandemic but mainly due to a lack of funding and increased demand. The ICBs have been presented with a report, (summarised version attached as Appendix 1) on the current service provision and various options for investment. It is not expected that any significant funding will be available to address the backlog of case starts, but list validation would provide a true picture of the funding deficit.

Challenges in the paediatric pathway remain with no reduction in the volume of referrals. The new referral form is currently being tested by CLCH and Whittington CDS prior to regional roll out. All stakeholders have been included in the creation of the new form and now significant issues are anticipated.

Barts remains an outlier for patients waiting over 52 weeks and is in a challenging position for all dental specialties. However, there is consistent sustained improvement over the last nine months and there are various initiatives in place to continue this trajectory.

Discussions have begun with East of England on the volume of paediatric patients referred into London. Through the MCNs, other dental specialties will be tackled, but this will be a long process.

The Direct Award C process under the Provider Selection Regime (PSR) for L2 Endodontics is on hold, a competitive procurement now seems likely. A request to extend Intermediate Minor Oral Surgery (IMOS) will be presented to the ICB with a plan to procure competitively thereafter. Community Dental Services will be extended under Direct Award C once approved by ICBs. These extensions are cost neutral.

## Barts Health

The sustained reduction in patients waiting over 65 weeks has slowed. While the number of patients waiting over 65 weeks has not changed in the last quarter, the Trust has suggested that an improvement will be seen in the next quarter. It should be noted the overall number of patients on the PTL is decreasing significantly; 15,225 in January, 14,710 in February and 14,150 in March

Barts are delivering additional Saturday lists for Oral Surgery and long waiters are being transferred to Homerton.

204 patients waiting over 65 weeks, of which 57 do not have an appointment booked. The Trust is particularly affected by workforce shortages, lack of access to theatres and possibly lower productivity that comparable trusts.

- **Oral Surgery**, 115 patients waiting over 65 weeks of which 77% have an appointment booked. Oral surgery remains challenging specialty, but Barts has done much work to improve their position.
- **Restorative**, 15 patients over 65 weeks the majority of which are special care and therefore more complex. 7 of the 15 have an appointment booked. The ICB granted funding for consultant led triage for Level 2 Complexity Endodontic Services will shortly be implemented.
- **Paediatric**, 35 patients waiting over 65 weeks of which 48% have an appointment booked.
- **Orthodontic**, 11 patients over 65 weeks of which 9 have an appointment booked.
- **Dental Medicine**, 26 patients waiting over 65 weeks, all but 1 with appointments booked. Significant workforce issues in this specialty and similar issues at UCLH
- **Maxillofacial**, 2 patients over 65 weeks without appointments booked. Some maxillofacial patients will be sitting under the oral surgery PTL.

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	47	43	60	43	62	33
	Non-admitted	290	73	342	75	275	82
Restorative	Admitted	22	8	18	7	14	7
	Non-admitted	71	6	91	8	103	8
Paediatric	Admitted	83	34	82	35	60	32
	Non-admitted	23	3	23	3	15	3
Orthodontic	Admitted	7	3	7	2	5	4
	Non-admitted	20	1	32	3	36	7
Dental Medicine	Admitted	0	0	0	0	0	0
	Non-admitted	303	36	224	28	205	26
Maxillofacial	Admitted	2	2	4	1	4	2
	Non-admitted	6	0	15	0	9	0
Sub-Total		874	209	898	205	788	204
Total		1,083		1,103		992	

## Barking, Havering & Redbridge University Trust

Zero patients waiting over 65 weeks.

- **Orthodontic**, 1 patient over 52 weeks without appointment booked. 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 East of England.
- **Maxillofacial**, 11 patients waiting over 52 weeks, 5 of which have appointments 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	0	0	0	0	0	0
	Non-admitted	18	1	16	1	9	1
Maxillofacial	Admitted	34	2	44	2	36	6
	Non-admitted	22	2	19	6	15	5
Sub-Total		74	5	79	9	60	12
Total		79		88		72	

## Homerton University Hospital

Zero patients waiting over 65 weeks. Trust is assisting Barts with long waiting oral surgery patients which are coded under Maxfax. While the number of patients waiting over 52 weeks is decreasing, it should be noted the overall number of patients on the PTL is increasing.

- **Maxillofacial**, 4 patients waiting over 52 weeks with appointments booked. Trust faces challenges with increasing referral numbers and the inability to match the overtime payments made by competing trusts.
- **Paediatric Maxillofacial**, zero patients over 52 weeks, all patients over 41 weeks have 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	112	8	116	10	128	4
	Non-admitted	29	0	12	0	10	0
Paediatric Maxillofacial	Admitted	10	0	7	1	19	0
	Non-admitted	0	0	0	0	0	0
Sub-Total		151	8	135	11	157	0
Total		159		146		161	

# ICB Secondary Dental Patient Flows - Provider Landing

View Point: Host Provider

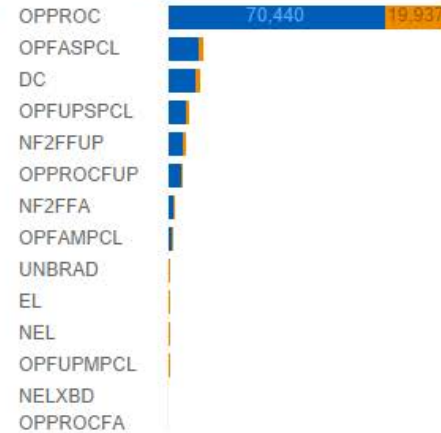


The map below displays Activity levels for NHS North East London Integrated Care Board providers, where patients accessing services within the ICB but are registered to a GP Practice outside of the ICB.

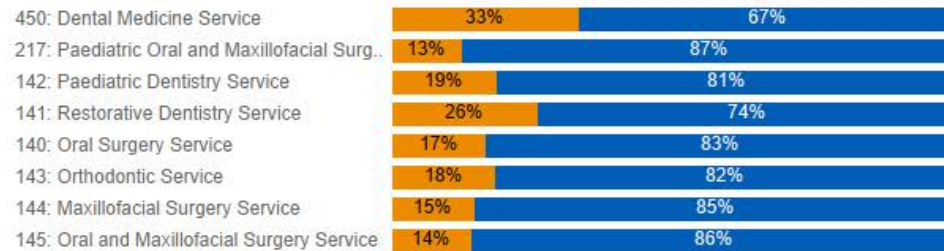
Total Provider flow for NHS North East London Integrated Care Board: All



## Attendance Type Summary



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



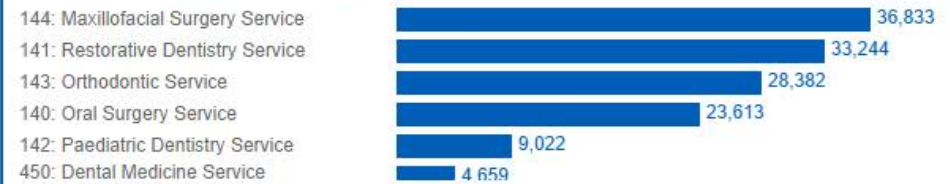
Out of Area In Area

## Provider Summary

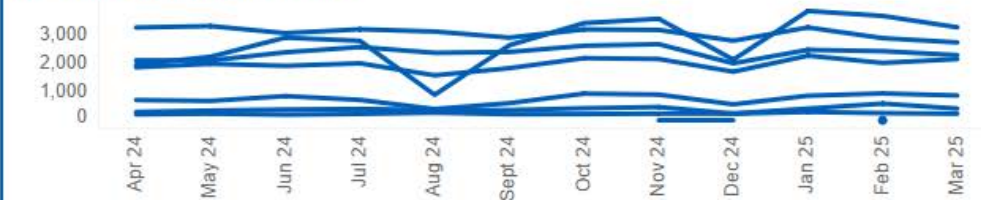


## Treatment Function Code (TFC) for all Activity

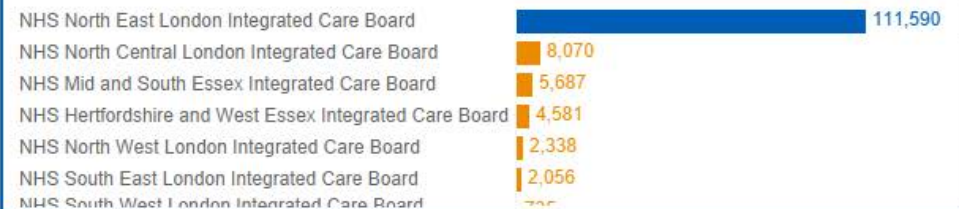
Select a TFC to highlight the monthly trend below



## TFC Monthly Trend for all Activity



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



- 76,865 NEL patient attendances at Barts, 18,608 NEL patient attendances at BHRUT, 16,117 NEL patient attendances at Homerton 11,590 in total
- 8,070 attendances for NCL patients
- 5,687 attendances for Mid and South Essex patients
- 4,581 attendances for Hertfordshire and West Essex
- Total of 26,983 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

**146,782**

Total Activity within the NHS North East London Integrated Care Board

**111,590**

Total Activity for patients from the NHS North East London Integrated Care Board, treated in other ICB's

**35,192**

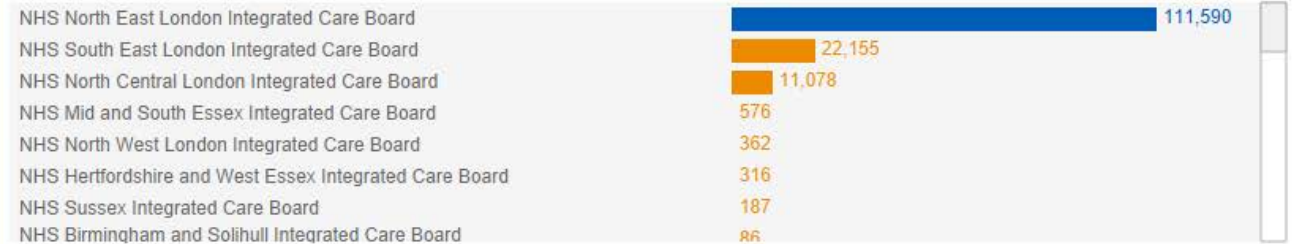
Percentage of activity within the NHS North East London Integrated Care Board



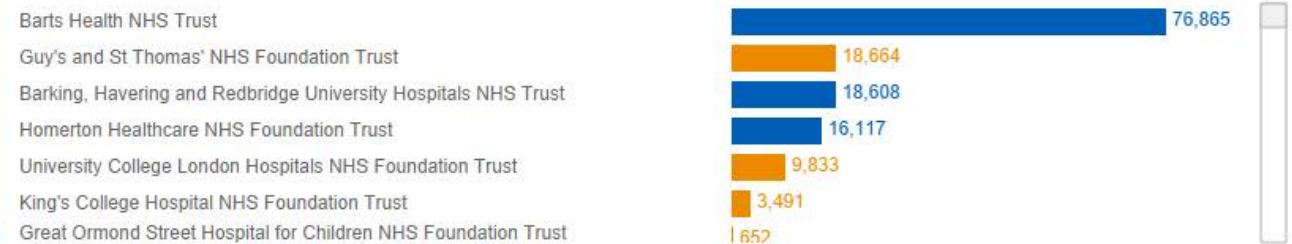
Breakdown of activity for the NHS North East London Integrated Care Board ICB to show patient flow where activity is not undertaken within the ICB's geographical footprint



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



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



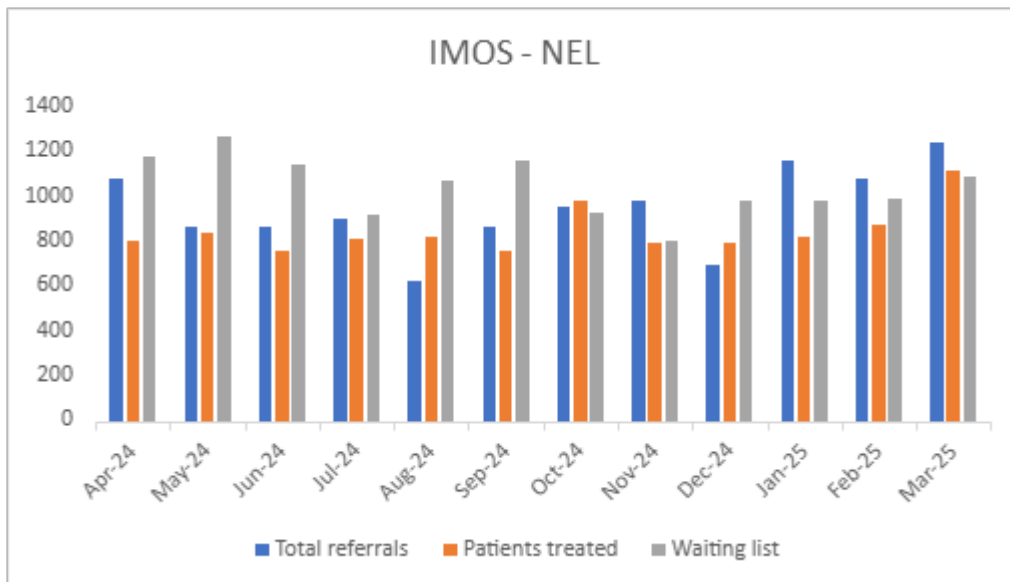
- 146,782 attendances for NEL patients
- 111,590 of which delivered in ICB (76%)
- 35,192 delivered in alternative ICBs (24%)

## **Community Dental Services**

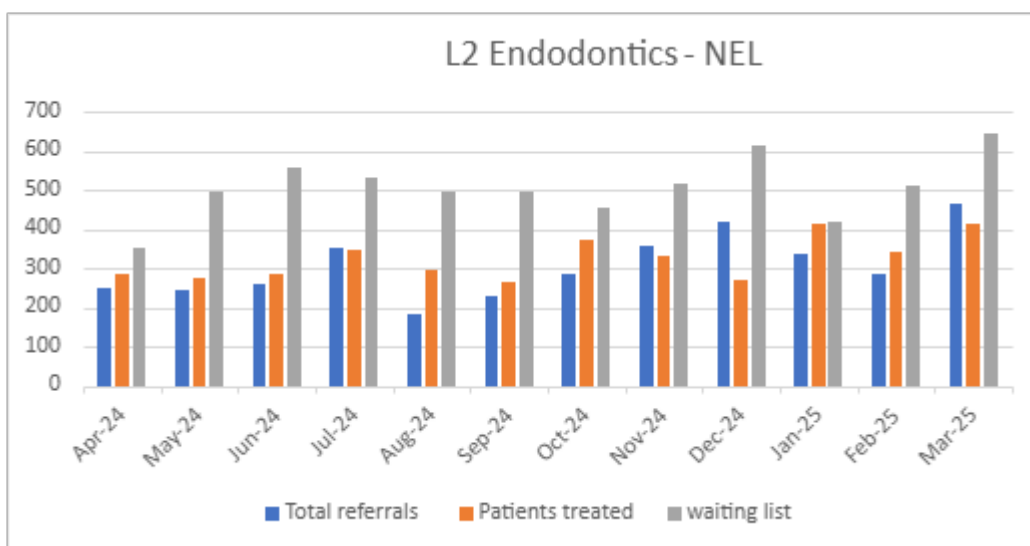
- CDS serves the following patient groups, paediatric, special care, elderly and rough sleeping homeless it also provides oral health promotion (OHP) on behalf of the local authorities that commission it.
- Number of referrals increasing, particularly paediatric.
- Kent Community Health (NEL CDS provider) has reduced average waiting time from referral to appointment to only 12 weeks, this is a significant achievement.
- **Paediatrics** - referrals into CDS are 40% higher than pre-pandemic levels, this is driven in part by a deterioration in the oral health of the population due to the pandemic. It would also indicate that children are able to access primary care dentistry due to the strong recovery of primary care services in London and the continued commitment of the ICBs to increase access in primary care. To combat the increase in referrals and prevent onwards referrals to secondary care oral health promotion is a focus for local authorities and the DOP team is liaising with them and CDS providers.
- **Special care** - referral volumes are increasing after a significant reduction during and immediately after the pandemic. A new IV sedation drug, remimazolam, is being trialed in various settings and with its shorter recovery time creates the possibility of increased capacity. Public Health working on a needs assessment to review the demands of this patient cohort
- **Elderly** - care and nursing home residents' oral health needs have evolved since the creation of domiciliary services which are no longer the most suitable method of treatment. National review of domiciliary due to start shortly with a local review already underway.
- **Rough sleeping homeless** numbers have increased, and the location of rough sleepers has changed since the procurement of CDS. DOP team is working with local authorities and advocates to review need and service provision.
- **Supervised Tooth Brushing** funding and equipment has been provided and the additional provision should commence at the start of the new academic year.

## Intermediate Oral Surgery Services and Level 2 Complexity Endodontics

- To increase workforce we have worked 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 accreditations 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.
- Approval of funding for consultant led triage (part of the patient pathway) will reduce waiting times for patients and providers, improving treatment outcomes
- Work on extension of L2 Endodontic contracts using the Provider Selection Regime



Current waiting list for NEL ICB IMOS providers 1,086. As a service, IMOS is well balanced.



Current waiting list for NEL ICB L2 Endo providers 645. As a service, L2 Endo is well balanced.

## London Region Orthodontic Report

This report was written by the London Region Dentistry, Pharmacy & Optometry Commissioning Hub, in collaboration with the London Region Orthodontic Managed Clinical Network, the Local Dental Network Chair and Consultants in Dental Public Health.

NHS orthodontic treatment is an additional service commissioned using the Personal Dental Services (PDS) Agreement contract platform. All dental services commissioned using the PDS contract are for a defined term, unlike mandatory services which are commissioned using the General Dental Services platform and are contracts in perpetuity.

The commissioning and delivery of NHS orthodontics is directed by the commissioning guide and clinical standard documents.

[guid-comms-orthodontics.pdf](#)

[B2015-Clinical-standard-for-dental-specialties-orthodontics-version-2-21-June-2023.pdf](#)

Following a competitive procurement, new orthodontic contracts were issued to London providers on 01/10/2019. The contract duration is ten years with a break clause at seven years.

Some existing providers were successful in bidding for new contracts while others were not. Those unsuccessful existing providers ceased to deliver NHS orthodontics once they had completed their cohort of existing patients.

It should be noted that the procurement was very challenging, and in many other regions it was abandoned, despite the national directive. London was successful in the delivery of the procurement, but this was not without a significant negative impact to the team and the providers involved.

There is insufficient funding to meet the dental needs of the population and this applies to orthodontics too. There is no workforce shortage for orthodontics. There are long waiting lists across the country and patient dissatisfaction is increasing. Excessive waiting times have a negative impact on the delivery and efficacy of treatment.

## Assessing Orthodontic Need

There are three main elements to assessing Orthodontic treatment need:

- Normative need – the professionally-judged need in a population cohort using a standardised clinical index, such as IOTN. This represents the capacity to benefit from healthcare.
- Expressed need – patients with need presenting for treatment.
- Demand (felt need) – a patient’s perception of need. This is generally a poor proxy for need and often reflects supply and other social factors.

Undertaking population orthodontic needs assessment and reviewing existing service provision as a minimum, should include:

- the orthodontic needs of the local population
- and if population projections alter, this needs assessment will require revision
- audit of current providers and their service and contract delivery performance
- assessment of whether local Orthodontic services are sufficient to serve the population and are currently in the right locations

The population representative sample indicated that the prevalence of orthodontic clinical need is between 30.5% and 33% of the population.

There are a number of methods for assessing need; however, published studies and surveys have consistently reported that around one third of children, in any given population, will need and want Orthodontic treatment. Demand is rising as the health and expectations of the population improve.

Based on population need estimated for the orthodontic procurement, the table below shows the shortfall in commissioned activity. Commissioned activity could not meet need due to funding limitations. Population increases during the intervening eight years will have increased this shortfall.

ICB	CoT Need	UOA Need	CoT Commissioned	UOAs Commissioned	CoT Difference	UOA Difference	%	Value
NCL	5,973	125,433	5,426	113,936	-547	-11,497	91%	-£852,503
NEL	8,287	174,027	8,009	168,196	-278	-5,831	97%	-£432,369
NWL	8,009	168,189	7,226	151,745	-783	-16,444	90%	-£1,219,323
SEL	6,848	143,808	6,252	131,288	-596	-12,520	91%	-£928,358
SWL	5,861	123,081	5,394	113,276	-467	-9,805	92%	-£727,041
<b>Total</b>	<b>34,978</b>	<b>734,538</b>	<b>32,307</b>	<b>678,441</b>	<b>-2,671</b>	<b>-56,097</b>	<b>92%</b>	<b>-£4,159,593</b>

The figures in this table are based on all UOAs discharged for CoTs. Not all UOAs will be utilised for CoTs, some will be discharged for assessments.

The CoTs and corresponding UOAs commissioned do not match the values in the previous table as they include UOAs commissioned in GDS blended contracts, those are mandatory services contracts with a small number of UOAs.

## Options

It is accepted that there is not currently sufficient funding within dental budgets to address the shortfall in commissioned activity and that ICBs have multiple patient groups requiring additional capacity.

Insufficient dental budgets is a national problem and should be addressed at a national level, including orthodontic provision. We are unaware of any review of orthodontic capacity at a national level.

Before this matter could be raised at a higher level, current and robust data is required. Historically, waiting list information is not collected for primary care dental services, however, for our Level 2 Complexity Oral Surgery and Endodontic services (delivered in primary care) this has been submitted by providers for some time.

In September 2024, a waiting list snapshot was taken for orthodontics, unfortunately, not all providers completed the survey, therefore, the figures used to estimate backlogs and need are lower than actual. A monthly data collection tool will be mobilised by the end of April. This will provide accurate data and enable further insight for the challenges faced and evidence of the impact any additional funding would have on the service.

### Potential Options

1. Commission additional capacity
2. Change of acceptance criteria
3. Review of waiting lists

#### 1. Commission Additional Capacity

The request from providers and patients is to increase capacity but the funding required to do this with any meaningful impact is not available. With over 16,000 patients assessed and waiting for their treatment to start, the collective cost would be £24m.

With an additional 60,000 patients waiting for an assessment, if only half of these patients met the acceptance criteria (a very conservative percentage), the collective cost would be £47m.

With 75,000 referrals received per year against a commissioned CoTs of 32,307, the waiting lists can only increase.

#### 2. Change of Acceptance Criteria

Whilst a change in acceptance criteria could not be applied retrospectively, it could reduce the volume of patients referred in the future. This would not be a popular decision with patients or parents but, if significant additional funding is never awarded, it may be necessary.

Data for the IOTN score of all patients commencing treatment in 2024/25 will be requested from the Business Services Authority and reviewed by commissioners and the Orthodontic MCN. Findings and options will be presented to the ICBs.

This would not be a quick option and the consequences of such a change should be carefully considered and discussed at a national level with appropriate stakeholders.

#### 3. Review of Waiting Lists

The September 2024 snapshot data indicates a minimum of 60,000 patients waiting for an orthodontic assessment. Without understanding the proportion of patients requiring rejection,

acceptance or onwards referral to secondary care, it is difficult to accurately establish current demand and forecast demand.

As in secondary care, an orthodontic waiting list validation exercise would establish a baseline from which costs to address the current backlog and future demand can be calculated. In addition to this, it would provide clarity to patients and enable them to make more informed choices on their future care.

A review of the waiting list would not result in an increase in case starts. This would be made clear to patients when invited for an orthodontic assessment. Once the waiting list has been validated, ICBs may choose if they wish to commit additional funding to orthodontic contracts to increase case starts.

Options 2 and 3 are recommended by the DOP Commissioning Hub.

## Waiting List Validation Method

The following proposal has been devised in collaboration with the London Orthodontic MCN, which has both orthodontic primary care providers and orthodontic consultants as its members.

Twenty minutes is sufficient to assess a patient, write notes and complete retention or discharge paperwork as appropriate.

Management of the waiting list validation will require significant administrative assistance, contacting patients, arranging appointments, processing of completed assessment outcomes and general enquiries.

There are limited consumables for an examination, however, decontamination of instruments, radiography and general wear and tear must be considered.

As this the waiting list validation sessions will not generate treatment, the activity can be decoupled from the existing UOA value and operate on a reduced value.

Item	Cost per hour	Cost per patient (3 per hour)	Cost per 4-hour session
Clinical	£120.00	£40.00	£480.00
Admin	£30.00	£10.00	£120.00
Overheads	£20.00	£6.67	£80.00
<b>Total</b>	<b>£170.00</b>	<b>£56.67</b>	<b>£680.00</b>
At UOA rate		£74.15	£889.80

A separate contract entry would be created for the submission of these assessment so activity and IOTN scores can be monitored and the success evaluated.

These assessments would be in addition to the existing assessments delivered by the service, the majority of which generate no income and form part of the overall claim for a CoT.

ICB	Referrals received per month	Referrals received per year	Patients in active treatment	Patients waiting for case start	Patient waiting for assessment	Case starts commissioned per year
NCL	1,412	16,944	13,225	7,572	8,973	5,426
NEL	1,479	17,748	12,709	2,862	21,453	8,009
NWL	1,330	15,960	14,532	1,549	8,339	7,226
SEL	1,030	12,360	15,895	5,162	14,420	6,252
SWL	1,371	16,452	8,921	1,707	7,491	5,394
<b>Total</b>	<b>6,622</b>	<b>79,464</b>	<b>65,282</b>	<b>18,852</b>	<b>60,676</b>	<b>32,307</b>

As already mentioned, the snapshot data is of limited quality and not every practice responded.

The table below gives an indication of the value of funding required to address the assessment waiting lists.

Funding	ICB Assessment Waiting List				
	NCL	NEL	NWL	SEL	SWL

	Number of patients	8,973	21,453	8,339	14,420	7,491
£500,000	8,823	98%	41%	106%	61%	118%
£400,000	7,070	79%	33%	85%	49%	94%
£300,000	5,293	59%	25%	63%	37%	71%
£200,000	3,529	39%	16%	42%	24%	47%
£150,000	2,646	29%	12%	32%	18%	35%
£100,000	1,764	20%	8%	21%	12%	24%
£50,000	882	10%	4%	11%	6%	12%

## Primary Care Contracts Sub Committee

8 July 2025

<b>Title of report</b>	Primary care operating plan – detailed action plan
<b>Author</b>	Dan Hodgson: Head of Primary Care Partnerships & Development
<b>Presented by</b>	Dan Hodgson: Head of Primary Care Partnerships & Development
<b>Contact for further information</b>	<a href="mailto:Daniel.Hodgson12@nhs.net">Daniel.Hodgson12@nhs.net</a>
<b>Executive summary</b>	<p>NHS England requires all ICBs to submit a detailed action plan for delivery of the annual operating plan (submitted in March).</p> <p>The detailed action plan sets out, for each action the ICB stated we would undertake this year:</p> <ul style="list-style-type: none"> <li>• Desired outcomes</li> <li>• Deadlines</li> <li>• Measures</li> <li>• Targets</li> <li>• Monitoring and reporting arrangements</li> <li>• Delivery confidence</li> <li>• Risks to delivery</li> <li>• Priority level (if in year review required based on changes to ICBs/funding)</li> </ul> <p>The focus is on access, digital and reducing variation – this is planned through multiple actions including contract monitoring, commissioning reviews, transformation programmes, and (across these) identifying practices as outliers across single or multiple metrics, assessing reasons for being an outlier, developing and delivering supportive interventions for improvement, and sharing learning.</p> <p>The data currently used to identify outliers comes from multiple sources, including national and local dashboards and datasets. However, we are developing our local primary care improvement dashboard to support streamlined processing – this is expected to be launched in year and further developed for future use.</p> <p>This detailed version of the action plan is held by the primary care directorate, including named leads, links to access measures, updates/comments for each action, and scheduling for oversight / monitoring / reporting. These elements will not be included in the submission to NHS England.</p>

<b>Action / recommendation</b>	For information
<b>Previous reporting</b>	<p>The action plan has been developed across multiple ICB teams, including clinical and non-clinical input, and has received informal feedback from NHS London Region.</p> <p>The action plan has been reviewed by the Primary Care Delivery Group, approved by the Commissioning Board, and submitted to NHS England.</p>
<b>Next steps/ onward reporting</b>	n/a
<b>Conflicts of interest</b>	n/a
<b>Strategic fit</b>	<ul style="list-style-type: none"> <li>• To improve outcomes in population health and healthcare</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To enhance productivity and value for money</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	Not applicable – the action plan aligns to NHS England operational planning guidance.
<b>Has an Equalities Impact Assessment been carried out?</b>	Not applicable – the action plan aligns to NHS England operational planning guidance.
<b>Impact on finance, performance and quality</b>	Not applicable – the action plan aligns with primary care SDF and other financial plans for the year.
<b>Risks</b>	<p>Risks to individual actions are outlined on the action plan.</p> <p>The overarching risk, which will be submitted via email alongside the action plan, is that ICB reorganisation might mean multiple elements of the action plan are not deliverable (ie the vast majority of the actions are dependent on having staff capacity and skills to deliver).</p> <p>The priority levels assigned to each action suggest which actions might be de-prioritised in year based on reduction to staffing – these generally align to areas where support is provided to practices (ie the ICB will be able to identify practices that are outliers in multiple metrics, potentially provide some guidance for how to improve, but may not have capacity to deliver the level of support required; practices will need to deliver the change themselves; and intervene where necessary). This broadly aligns to the model ICB blueprint and NEL ICB plans for the future.</p>

Key area of focus - operating plan March submission	Sub-focus - operating plan March submission	Action	Desired outcome	Deadline	Measure	Target	Reporting arrangements	Risks	Delivery confidence	Prioritisation level (if need to review in year based on ICB reorganisation)	
Improve general practice contract oversight, commissioning and transformation	National contracts oversight	Review of annual EDEC returns - assessment of outliers, supportive interventions for identified practices; consideration of contractual action	Full compliance with contractual requirements for all practices	end March 2026	e-Dec report confirmation of compliance	100%	Contracts SC annual report	Capacity to follow up with practices that action has been taken where appropriate	G	1	
		GMS/PMS contract reviews by exception - assessment of contractual issues and supportive interventions to resolve	Any contractual issues (including estates) resolved within appropriate timeframes	n/a	time from reporting of issue to closing of issues	within 6 months	PCDG by exception; Contracts SC annual report	Capacity of Primary Care and other relevant teams to undertake necessary reviews; access to UMF for estates issues resolution.	G	1	
		Annual APMS contract reviews	Review all APMS contracts, any issues (including estates) resolved	ongoing	proportion of APMS contracts reviewed in year;	100% APMS contracts reviewed and template reports completed	PCDG by exception; Contracts SC annual report	Capacity of Primary Care team to undertake necessary reviews; access to UMF for estates issues resolution.	A-G	1	
		Procurement of new practices	Four practices procured within appropriate timeframes - including estates strategy for each	ongoing	time from commencement to completion of procurements	within 9 months	Contracts SC	Capacity of Primary Care and other relevant teams. Risk of legal challenge. Access to UMF for estates issues resolution.	A-G	1	
	GP contract changes monitoring	Review of compliance with the requirement to have O/C during core hours from Oct - identify outliers, assess considerations, supportive interventions to identified practices	Full compliance with new contractual requirement for all practices to have o/c enabled during core hours from Oct 25.	end Oct 2025	e-Dec report confirmation of compliance PCN CAIP Plans 25/26 (Access Domain)	100%	PCDG by exception; Contracts SC annual report	Risk of non-compliance. Participation in GP/PC could help support practices to change their systems and processes so O/C can be offered during core hours in a safe way.	G	1	
		ICB oversight of contract change implementation - ensure ICB support and communication in place; assess outliers in practice implementation; supportive interventions for identified practices; consider contractual action	Implementation completed appropriately	end October 2025	Completed actions on action plan	100%	Contracts SC annual report	Capacity of Primary Care team to undertake necessary reviews	G	1	
	Local contracts oversight (including tackling unwarranted variation and minimising health inequalities)	Continue standardised contract management processes	All contracts to receive management meeting under standard process;	ongoing	At least 1 contract management meetings completed for each contract (using standardised process);	100% of contracts managed under standard process;	Contracts SC annual report	Capacity of Primary Care to undertake necessary reviews	A	1	
		Identify poorly performing contracts/providers (including outliers in performance) through standardised contract management processes, and create individual remedial action plans to address issues	Identification of poor performing suppliers/providers; Improved delivery against contractual requirements and KPIs.	ongoing	Proportion of poorly performing contracts/providers identified through standardised contract management processes with individual remedial action plan	100% of poorly performing contracts/providers with action plan (completed or in progress)	Contracts SC 6-monthly report	Capacity of Primary Care to undertake necessary reviews	A-G	1	
	Subcontracts oversight	Review of subcontracts	Ensure all subcontracts are fit for purpose and are meeting population need	end March 2026	Proportion of subcontracts reviewed; Proportion of subcontracts marked as fit for purpose	100%	Contracts as they are reviewed and contracted as per sign of governance process.	Capacity of Primary Care to undertake necessary reviews	A	3	
	Improvements to commissioning (including tackling unwarranted variation and minimising health inequalities)	Review of LES contracts/specifications; identify effective interventions to improve services, reduce unwarranted variation and minimise health inequalities; commission these uniformly across all NEL places/sub-locations	Standardised commissioning of LES' under specifications that improve outcomes, tackle unwarranted variation and minimise health inequalities.	Minimum 24 month programme, March 2026 milestones include review all existing LES to identify issues, and commence resolution; standardised LTC outcomes framework implementation.	Progress against 12 month LES review programme plan	All LES contracts/specifications reviewed with recommendations for next steps; implementation of LTC Outcomes Framework in a minimum of 5 NEL places	PCDG every other month; Contracts SC 6-monthly report; Collaborative SC 6-monthly report	Capacity of Primary Care to undertake necessary reviews	A-G	1	
		SDA model review and implementation	A single SDA framework to improve access to same day care.	ongoing	Approval of the direction of travel and commissioning intentions to align with plans.	n/a	PCDG every other month; Contracts SC 6-monthly report; Collaborative SC 6-monthly report	Capacity of Primary Care team	A	2	
		Implement learning/changes identified in CATS tool	Improvements to commissioning and transformation processes within NEL	end Dec 2025	change in level within the CATS tool based on self-assessment	n/a	Collaborative SC 6-monthly report	Chanes to ICB staffing and functions	A-G	3	
	Improvements to transformation (including tackling unwarranted variation and minimising health inequalities)	Annual Transformation plans in place and being delivered	Development of primary care and implementation into BAU	ongoing	n/a	n/a	PCDG every other month; Collaborative SC 6-monthly report	Chanes to ICB staffing and functions	A-G	2	
		Development of Primary Care 10 Year Transformation Delivery Plan	Single strategic direction for primary care delivery and improvement	end July 2025	Publication of our plan	n/a	Collaborative SC 6-monthly report	Capacity of Primary Care team	A-G	2	
		Commence implementation of PC10 Year TDP	Single strategic direction for primary care delivery and improvement	end March 2026	Buy in to delivery of the plan	n/a	Collaborative SC 6-monthly report	Capacity of Primary Care team	A-G	2	
	Support delivery of modern general practice.	Financial support for practices for MGP digital tools	Implement learning/changes identified in CATS tool	Improvements to commissioning and transformation processes within NEL	end Dec 2025	change in level within the CATS tool based on self-assessment	n/a	Collaborative SC 6-monthly report	Chanes to ICB staffing and functions	A-G	3
			OCVC - ICB funded tool; assessment of outliers in tool utilisation (low usage practices) and supportive interventions for identified outliers to improve uptake.	Increase overall OC utilisation for NEL by 10%. All practices making use of OC tool.	end Dec 2025	Number of OCs per 1000 patients per month	Minimum of 45 OCs/1000 patients/month in each practice. 10% overall increase in NEL usage of OC	PCDG every other month, PC Contracts SC annual report, PC Collab annual report.	Failure to deliver due to lack of PM resource and PCIL / Facilitator resource. Potential resistance to new contract stipulations may impede take-up. Tool may not be appropriate for some specialised practices, e.g. homeless.	G	1
			NHS App - promotion of the App; assessment of outliers in App utilisation and supportive interventions for identified outliers	Increased patient usage of NHS App	end March 2026	Logins per 1000 registered patients per month	Maintain current upward trend to reach 1300 logins per 1000 registered patients by 31/3/26	PCDG every other month, PC Contracts SC annual report, PC Collab annual report.	The SDF support for this was reduced/removed due to funding constraints; promotion of the NHS App and patient use thereof is largely outside of ICB control. Likely lack of local comm team to run advertising campaign and lack of national campaign. Failure to deliver due to lack of PM resource and PCIL / Facilitator resource.	A-G	1
			Patient self-booking - ICB funded tool; assessment of outliers in tool utilisation and supportive interventions for identified outliers	Increased patient self-booking	end Dec 2025	Patients booking/cancelling appointments via AccuRx and NHS App	To maintain usage at or above London average. More appointments booked overall is not necessarily a good thing, given the attempt to promote self-care and pharmacy first.	PCDG every other month, PC Contracts SC annual report, PC Collab annual report.	Capacity of Primary Care team. Ability for AccuRx selfbook appointments booked via the NHSApp to appear in the dashboard	A	2
			SMS - ICB funded tool; assessment of outliers in SMS utilisation and supportive interventions for identified outliers	Efficient use of SMS in General Practice	end March 2026	SMS usage and staying within the budget	SMS usage within the allocated budget	PCDG every other month, PC Contracts SC annual report, PC Collab annual report.	Capacity of Primary Care team	A-G	1
Cloud-based Telephony - ICB funded tool; assessment of outliers in CBT utilisation and supportive interventions for identified outliers			100% of practices utilising CBT; maximise use of CBT for practices (through training of identified outliers)	end Dec 2025	Number of practices that have undertaken training	All practices utilising within appropriate range	PCDG every other month, PC Contracts SC annual report, PC Collab annual report.	Capacity of Primary Care team	G	1	
Target support to practices to deliver access and a good overall experience for patients		Review national dashboard, O/C data, CAIP 24/25, and other (local) data for all practices, to identify outliers and struggling practices, that would benefit from intervention (GPIP or EQUIP programmes)	Identify appropriate practices (outliers) requiring support - including deciding what aspects of access need to be addressed	end June 2025	No of Practices and PCNs that might benefit from support identified (outliers)	100% of identified outliers	PCDG, Collab 6 monthly report	Appropriate practices (including outliers) identified, but they need to agree to participate in Programme - depends on buy-in and recognition of being an outlier	G	1	
		Gain agreement from identified practices to participate in the GPIP or EQUIP programmes	Outlier practices identified signed up to participate in improvement programmes	end Sept 2025	Number of practices signed up to GPIP and EQUIP programmes. Expenditure against notional NEL budget for GPIP Programme (£316K)	19 practices to participate in GPIP. Notional budget of £316K to be fully spent.	PCDG, Collab 6 monthly report	Risk that practices won't agree to participate due to time commitment and cost of backfill	G	1	
		Provide support to 19 identified practices through the GPIP Programme with each practice identifying areas of improvement to focus on and provide support to practices to make best use of cloud based telephony through the EQUIP programme	Practices complete programme, improve performance in identified areas, and share good practice with other practices (positive and negative outliers)	end March 2026	Proportion of identified practices completing programmes; Proportion of practices achieving increased performance in identified areas	All practices to complete programme. Practices to achieved increased performance in identified areas	PCDG, Collab 6 monthly report	Risk that practices won't complete programme due to time commitment and cost	G	1	
		Promote PF dashboard to practices to self-identify improvements needed.	Increased number of referrals from practices to pharmacies	end Dec 2025	number of PF referrals	Increase in PF referrals overall Reduction of outliers (number of referrals)	PCDG end of year report	Capacity of Primary Care team; capacity of practices to make changes.	G	1	
Optimise use of other services to improve access (Pharmacy First).		Review PF data for all practices to identify outliers in referrals	Identify practices requiring support	end Dec 2025	No of Practices and PCNs that might benefit from support identified	All major outliers	PCDG 6 monthly report	Capacity of primary care team	A-G	2	
		Develop engagement and improvement plans for identified practices	Clear agreed improvement plans	end Dec 2025	Proportion of identified practices with clear plans	100% of all major outliers	PCDG 6 monthly report	Capacity of Primary Care team; capacity of practices to make changes.	A	3	
		Provide support to identified practices in line with plans	Increased number of referrals from practices to pharmacies	end Dec 2025	number of PF referrals	Increase in PF referrals overall	PCDG end of year report	Capacity of Primary Care team; capacity of practices to make changes.	A	3	
		Pilot blood pressure monitoring through dental and optom identifying at-risk patients	Increased number of identified at-risk patients; Increase number of follow-ups in CP or GP	end March 2026	Number of patients tested; Numbers of case finding in GP/CP	No target as this is a pilot	PCDG 6 monthly report	Capacity of primary care team	G	2	
Workforce programmes		Continue to invest in workforce programmes that will increase capacity and capability to improve access	Increased workforce in NEL; Increased skills in NEL; Increase staff satisfaction in NEL	end March 2026	Percentage workforce increase; appropriate skills mix; GP and NHS staff survey results	Figures as in PC workforce submission	Workforce Group; PCDG 6 monthly report	Chanes to ICB staffing and functions	G	1	
Other digital programmes		Social prescribing tools - due to funding restrictions and reduction to SFD, the tools will not be provided to all practices as expected - continuation of existing provision and exploration of expansion.						This will not be delivered due to lack of approval for funding for the tool (due to reduced and non- ringfenced SDF).		3	
		AI and automation - ICB funded tool (Held) for piloting in 42 practices; assessment of usage and impact; depending on results and funding, stop or expand. Investigate non-ambient AI tools	Identify challenges & benefits (including time and financial savings) & lessons learnt.	end Dec 2025	Held in use in designated practice and benefits report produced - comparison between high and low users, and an understanding of barriers limiting usage.	n/a	PCDG 6 monthly report	Capacity of Primary Care team; capacity of practices to implement the tool and engage with evaluation.	G	2	
		Support for changes to estates to enable workforce, digital and other initiatives.	Estates and infrastructure appropriate for delivery of other initiatives to improve access and experience.	ongoing process	Number of practices reviewed for estates/infrastructure support related to other initiatives.	n/a	PCDG 6 monthly report	Access to UMF for supporting estates / infrastructure initiatives.	G	1	
Targeted support to improve access and move to modern general practice		Identify potential practices (see targeted support to practices section above)	Identify practices requiring support	end June 2025	See above	See above	See above	See above	G	1	
		Develop primary care improvement dashboard	Dashboard published and utilised	end October 2025	Roll out of the dashboard internally and in use across multiple teams (Place, Commissioning etc).	See above	See above	Launch report to PCDG, PCCollab, PCContracts, 6-monthly reporting thereafter for monitoring.	G	1	
	Secure agreement from practices to participate in GPIP/EQUIP Programme (see targeted support to practices above)	See above	See above	Sep-25	See above	See above	See above	G	1		
Urgent dental appointments	Commission NEL share	NEL has sufficient Urgent Dental Care activity over and above the national baseline requirement. We will monitor the activity returns based on the trajectory submitted. We will increase awareness of the service available via NHS11 to improve uptake, by refreshing the current communications material.	Increased patient awareness of the availability of urgent dental care in NEL, leading to improved uptake.	end March 2026	NHS England returns of commissioned activity and uptake.	Net increase in uptake, aligned to activity trajectory	Contracts SC annual report	Chanes to ICB staffing and functions	G	1	
	Secure/provide support through GPIP/EQUIP Programme (see targeted support to practices above)	See above	See above	end March 2026	See above	See above	See above	A-G	1		
Primary Secondary Care interface	Continue work programmes working with Local Trusts	There is a wider ongoing work programme than the primary care operating plan; we will continue to make progress on this in line with the work programme	Achieve level 2 in the 4 improvement areas (onward referrals, fit notes, call/telex, clear points of contact).	end March 2026	levels on improvement areas	Level 2 across the four improvement areas	PCDG end of year report	Capacity of Primary Care; changes to ICB staff and functions; lack of engagement and capacity in secondary care (already) and reduced Trust corporate spend.	A	2	
GP contract changes implementation	Oversee contract change implementation	Separate detailed action plan includes actions related to monitoring of A&G ES, provision of support for PHM and risk stratification, support for digital delivery, and monitoring of OC accessibility within core hours (link to OCVC line above re usage and utility).	Implementation completed appropriately	end October 2025	Completed actions on action plan	100%	Contracts SC annual report	Chanes to ICB staffing and functions	G	1	

## Primary Care Contracts sub-committee

8 July 2025

<b>Title of report</b>	Lucas Avenue Practice (Newham) – Strategic Review
<b>Author</b>	Safdar Raffiq, Primary Care Commissioning Manager
<b>Presented by</b>	Benjamin Smith, Senior Primary Care Commissioning Manager
<b>Contact for further information</b>	<a href="mailto:Safdar.raffiq@nhs.net">Safdar.raffiq@nhs.net</a> <a href="mailto:benjamin.smith10@nhs.net">benjamin.smith10@nhs.net</a>
<b>Executive summary</b>	<p>The Lucas Avenue practice (Newham) APMS contract is currently held by Operose Health. The contract was awarded in August 2016 under the Londonwide financial offer. The practice delivers services from 1a Lucas Avenue to a list size of 14,072 (Jan 2025).</p> <p>Clause 2.3 has already been exercised, resulting in a maximum extension of the contract by five years. The current contract is set to expire on 31 July 2026. As there are no further options to extend the contract, the procurement of a new APMS contract, via Provider Selection Regime (PSR) competitive process is required to ensure continuity of services.</p>
<b>Action / recommendation</b>	The Primary Care Contracts Sub Committee are asked to: Approve procuring a new APMS contract for The Lucas Avenue Practice, as part of the upcoming “NEL Tranche 3” APMS procurement programme, which has received endorsement from the NEL Procurement Group (PG).
<b>Previous reporting</b>	This report has been discussed at the Newham Primary Care Transformation Group and the recommendation endorsed
<b>Next steps</b>	<ul style="list-style-type: none"> <li>• Enact selected PSR routes for the procurement of the contract (Oct 2025 – June 2026)</li> <li>• Contract Mobilisation (June – July 2026)</li> <li>• New Contract commencement (1 August 2026)</li> </ul>
<b>Conflicts of interest</b>	All GP practices across North East London; the decision is to be made by non-conflicted members only. Any conflicts of interest to be managed in line with the Terms of Reference (ToR) of the Committee.
<b>Strategic fit</b>	<p>Which of the ICS aims does this report align with?</p> <ul style="list-style-type: none"> <li>• To improve outcomes in population health and healthcare</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	Securing contractual arrangements to ensure continuity of primary medical services and reduction in health inequalities.

<b>Impact on finance, performance and quality</b>	<p>There will be a cost implication for running a procurement process, however there will be a number of cost efficiencies in grouping together the procurements in one tranche.</p> <p>Re-procuring the contract on equalised APMS terms will generate a saving of c£147,465.62 to the ICB.</p>
<b>Risks</b>	<ul style="list-style-type: none"> <li>• Failure to reprocure the APMS contract in a timely manner poses a risk to the continuity of primary care services for 14,072 patients, potentially impacting population health outcomes and system resilience.</li> <li>• If the application of PSR is not applied robustly, the ICB may be exposed to legal challenges.</li> </ul>
<b>Attachments</b>	<p>Appendix 1 – Lucas Avenue Practice GP Contract Strategic Commissioning Review Business Case</p>

Lucas Avenue Contract Strategic Commissioning Review Business Case

<b>Place:</b>	<b>PCN:</b>
Newham	Newham Central
<b>Practice name:</b>	<b>Practice code:</b>
Lucas Avenue	F84642
<b>Raw list size:</b>	<b>Weighted list:</b>
14072	11966.7709890175
<b>Current provider:</b>	
AT Medics Ltd. Under Operose Health	
<b>Contract Start Date:</b>	<b>Contract End date:</b>
01/08/2016	31/07/2026
<b>Contract Term Provision for Extension/Break Clause:</b>	
No further option to extend. Clause 2.3 has already been exercised, resulting in a maximum extension of the contract by five years. The current contract is set to expire on 31 July 2026.	
<b>Reason for contract review:</b>	
Contract expires on 31/8/2026 and decision is required on future of the contract	
<b>Practice website:</b>	
<a href="#">Home - Lucas Avenue Practice</a>	
<b>Report Completed by:</b>	
Benjamin Smith, Senior Primary Care Commissioning Manager	
<b>Equality Impact Assessment Completed:</b>	
Not required as no change to service provision.	
<b>Summary of Recommendation:</b>	
Recommendation is to procure a new APMS contract, via PSR competitive process and include in tranche 3 APMS procurement.	
<b>1.0 Contract Overview / History</b>	
1.1 Lucas Avenue was first commissioned as an APMS contract in August 2016, on a 5-year contract. Previously, the contract was know as Sinha Medical Teaching Practice, before the name was changed upon AT Medics Ltd. commencing the contract on 1 August 2016. The previous contractor had their registration cancelled by the CQC.	

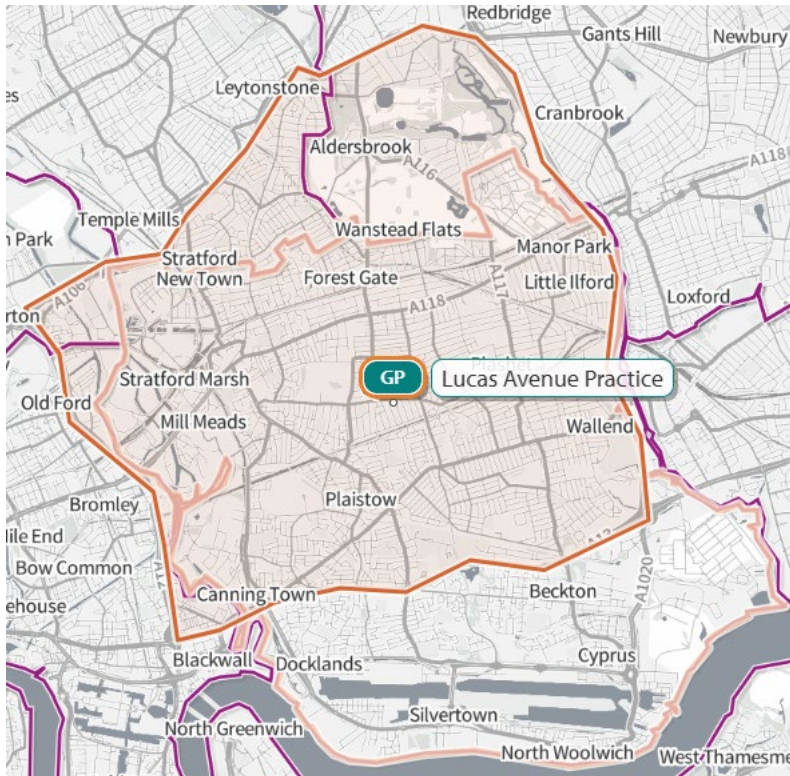
1.2 There is no further option to extend the contract and there are terms that will need to be varied. The current contract receives payments based on KPI performance and based on previous terms known as the Londonwide APMS Mandatory Terms & Services Price. These terms are no longer included in APMS contracts and would not be included in any future APMS contract.

## 2.0 Practice Specific Information

2.1 Lucas Avenue is situated within the West Ham area of Newham. The practice operates in line with GMS/PMS core hours (Monday to Friday, 8am – 6.30pm (excluding bank holidays), plus Saturday 9am-1pm. The site is purpose built.

2.2 Premises Occupied:

1a Lucas Avenue  
 London  
 E13 0QP

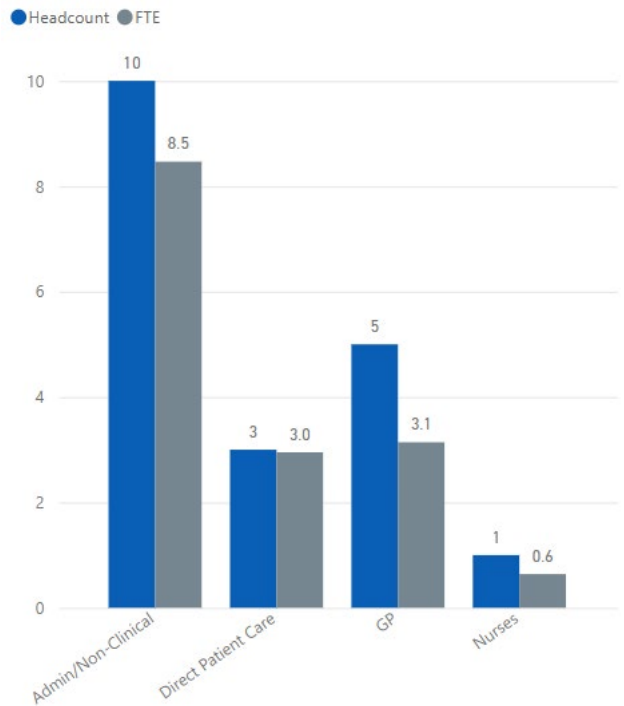


(Figure 1.0 Practice catchment area)

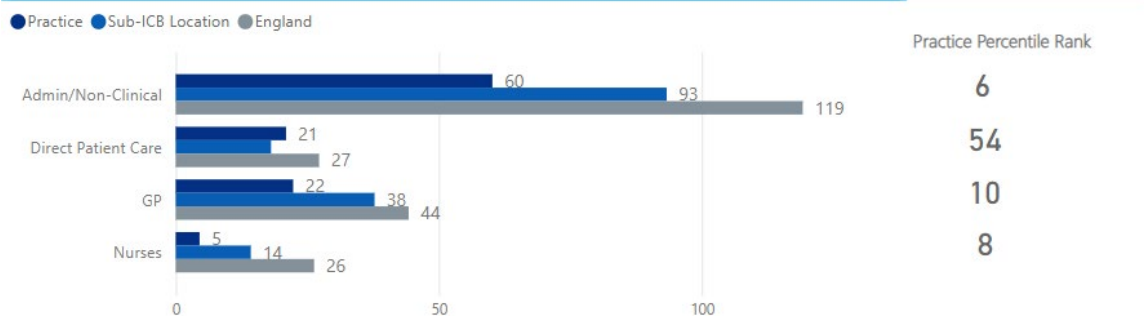
## 2.3 Clinical Workforce

The GP FTE per 100k registered patients is below the ICB average and national average. The nurses FTE per 100k registered patients is below the ICB and national average too.

Practice headcount and FTE by staff group



Staff FTE per 100,000 patients, Sub-ICB Location and England



(Figure 2.0 Practice Workforce)

(Source: [NHS Digital, Primary Care Workforce Dashboard](#))

2.4 Patient List

The registered patient list size has increased but not by significant amounts over the last 5-year period and the weighted list has stayed at approximately 12,000 patients.

Date	Raw List Size	Weighted List Size
Apr-25	14072	11966.77
Apr-24	14551	12489.31
Apr-23	14302	12066.52
Apr-22	12976	12392.61

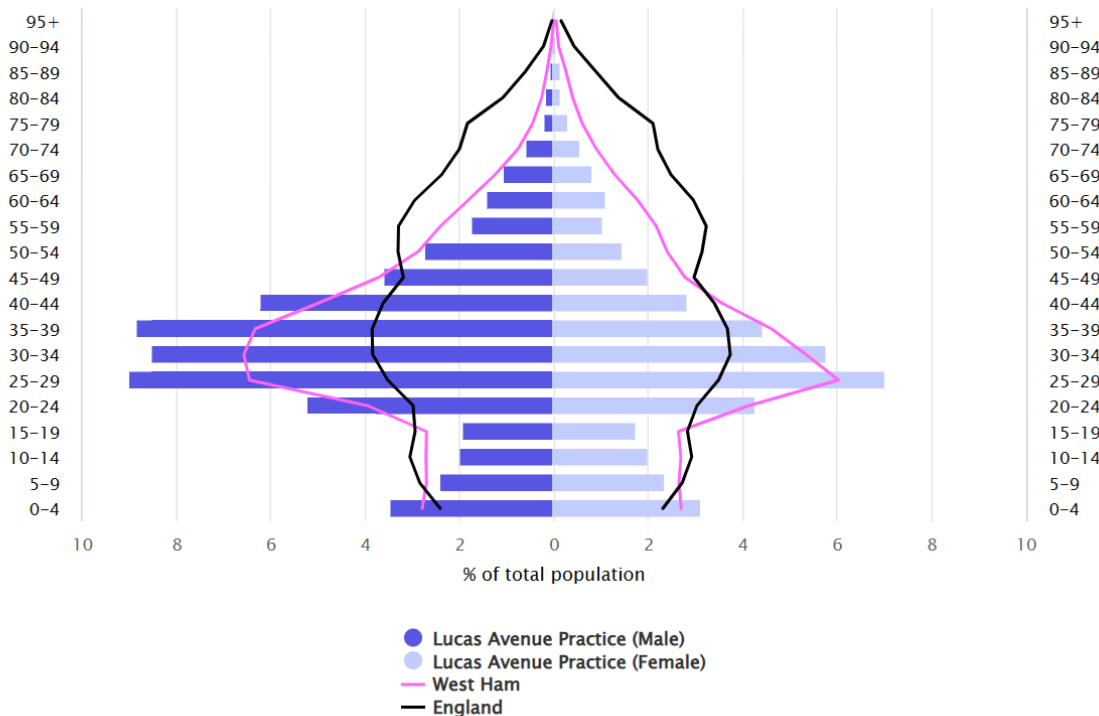
Apr-21	12259	11925.64
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(Figure 3.0 List size growth)

### 2.5 Patient Demographics

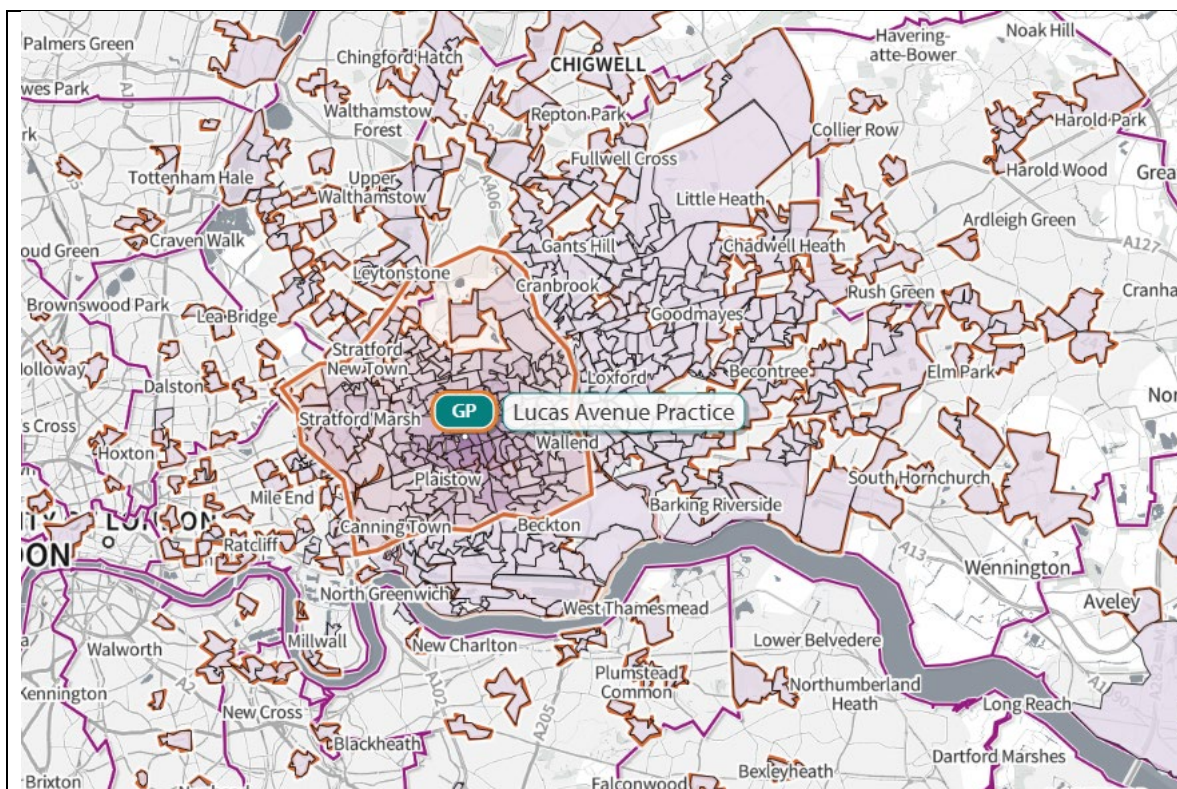
The patient demographic data suggests that the ratio of males to females is higher. There is a high demographic of females and males aged between 25-39. The practice is above the average for West Ham for patients 0-4. Overall, much lower amount of older patients compared to the locality and national average and the same for patients aged 5-19.

Population age profile  
GP registered population by sex and quinary age band 2024



According to the 2021 Census data, the ethnic breakdown of the patient demographic consists of 19.9% White, 3.3% mixed, 58.8% Asian, 12.6% black and 4.4% other non-white ethnic groups. In terms of deprivation, the practice resides within the fourth most deprived decile.

Source: <https://fingertips.phe.org.uk/>



Based on April 2025 figures. 98.64% reside within the borough, with 1.36% outside the borough.

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

**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 4.0 below:

(Figure 4.0 – QOF Achievement)

Financial year	Practice Achievement	Newham Average	Variance
2023-24	591.51 out of 635 points	589.14	2.37 percentage points above
2022-23	579.15 out of 635 points	576.55	2.6 percentage points above
2021-22	580.11 out of 635 points	577.27	2.84 percentage points above

Source: [NHS Digital QOF Data](#)

**3.2 Childhood Immunisations**

In 2024-25 the uptake of childhood immunisations for this practice, particularly MMR was below the Newham average.

Patients becoming 12m	DTaP/IPV/Hib/HepB(%)	Men B(%)	PCV(%)	Rotavirus(%)
Lucas Avenue Surgery	93.2%	92.7%	95.3%	93.8%

Newham Average	<b>89.4%</b>	<b>88.4%</b>	<b>92.2%</b>	<b>87.6%</b>
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	DTaP/IPV/Hib/HepB (%)	MMR(%)	HiB/Men C (%)	PCV (Booster)(%)
<b>Patients becoming 24m</b>				
Lucas Avenue Surgery	87.2%	83.6%	82.6%	83.6%
Newham Average	<b>88.6%</b>	<b>83.7%</b>	<b>83.6%</b>	<b>82.2%</b>

	DTaP/IPV/Hib/HepB(%)	MMR (Primary)(%)	DTaP/IPV (Booster)(%)	MMR (Booster)(%)	HiB/Men C(%)
<b>Patients becoming 5 yrs</b>					
Lucas Avenue Surgery	85.6%	86.2%	72.5%	76.6%	86.8%
Newham Average	<b>87.7%</b>	<b>87.3%</b>	<b>76.1%</b>	<b>80.2%</b>	<b>86.2%</b>

(Source: CEG data 2024-25)

### 3.3 Flu

In 2024-25 the uptake of the seasonal flu vaccine was higher than the Newham average.

Seasonal Flu Uptake 24-25	Patients Age 65+ (exc. care homes and housebound)
Lucas Avenue Surgery	58%
PCN Average	52%
Newham Average	48%

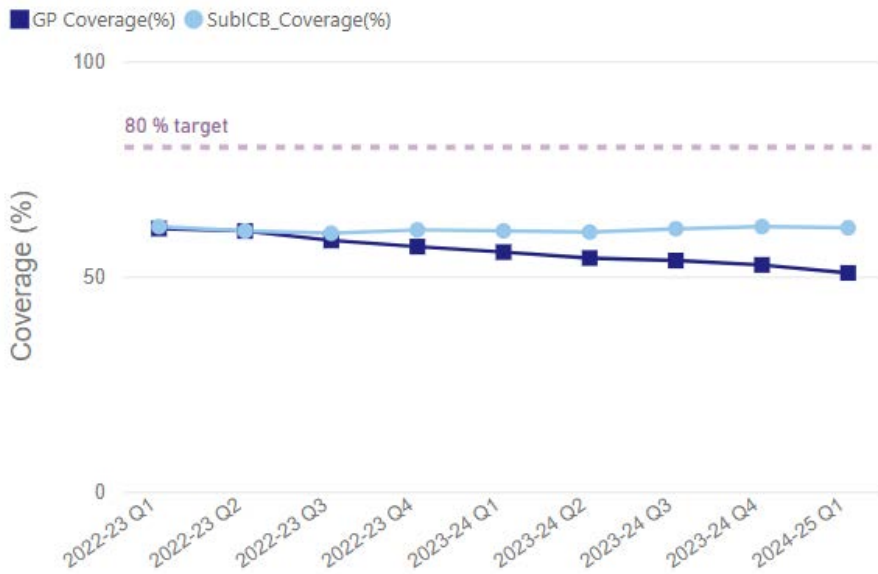
(Source: CEG data 2024-25)

### 3.4 Cervical Screening

Lucas Avenue Surgery achieved slightly below the NEL average for both age groups, however there is a higher coverage in the 50-64 age group.

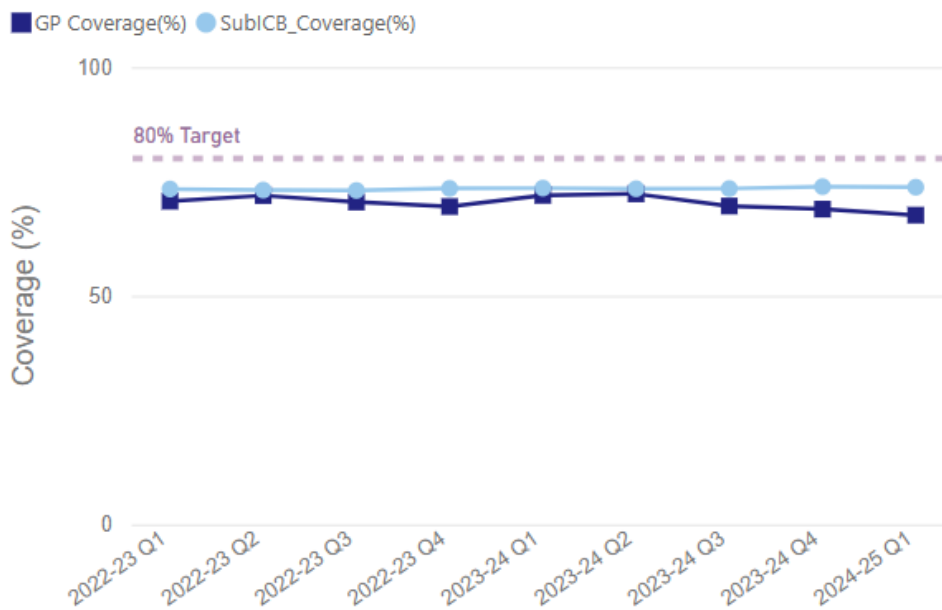
Coverage for the practice and NEL are lower than the national target of 80%.

**GP Practice Coverage - Ages 25 to 49**



(Source: NHS Digital)

**GP Practice Coverage - Ages 50 to 64**



(Source: NHS Digital)

**4.0 Service Delivery**

4.1 Access

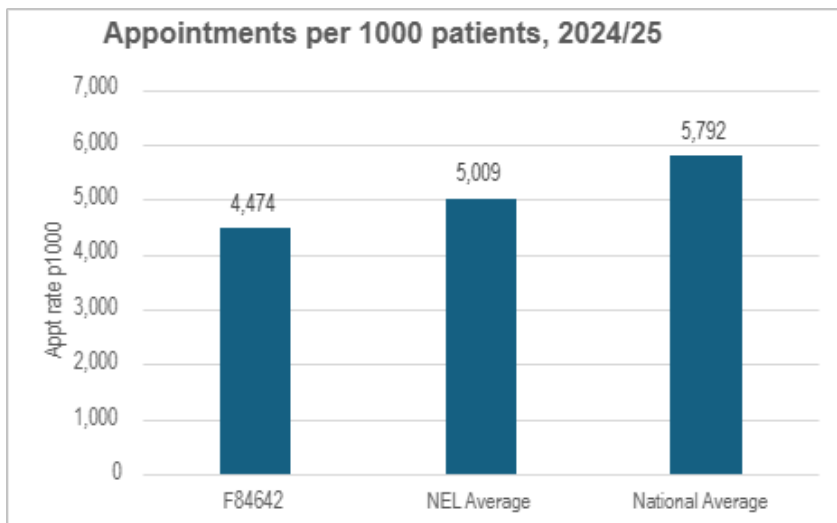
In 2024-25 the practice delivered 4,474 appointments per 1000 patients compared to the NEL average of 5,009 and national average of 5,792.

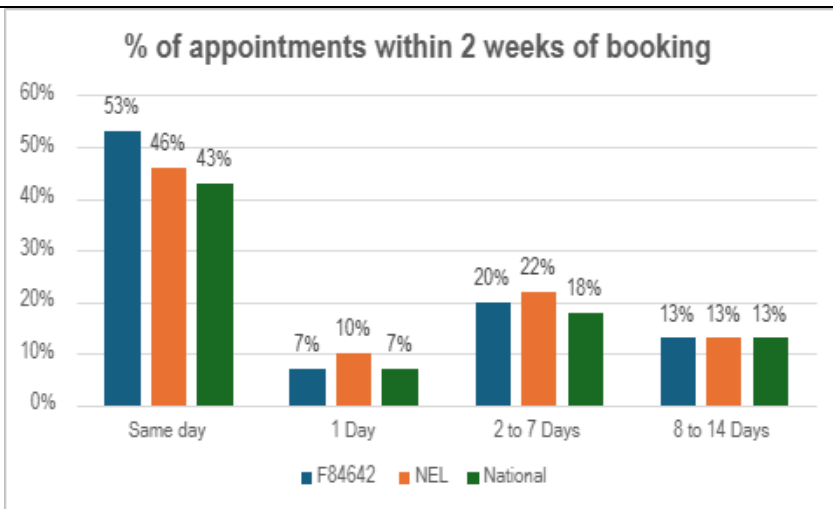
93% of appointments took place within 2 weeks of booking compared to 90% in NEL and 81% national average. NHSE operational planning guidance indicates that a minimum of 85% of GP appointments should take place within 2 weeks of booking.

Lucas Avenue Practice offers fewer appointments per 1000 patients than the NEL average and the national average. However, the majority of appointments took place within 2 weeks of booking.

### GPAD data 2024-25

	Appt rate p1000	Same Day	1 Day	2 to 7 Days	8 to 14 Days
Lucas Avenue Practice	4,474	53%	7%	20%	13%
NEL Average	5,009	46%	10%	22%	13%
National Average	5,792	43%	7%	18%	13%





**4.2 A&E data/in hours calls to NHS111:**

In 2024/25 the practice rate of in hours calls to NHS111 was slightly higher than the NEL average but lower than the Newham average and PCN average. This could be partly attributed to the comparative lower rate of appointments offered per 1000.

**Period April 23 – March 24\***

Practice/Benchmark	In hours calls per 1000 patients
Lucas Avenue Practice	71
PCN	85
Newham	78
NEL	66

(Source: NEL BI – PC Dashboard Suite – latest available data\*)

**4.3 Prescribing Quality and Efficiency**

**Pharmacy and Medicines Optimisation**

The summary of the practice’s implementation and delivery of NEL Pharmacy and Medicines Optimisation programmes to ;

- Improve appropriate, cost-effective and safe use of medicines
- Improve patient health outcomes
- Collaborate with community pharmacy providers and Clinical referral services

**Referral to Community Pharmacy Clinical Pathways**

Service	Period	Number of referrals-Practice
Pharmacy First	January 2025	441 referrals per 10,000 patients

**Delivery of the Prescribing Quality Scheme**

**Prescribing Efficiency Scheme 2024/2025**

The Prescribing Efficiency Scheme (PES) is an initiative aimed at enhancing cost-effectiveness of medicines within Primary Care.

Indicator	Practice Output
% current recommended Blood Glucose Testing Strip (BGTS) items	61.9% vs a target of 50%.
Selected Cost Improvement Plan Savings	£62454 vs a target of £53221

**Antibiotics**

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 25 (12 months rolling data)	Proportion of co-amoxiclav, cephalosporin & quinolone items position March 25 (12 months rolling data)	Amoxicillin 500mg capsule: % of total items, 5 days (Quantity=15) March 245 (12 months rolling data)
≤0.871	≤10%	>40%
0.524	6.25%	70.7%

4.4 KPIs

This contract was originally commissioned on London-wide APMS terms and conditions when procured in 2015. Therefore, the contract included an APMS Mandatory Terms and Services Price of £12.57 and KPI payment of £5.35 per normalised weighted patient (pnwp).

As part of the national and local implementation of the equalisation of GMS, PMS and APMS contracts (effective from 2019/20), all new APMS contracts that have been commissioned across NEL now include a reduced APMS Mandatory Terms and Services Price of £5 pnwp and KPI payments have been removed. Practices can still supplement their income by signing up to Local Incentive Schemes (LISs) at borough level. This is the proposed approach for the re-procurement of this contract.

In 2023/24 Lucas Avenue achieved Band A for all of the outcome measures except three for which the practice achieved Band B. This resulted in a clawback of approximately £6k.

#### 4.5 Innovation

The practice was successful in applying for a NHS Improvement Grant and they have recently undertaken a significant building extension project to increase the number of clinical consultation rooms. This will enable the practice to increase the number of appointments offered, improve their access to primary care services and meet the increasing demand of the local population and growing patient list size.

### **5.0 Contract & Regulatory Compliance**

5.1 The practice is currently rated as 'Good' by the CQC. This was inspected in May 2017 but was reviewed in July 2023. 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 Lucas Avenue.

5.3 The last annual contract review for financial year 2023/24 was undertaken earlier this year and there was no other contractual or performance concerns highlighted with this practice.

### **6.0 Premises and Estates**

6.1 The building is privately owned by a 3<sup>rd</sup> party. The practice has a 10-year lease which is due to expire on 19/01/2026 and discussions are ongoing to extend the lease. It's expected that any contractor will enter negotiations with the landlord to extend the lease.

6.2 The site is listed as 'Flex B' within the NEL Primary Care Estates Strategy. This means that while the estate is outside of NHS or local authority control or ownership, minimal investment is required, and a long-term solution needs to be developed as neighbourhood models of care evolve and local authority areas of development progress.

### **7.0 Patient Experience**

#### 7.1 PPG

The practice has an active PPG with 8 members currently. They have a meeting every 3 months and members also attend the PCN PPG meeting. The most recent meetings were held in April 2025 (PCN PPG) and May 2025 (practice PPG). They actively take Friend and Family feedback forms from patients and submit to internal team on a monthly basis for review.

#### 7.2 GP Patient Survey (GPPS)

The GPPS results for 2023 were around the ICB average for some of the key questions that were analysed.

(Figure 6.0 – GPPS Results 2023)

	Practice Result	ICB Result	Above / Below ICB Average
Describe their overall experience of this GP practice as good	67%	68%	Below
Were offered a choice of time or day when they last tried to make a general practice appointment	48%	52%	Below
Find it easy to get through to this GP practice by phone	58%	48%	Above

### 8.0 Contract Value

Lucas Avenue	Price
Global Sum +Londonwide APMS Mandatory Terms & Services Price	£ 1,607,855.35
London Allowance	£ 30,676.96
OOHs deduction - %	-£ 77,830.28
Aspiration payment - Band B	£ 25,608.89
100% Achievement - Band A	£ 38,413.33
<b>Total</b>	<b>£ 1,624,724.25</b>

### 9.0 Options/ Preferred Option/Risks

Considerations	Option 1 - Do nothing (Dispersal)	Option 2 – Award a new contract via PSR Direct Award Route C	Option 3 – Procure a new contract via PSR Competitive Process
<b>Pros</b>	This is not a viable option as NEL ICB has a statutory duty to ensure suitable medical service provision is in place for its local population.	<ul style="list-style-type: none"> <li>If the ICB is satisfied with the current contractor, this would cause no disruption to services or patients.</li> <li>Maintains existing working relationships for current contractor and</li> </ul>	<ul style="list-style-type: none"> <li>Will ensure continuity of care for patients with minimum disruption to services</li> <li>Will help retain GP services within an area of high deprivation in Newham</li> </ul>

		<ul style="list-style-type: none"> <li>other stakeholders.</li> <li>Would reduce administrative burden on the ICB as contract would not be procured using a competitive process.</li> </ul>	<ul style="list-style-type: none"> <li>Will ensure the least resistance backlash from patients and stakeholders</li> </ul>
<b>Cons</b>	Not applicable	<ul style="list-style-type: none"> <li>Only suitable for contracts where there is no substantial change to the contract.</li> <li>This would mean no equalisation of the APMS terms, which would mean a financial disbenefit to the ICB.</li> </ul>	<ul style="list-style-type: none"> <li>There are financial costs associated with undertaking a full procurement such as buying in external expertise</li> </ul>
<b>Risks</b>	Not applicable	<ul style="list-style-type: none"> <li>Substantial risk of challenge from other contractors due to size and length of contract</li> </ul>	<ul style="list-style-type: none"> <li>Delays to procurement timeline</li> <li>Lack of interest from suitable bidders</li> </ul>
<b>Mitigation</b>	Not applicable	<ul style="list-style-type: none"> <li>Follow NHSE direct award route C process and toolkit.</li> </ul>	<ul style="list-style-type: none"> <li>Align procurement to the timelines for the APMS Tranche 3 programme</li> </ul>

**Preferred Option:**

The preferred option is to procure a new APMS contract, through PSR competitive process, based on the following rationale:

- Minimal impact to patient care as service delivery will continue to operate, under a substantive provider
- Primary medical service provision will be maintained in an area that is expecting high-population growth
- There will be a financial benefit as the new APMS contract will be on financially equalised terms to other APMS contracts (see Figure 7.0)

- Patient satisfaction in the assurance of continuity of care

(Figure 7.0 – Proposed contract value under equalised APMS terms)

Lucas Avenue	Price
Global Sum price	£1,457,433.04
London Allowance	£30,676.96
Risk Premium	£59,833.85
<b>Sub-total</b>	<b>£1,547,943.85</b>
Less: OOH deduction (% of Global Sum + London Weighting)	<b>-£70,685.22</b>
<b>Total</b>	<b>£1,477,258.63</b>
<b>Saving to ICB</b>	<b>£147,465.62</b>

### 10.0 Next steps

If approved, move to procurement of the contract under the T3 APMS procurement programme.

- Enact selected PSR routes for the procurement of the contract (Oct 2025 – June 2026)
- Contract Mobilisation (June – July 2026)
- New Contract commencement (1 August 2026)

## Primary Care Contracts sub-committee

8 July 2025

<b>Title of report</b>	The Loxford Surgery (Redbridge) – Strategic Review
<b>Author</b>	Adeel Aksar, Primary Care Commissioning Manager
<b>Presented by</b>	Benjamin Smith, Senior Primary Care Commissioning Manager
<b>Contact for further information</b>	<a href="mailto:Adeel.aksar@nhs.net">Adeel.aksar@nhs.net</a> <a href="mailto:benjamin.smith10@nhs.net">benjamin.smith10@nhs.net</a>
<b>Executive summary</b>	<p>The Loxford Surgery (Redbridge) APMS contract is currently held by Operose Health. The contract was awarded in August 2016 under the Londonwide financial offer. The surgery delivers services from, a purpose-built premises at the Loxford Polyclinic, 417 Ilford Lane, Ilford, IG1 2SN to a list size of 32,728 (Jan 2025).</p> <p>Clause 2.3 has already been exercised, resulting in a maximum extension of the contract by five years. The current contract is set to expire on 31 July 2026. As there are no further options to extend the contract, the procurement of a new APMS contract, via PSR competitive process is required to ensure continuity of services.</p>
<b>Action / recommendation</b>	Approve procuring a new APMS contract for The Loxford Surgery, as part of the upcoming “NEL Tranche 3” APMS procurement programme, which has received endorsement from the NEL Procurement Group (PG).
<b>Previous reporting</b>	This report has been discussed at the Redbridge local fora and the recommendation endorsed.
<b>Next steps</b>	<ul style="list-style-type: none"> <li>• Enact selected PSR routes for the procurement of the contract (Oct 2025 – June 2026)</li> <li>• Contract Mobilisation (June – July 2026)</li> <li>• New Contract commencement (1 August 2026)</li> </ul>
<b>Conflicts of interest</b>	All GP practices across North East London; the decision is to be made by non-conflicted members only. Any conflicts of interest to be managed in line with the Terms of Reference (ToR) of the Committee.
<b>Strategic fit</b>	<p>Which of the ICS aims does this report align with?</p> <ul style="list-style-type: none"> <li>• To improve outcomes in population health and healthcare</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	Securing contractual arrangements to ensure continuity of primary medical services and reduction in health inequalities.

<b>Impact on finance, performance and quality</b>	There will be a cost implication for running a procurement process, however there will be a number of cost efficiencies in grouping together the procurements in one tranche. Re-procuring the contract on equalised APMS terms will generate a saving of £333,896.42 to the ICB.
<b>Risks</b>	<ul style="list-style-type: none"> <li>• Failure to reprocure the APMS contract in a timely manner poses a risk to the continuity of primary care services for 32,000 patients, potentially impacting population health outcomes and system resilience.</li> <li>• If the application of PSR is not applied robustly, the ICB may be exposed to legal challenges.</li> </ul>
<b>Attachments</b>	Appendix 1 - Loxford Surgery GP Contract Strategic Commissioning Review Business Case

**Loxford Surgery GP Contract Strategic Commissioning Review Business Case**

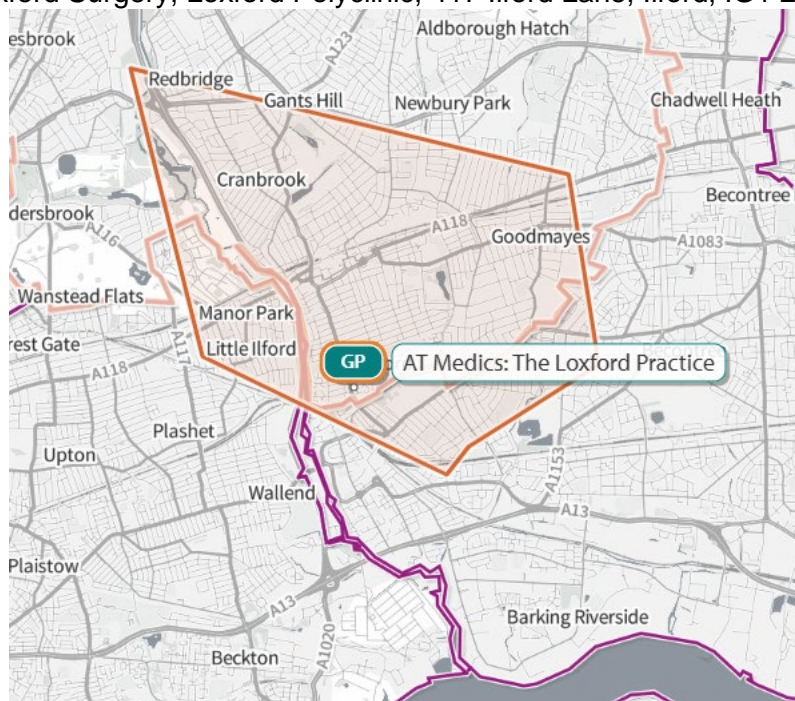
<b>Place:</b>	<b>PCN:</b>
Redbridge	Loxford PCN
<b>Practice name:</b>	<b>Practice code:</b>
The Loxford Surgery	Y02987
<b>Raw list size: (April 2025)</b>	<b>Weighted list: (April 2025)</b>
32728	27095.55
<b>Current provider:</b>	
AT Medics Ltd. Under Operose Health	
<b>Contract Start Date:</b>	<b>Contract End date:</b>
01/08/2016	31/07/2026
<b>Contract Term Provision for Extension/Break Clause:</b>	
No further option to extend. Clause 2.3 has already been exercised, resulting in a maximum extension of the contract by five years. The current contract is set to expire on 31 July 2026.	
<b>Reason for contract review:</b>	
Contract expires on 31/7/2026 and decision is required on future of the contract	
<b>Practice website:</b>	
<a href="#">Home - The Loxford Practice</a>	
<b>Report Completed by:</b>	
Benjamin Smith, Senior Primary Care Commissioning Manager Adeel Aksar, Primary Care Commissioning Manager	
<b>Equality Impact Assessment Completed:</b>	
Not required as no change to service provision.	
<b>Summary of Recommendation:</b>	
Recommendation is to procure a new APMS contract, via PSR competitive process and include in tranche 3 APMS procurement.	
<b>1.0 Contract Overview / History</b>	
1.1 The Loxford practice APMS contract is currently held by AT Medics Ltd. under Operose Health. The contract was awarded in August 2016 under the Londonwide financial offer.	

1.2 There is no further option to extend the contract and there are terms that will need to be varied. The current contract receives payments based on KPI performance and based on previous terms known as the Londonwide APMS Mandatory Terms & Services Price. These terms are no longer included in APMS contracts and would not be included in any future APMS contract.

## 2.0 Practice Specific Information

2.1 Loxford Surgery is situated within the Ilford South area of Redbridge. The practice operates in line with GMS/PMS core hours (Monday to Friday, 8am – 6.30pm (excluding bank holidays), plus Saturday 9am-1pm. The site is purpose built.

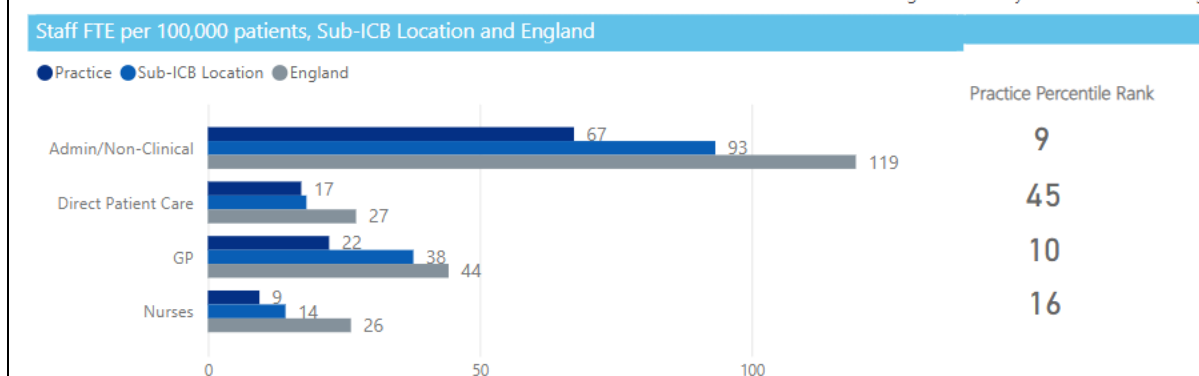
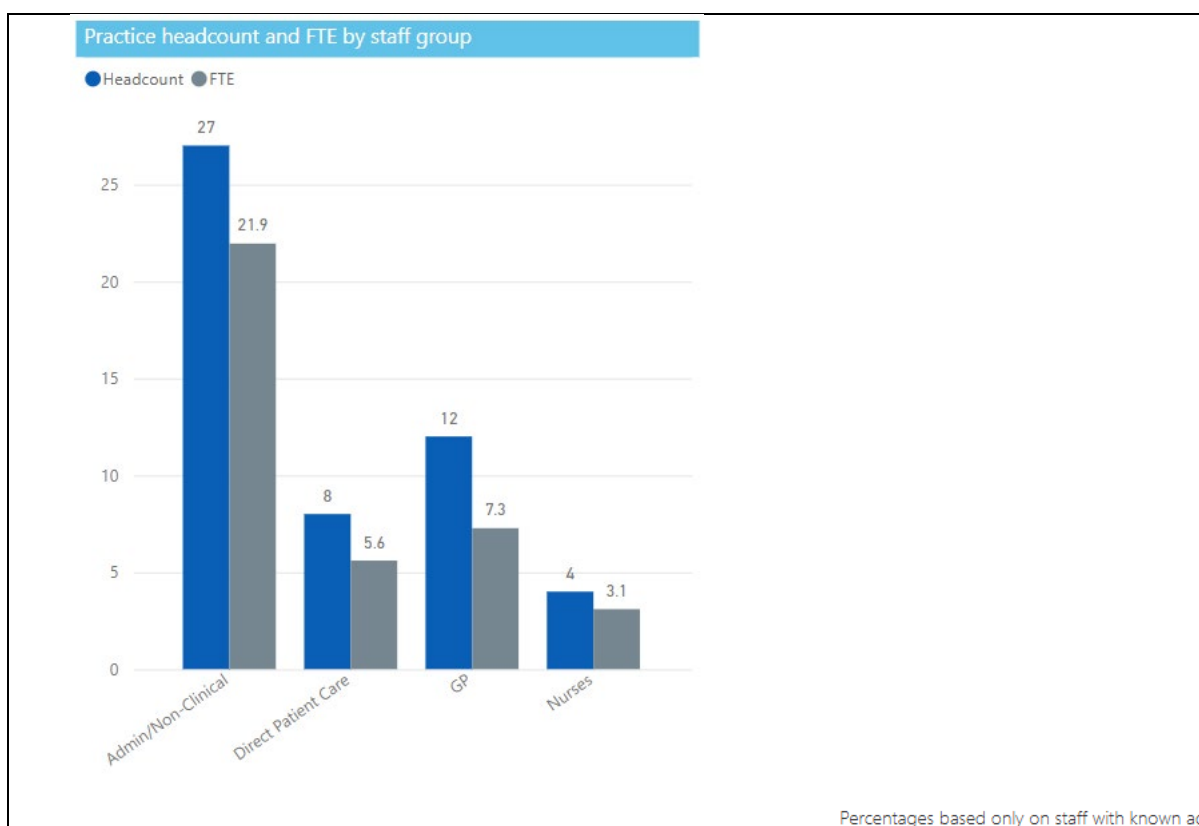
2.2 Loxford Surgery, Loxford Polyclinic, 417 Ilford Lane, Ilford, IG1 2SN



(Figure 1.0 Practice catchment area)

## 2.3 Clinical Workforce

The GP FTE per 100k registered patients is below the ICB average and national average. The nurses FTE per 100k registered patients is below the ICB and national average too.



(Figure 2.0 Practice Workforce)  
 (Source: [NHS Digital, Primary Care Workforce Dashboard](#))

## 2.4 Patient List

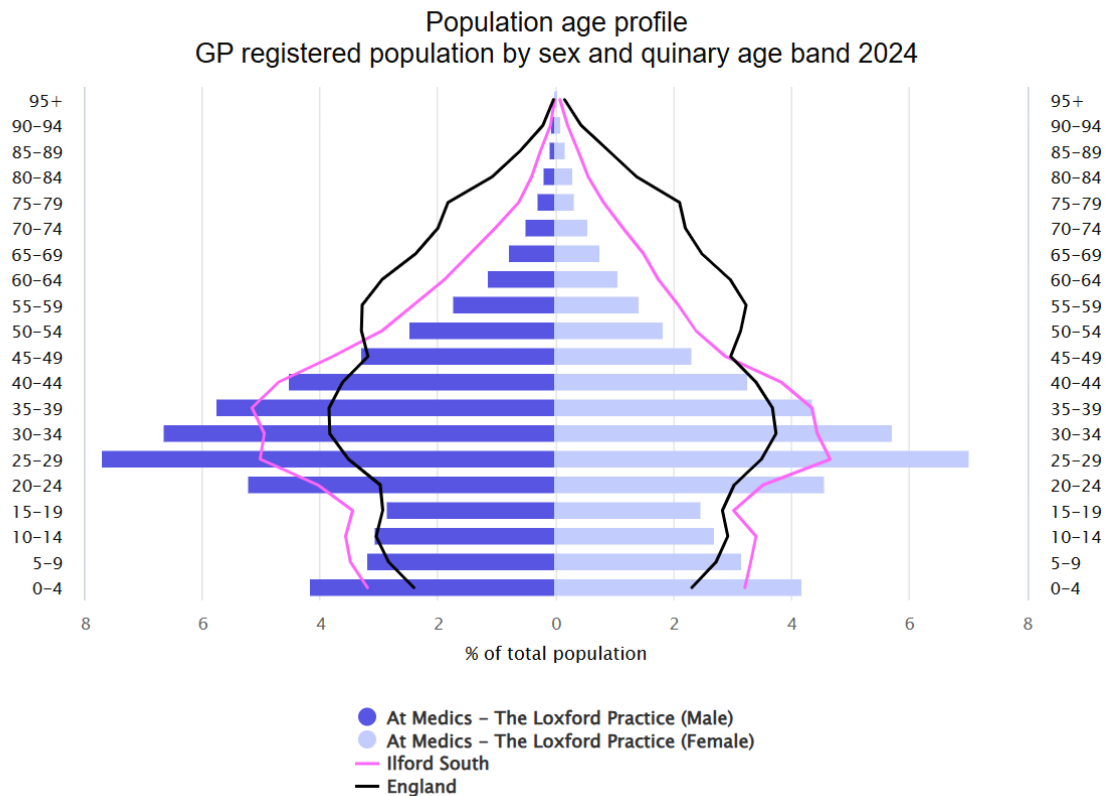
There has been substantial growth in the patient list size over a 5-year period.

Date	Raw List Size	Weighted List Size
Apr-25	32728	27095.55
Apr-24	33206	28028.76
Apr-23	30043	25705.6
Apr-22	24382	21243.87
Apr-21	21512	18303.44

(Figure 3.0 List size growth)

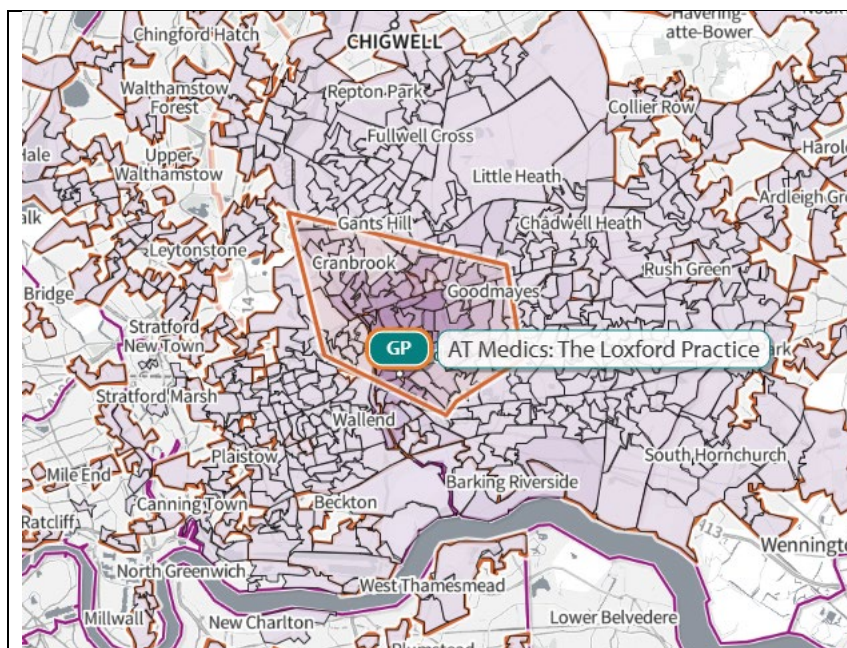
### 2.5 Patient Demographics

The patient demographic data suggests that the ratio of males to females is higher. There is a high demographic of females and males aged between 20-39. The practice is above the average for Ilford South for patients 0-4. Overall, much lower amount of older patients compared to the locality and national average and the same for patients aged 5-19.



According to the 2021 Census data, the ethnic breakdown of the patient demographic consists of 20.9% White, 3.3% mixed, 58.4% Asian, 11.8% black and 5.6% other non-white ethnic groups. In terms of deprivation, the practice resides within the fourth most deprived decile.

Source: <https://fingertips.phe.org.uk/>



Based on April 2025 figures. 98.52% reside within the borough, with 1.48% outside the borough.

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

### 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 4.0 below:

(Figure 4.0 – QOF Achievement)

Financial year	Practice Achievement	Redbridge Average	Variance
2023-24	582.56 out of 635 points	581.60	0.96 percentage point
2022-23	575.42 out of 635 points	573.42	2.02 percentage point
2021-22	580.96 out of 635 points	577.99	2.97 percentage point

Source: [NHS Digital QOF Data](#)

#### 3.2 Childhood Immunisations

In 2024-25 the overall uptake of childhood immunisations for this practice was slightly lower than the Redbridge average.

Patients becoming 12m	DTaP/IPV/Hib/ HepB (%)	Men B (%)	PCV (%)	Rotavirus (%)
The Practice Loxford	86.1%	84.80%	89.90%	83%
Redbridge average	<b>90.8%</b>	<b>89.50%</b>	<b>93.80%</b>	<b>89%</b>

Patients becoming 24m	DTaP/IPV/Hib/HepB (%)	MMR (%)	HiB/Men C (%)	PCV (Booster) (%)
The Practice Loxford	87.90%	83.30%	84%	82.60%
Redbridge Average	<b>89.50%</b>	<b>86.70%</b>	<b>86.50%</b>	<b>85.40%</b>

Patients becoming 5y	DTaP/IPV/Hib/HepB (%)	MMR (Primary) (%)	DTaP/IPV (Booster) (%)	MMR (Booster) (%)	HiB/Men C (%)
The Practice Loxford	84.50%	80.80%	71.2	77.6	82.70%
Redbridge Average	<b>87.90%</b>	<b>88.90%</b>	<b>79.10%</b>	<b>85.60%</b>	<b>87%</b>

(Source: CEG dashboard data 24/25)

### 3.3 Flu

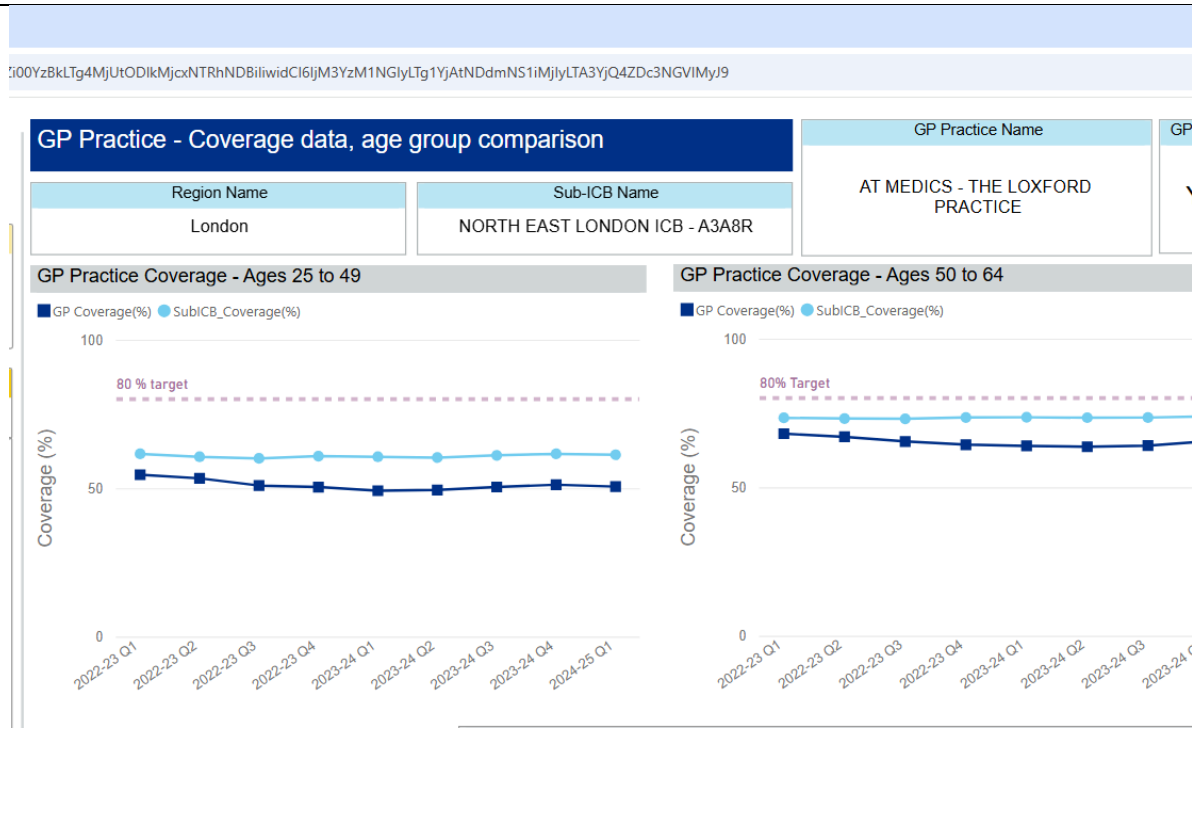
The uptake of the seasonal flu vaccine was lower than the Redbridge average in all cohorts except in healthy Pregnant patients.

FLU (CEG Data 03/03/25)	Loxford	Redbridge Total
Patients 65 over (excluding care homes & housebound)	49%	63%
Patients living in residential/care homes	47%	62%
Patients who are housebound (age 65 & over with clinical risk)	64%	72%
Patients aged 50 - 64 at clinical risk (excluding housebound)	41%	45%
Patients aged 18 to 49 yrs at clinical risk(excluding housebound)	28%	29%
Pregnant patients at clinical risk	44%	51%
Healthy pregnant patients	29%	29%
Children aged 2 to 3 yrs at clinical risk	35%	44%
Healthy children aged 2-3 yrs	27%	32%

### 3.4 Cervical Screening

The Loxford Practice achieved lower than the NEL average for both 25-49 yrs and 50-64 yrs.

Cervical screening	%
Age 25-49 % cervical smear age 25-49	50.54%
Age 50-64 % cervical smear age 50-64	66.31%
<b>NHS digital Q1 24/25</b>	



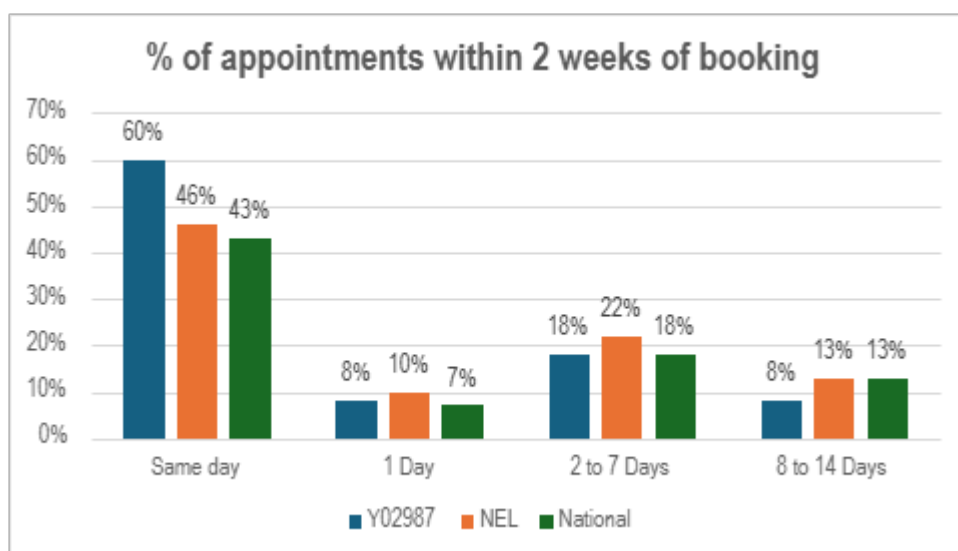
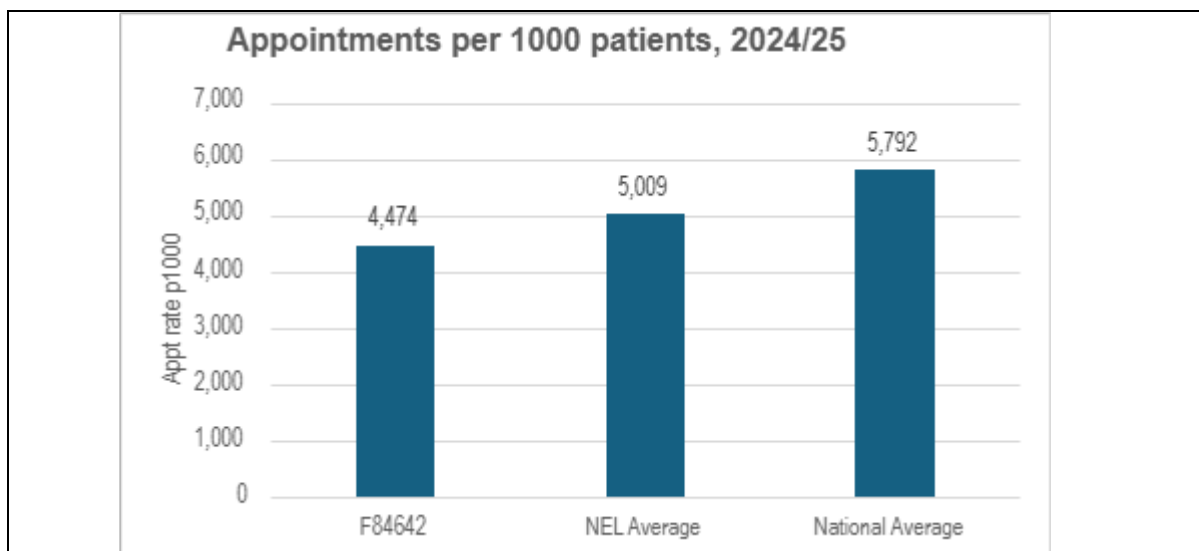
## 4.0 Service Delivery

### 4.1 Access

The following data has been extracted from the GPAD data from 2024/2025, this shows the practice is below the borough average for appointments per 1000 patients.

In 2024/25 the practice appointment rate per 1000 was 4,474 compared to a NEL average of 5,009 and national average of 5,792. We are not performance monitoring the practice in relation to this.

94% of appointments took place within 2 weeks compared to 90% in NEL average and 81% national average. NHSE operational planning guidance indicates that a minimum of 85% of GP appointments should take place within 2 weeks of booking. 60% of these appointments take place on the same day.



The following data has been extracted from the GPAD data from 2024/2025, this shows the practice is below the borough average.

#### 4.2 A&E data

In 2024/25 the practice rate of in hours attendances per 1000 to A&E was higher than the PCN, Redbridge and NEL average. This could be due to the level of deprivation in the locality.

Practice/Benchmark	In hours A&E attendance per 1000
Y02987	19.2
Loxford PCN	18.3
Redbridge Average	15.8
NEL Average	15.6

4.3 Prescribing Quality and Efficiency

**Pharmacy and Medicines Optimisation**

The summary of the practice’s implementation and delivery of NEL Pharmacy and Medicines Optimisation programmes to ;

- Improve appropriate, cost-effective and safe use of medicines
- Improve patient health outcomes
- Collaborate with community pharmacy providers and Clinical referral services

**Referral to Community Pharmacy Clinical Pathways**

Service	Period	Number of referrals-Practice
Pharmacy First	January 2025	60 referrals per 10,000 patients

**Delivery of the Prescribing Quality and Efficiency Scheme**

The Prescribing Efficiency Scheme (PES) is an initiative aimed at enhancing cost-effectiveness of medicines within Primary Care.

Indicator	Practice Output
% current recommended Blood Glucose Testing Strip (BGTS) items	34.5% vs a target of 50%.
Selected Cost Improvement Plan Savings	£89297 vs a target of £83553

**Antibiotics**

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)
<b>Target</b>	≤0.871	≤10%	>40%
<b>Practice achievement</b>	12m Rolling data (Mar-24) 0.644	12m Rolling data (Mar-24) 5.20%	12m rolling data (Mar-24) 60.07%

#### 4.4 KPIs

This contract was originally commissioned on London-wide APMS terms and conditions when procured in 2015. Therefore, the contract included an APMS Mandatory Terms and Services Price of £12.57 and KPI payment of £5.35 per normalised weighted patient (pnwp).

As part of the national and local implementation of the equalisation of GMS, PMS and APMS contracts (effective from 2019/20), all new APMS contracts that have been commissioned across NEL now include a reduced APMS Mandatory Terms and Services Price of £5 pnwp and KPI payments have been removed. Practices can still supplement their income by signing up to Local Incentive Schemes (LISs) at borough level. This is the proposed approach for the re-procurement of this contract.

For 23/24, the practice underachieved in areas regarding screening, vaccinations and patient voice and a clawback of approximately £9.5k was issued.

#### 4.5 Innovation

Over the past year, the practice has made significant improvements to enhance patient access and service delivery through the implementation of a new digital platform. The registration process has been fully automated using Health Tech 1, making it easier for new patients to register and book appointments. They have also introduced the Health Tech Bookable feature, allowing new patients to conveniently book their first appointments online. The practice now operates under the Doctor First Triage Model, where all appointment requests are reviewed and triaged by a GP. This approach ensures patients are seen by the right clinician at the right time.

As a result of these improvements, they are seeing a reduction in the number of DNAs (Did Not Attend) and double bookings, contributing to better efficiency and patient satisfaction.

### 5.0 Contract & Regulatory Compliance

5.1 The practice is currently rated as 'Good' by the CQC. This was inspected in May 2019 but was reviewed in July 2023. 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 Loxford Surgery.

5.3 The last annual contract review for financial year 2023/24 was undertaken earlier this year and there was no other contractual or performance concerns highlighted with this practice.

### 6.0 Premises and Estates

6.1 The practice has a lease with NHSPS that is due to expire on 31 August 2029.

6.2 The site is listed as 'Core' within the NEL Primary Care Estates Strategy. This means the site is managed or owned by the NHS or local authority and greater utilisation of the

estate is to be identified, as neighbourhood models of care develop and further opportunities for estate usage identified.

### 7.0 Patient Experience

#### 7.1 PPG & Patient experience outcomes reported

The practice has an active PPG and meetings are held every 3 months. They actively take Friend and Family feedback forms from patients and submit monthly returns to the internal team for review. Following a PPG suggestion they have organised drop in events at the practice to encourage patient to use the NHS app and Evergreen app, to promote digital inclusion.

#### 7.2 GP Patient Survey (GPPS)

The GPPS results for 2023 were around the ICB average for some of the key questions that were analysed.

(Figure 6.0 – GPPS Results 2023)

	Practice Result	ICB Result	Above / Below ICB Average
Describe their overall experience of this GP practice as good	51%	68%	Below
Were offered a choice of time or day when they last tried to make a general practice appointment	35%	52%	Below
Find it easy to get through to this GP practice by phone	18%	48%	Below

### 8.0 Contract Value

Loxford Practice	Price
Global Sum +Londonwide APMS Mandatory Terms & Services Price	£ 3,640,557.96
London Allowance	£ 71,347.04
OOHs deduction - %	-£ 176,315.49
Aspiration payment - Band B	£ 57,984.47
100% Achievement - Band A	£ 86,976.71
<b>Total</b>	<b>£ 3,680,550.70</b>

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

Considerations	Option 1 - Do nothing (Dispersal)	Option 2 – Award a new contract via PSR Direct Award Route C	Option 3 – Procure a new contract via PSR Competitive Process
<b>Pros</b>	This is not a viable option as NEL ICB has a statutory duty to ensure suitable medical service provision is in place for its local population.	<ul style="list-style-type: none"> <li>• If the ICB is satisfied with the current contractor, this would cause no disruption to services or patients.</li> <li>• Maintains existing working relationships for current contractor and other stakeholders.</li> <li>• Would reduce administrative burden on the ICB as contract would not be procured using a competitive process.</li> </ul>	<ul style="list-style-type: none"> <li>• Will ensure continuity of care for patients with minimum disruption to services</li> <li>• Will help retain GP services within an area of high deprivation in Redbridge</li> <li>• Will ensure the least resistance backlash from patients and stakeholders</li> </ul>
<b>Cons</b>	Not applicable	<ul style="list-style-type: none"> <li>• Only suitable for contracts where there is no substantial change to the contract.</li> <li>• This would mean no equalisation of the APMS terms, which would mean a financial disbenefit to the ICB.</li> </ul>	<ul style="list-style-type: none"> <li>• There are financial costs associated with undertaking a full procurement such as buying in external expertise</li> </ul>
<b>Risks</b>	Not applicable	<ul style="list-style-type: none"> <li>• Substantial risk of challenge from other contractors due to size and length of contract</li> </ul>	<ul style="list-style-type: none"> <li>• Delays to procurement timeline</li> <li>• Lack of interest from suitable bidders</li> </ul>
<b>Mitigation</b>	Not applicable	<ul style="list-style-type: none"> <li>• Follow NHSE direct award route C process and toolkit.</li> </ul>	<ul style="list-style-type: none"> <li>• Align procurement to the timelines for the APMS Tranche 3 programme</li> </ul>

**Preferred Option:**

The preferred option is to procure a new APMS contract, through PSR competitive process, based on the following rationale:

- Minimal impact to patient care as service delivery will continue to operate, under a substantive provider
- Primary medical service provision will be maintained in an area that is expecting high-population growth
- There will be a financial benefit as the new APMS contract will be on financially equalised terms to other APMS contracts (see Figure 7.0)
- Patient satisfaction in the assurance of continuity of care

(Figure 7.0 – Proposed contract value under equalised APMS terms)

<b>Loxford Surgery</b>	<b>Price</b>
Global Sum price	£3,299,966.91
London Allowance	£71,347.04
Risk Premium	£135,477.74
<b>Sub-total</b>	<b>£3,506,791.69</b>
Less: OOH deduction (% of Global Sum + London Weighting)	<b>-£160,137.41</b>
<b>Total</b>	<b>£3,346,654.28</b>
<b>Saving to ICB</b>	<b>£333,896.42</b>

**10.0 Next steps**

If approved, move to procurement of the contract under the T3 APMS procurement programme.

- Enact selected PSR routes for the procurement of the contract (Oct 2025 – June 2026)
- Contract Mobilisation (June – July 2026)
- New Contract commencement (1 August 2026)

## Primary Care Contracts Sub-committee

8 July 2025

<b>Title of report</b>	APMS Commissioning Intentions - Newham Transitional Practice
<b>Author</b>	Safdar Raffiq, Primary Care Commissioning Manager, NEL ICB
<b>Presented by</b>	Benjamin, Senior Primary Care Commissioning Manager, NEL ICB
<b>Contact for further information</b>	<a href="mailto:Safdar.raffiq@nhs.net">Safdar.raffiq@nhs.net</a>
<b>Executive summary</b>	<p>Newham Transitional Practice (NTP) is a specialist APMS contract that provides primary care services for individuals experiencing homelessness and social exclusion. The contract has been managed by East London Foundation Trust (ELFT) since April 2020.</p> <p>The original contract had a maximum term of 15 years, with break clauses every five years. A break clause was activated in 2024, and the contract was subsequently extended for 12 months from 1 April 2025, with the current term now set to expire on 31 March 2026. Key Performance Indicators (KPIs) for this period became effective from 1 July 2024 and contract performance is reviewed annually.</p> <p>The Strategic Commissioning Review provides an overview of contract performance and highlights key considerations for determining the future of the contract beyond its current expiry.</p> <p>NTP has maintained strong performance across a range of indicators and has exceeded borough and ICB averages in several areas, including GP access and results from the GP Patient Survey. Areas for improvement have been identified in QOF achievement and childhood immunisation rates. Efforts are underway to address these gaps, including initiatives aimed at reducing vaccine hesitancy within the wider community.</p> <p>There are no contract compliance issues or concerns with the practice. Given the current performance and the ongoing strategic developments, we propose extending the contract for a further 12 months, to 31 March 2027. This extension will provide the necessary time to incorporate recommendations from the NEL Homelessness Strategy Framework, which is currently under development.</p>
<b>Action / recommendation</b>	The Committee is asked to approve the recommendation to extend the contract for a further year, until 31 March 2027, in the first instance. This extension will allow time to incorporate the NEL Homelessness Strategy, which is currently being finalised.
<b>Previous reporting</b>	This report has been discussed at the Newham Primary Care Transformation Group and the extension proposal supported

<b>Next steps/ onward reporting</b>	<ul style="list-style-type: none"> <li>• Issue contract extension</li> <li>• Continue monitoring progress and the areas for improvement will be reviewed as part of the 25/26 contract review</li> </ul>	
<b>Conflicts of interest</b>	Any conflicts of interest to be managed in line with the Terms of Reference (ToR) of the Committee.	
<b>Strategic fit</b>	<p>Which of the ICS aims does this report align with?</p> <ul style="list-style-type: none"> <li>• To improve outcomes in population health and healthcare</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To support broader social and economic development</li> </ul>	
<b>Impact on local people, health inequalities and sustainability</b>	<p>Extending this contract will ensure the continued delivery of specialised primary care services for the homeless population in Newham. These services are specifically designed to meet the complex and unique needs of individuals experiencing homelessness, helping to address health inequalities linked to socio-economic deprivation. Furthermore, the provision of targeted care plays a critical role in reducing disparities in physical health outcomes among a population disproportionately affected by mental illness and substance misuse.</p>	
<b>Impact on finance, performance and quality</b>	<p>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.</p>	
<b>Risks</b>	<b>Risk</b>	<b>Mitigation</b>
	<p>NEL Homeless Strategy may not be ready in time for commissioning cycle 26/27.</p> <p>Short length of contract extension may not be attractive to current provider</p>	<p>Offer a further extension if NEL Homeless Strategy is delayed.</p> <p>Discuss with ELFT if there are issues with a 12-month extension.</p>
<b>Appendices</b>	Appendix 1 – Newham Transitional Practice Strategic Review	

GP Contract Strategic Commissioning Review Business Case

<b>Place:</b>	<b>PCN:</b>
Newham	Stratford PCN
<b>Practice name:</b>	<b>Practice code:</b>
Newham Transitional Practice	F84740
<b>Raw list size:</b>	<b>Weighted list:</b>
4236 (1 April 2025)	4042.09 (1 April 2025)
<b>Current provider:</b>	
East London Foundation Trust (ELFT)	
<b>Contract Start Date:</b>	<b>Contract End date:</b>
1 April 2020	31 March 2026
<b>Contract Term Provision for Extension/Break Clause:</b>	
This contract was procured for a term of 15 years (5+5+5) with the option to extend until 31 March 2035. After the 5 year break clause, it was agreed to extend the contract for a further 12 months until 31 March 2026.	
<b>Reason for contract review:</b>	
This contract is approaching the end of the 12 months extension.	
<b>Practice website:</b>	
<a href="https://newhamtransitionalpractice.co.uk/">https://newhamtransitionalpractice.co.uk/</a>	
<b>Report Completed by:</b>	
Safdar Raffiq, Commissioning Manager, NHS North East London	
<b>Equality Impact Assessment Completed:</b>	
Not required as no change to service provision.	
<b>Summary of Recommendation:</b>	
Recommendation is to extend the contract for a further 12 months until 31 March 2027.	
<b>1.0 Contract Overview / History</b>	
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.	

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

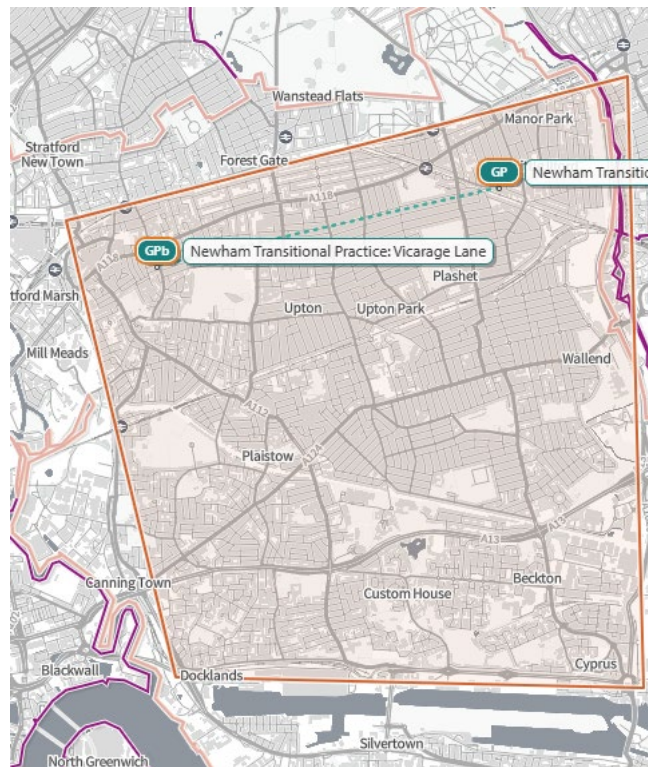
1.3 The contract has passed its 5 year break clause and was extended for a further 12 months on 1 April 2025.

## 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. Premises Occupied:

- 30 Church Road, London E12 6AP (main site)
- 10 Vicarage Lane, London E15 4ES (branch site)



(Figure 1.0 Practice catchment area)

### 2.3 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	5.0	3.0	1.0	1.0	0.7	0.2	845

(Figure 2.0 Practice Workforce)

(Source: [NHS Digital, Primary Care Workforce Dashboard](#))

### 2.4 Patient List

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.

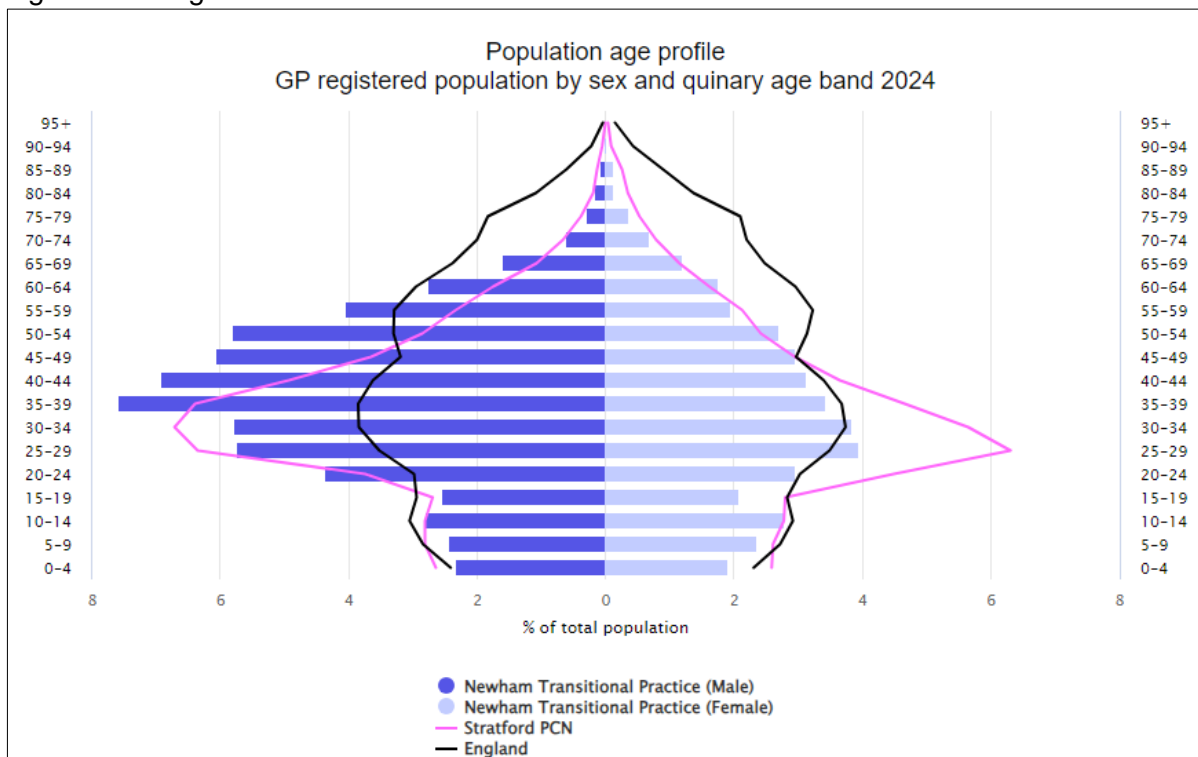
Period	Raw List Size	Variation to Previous Year (count)	Variation to Previous Year (%)
Apr-25	4,236	-60	-1.4
Apr-24	4,296	378	9.6
Apr-23	3,918	-190	-4.6
Apr-22	4,108	114	2.9

(Figure 3.0 List size growth)

### 2.5 Patient Demographics

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

We have not identified any specific areas of concern, nor do we believe there is a need for a targeted plan. Overall performance will be discussed at the next contract meeting.

#### 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 4.0 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 4.0 – QOF Achievement)

Financial year	Practice Achievement	Newham Average	Variance
2023-24	534.32 out of 635 points	542.89	3.64 percentage points below
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

Source: [NHS Digital QOF Data](#)

### 3.2 Childhood Imms

In 2024-25 the overall uptake of childhood immunisations for patients becoming 5yrs was above the Newham average, including uptake of MMR primary and booster. The uptake of childhood immunisations for patients becoming 24m is slightly below than the Newham average.

Patients becoming 12m	DTaP/IPV/Hib/HepB(%)	Men B(%)	PCV(%)	Rotavirus(%)
Newham Transitional Practice	90.9%	87.5%	93.8%	87.5%
Newham Average	<b>89.4%</b>	<b>88.4%</b>	<b>92.2%</b>	<b>87.6%</b>

Patients becoming 24m	DTaP/IPV/Hib/HepB (%)	MMR(%)	HiB/Men C (%)	PCV (Booster)(%)
Newham Transitional Practice	87.9%	80.2%	79.3%	77.6%
Newham Average	<b>88.6%</b>	<b>83.7%</b>	<b>83.7%</b>	<b>82.2%</b>

Patients becoming 5 yrs	DTaP/IPV/Hib/HepB(%)	MMR (Primary)(%)	DTaP/IPV (Booster)(%)	MMR (Booster)(%)	HiB/Men C(%)
Newham Transitional Practice	92.9%	92.9%	82.1%	89.3%	82.1%
Newham Average	<b>87.7%</b>	<b>87.3%</b>	<b>76.1%</b>	<b>80.2%</b>	<b>86.2%</b>

(Source: CEG data 2024-25)

### 3.3 Flu

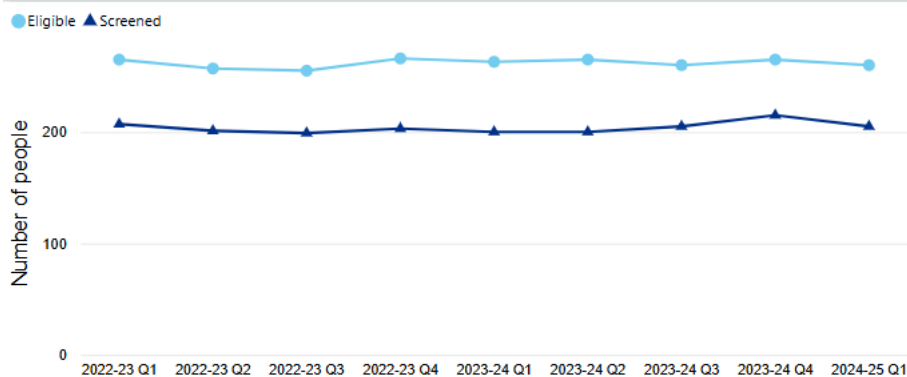
In 2024-25 the uptake of the seasonal flu vaccine was higher than the Newham average.

Seasonal Flu Uptake 24-25	Patients Age 65+ (exc. care homes & housebound)
Newham Transitional Practice	57%
PCN Average	48%
Newham Average	54%

(Source: CEG data 2024-25)

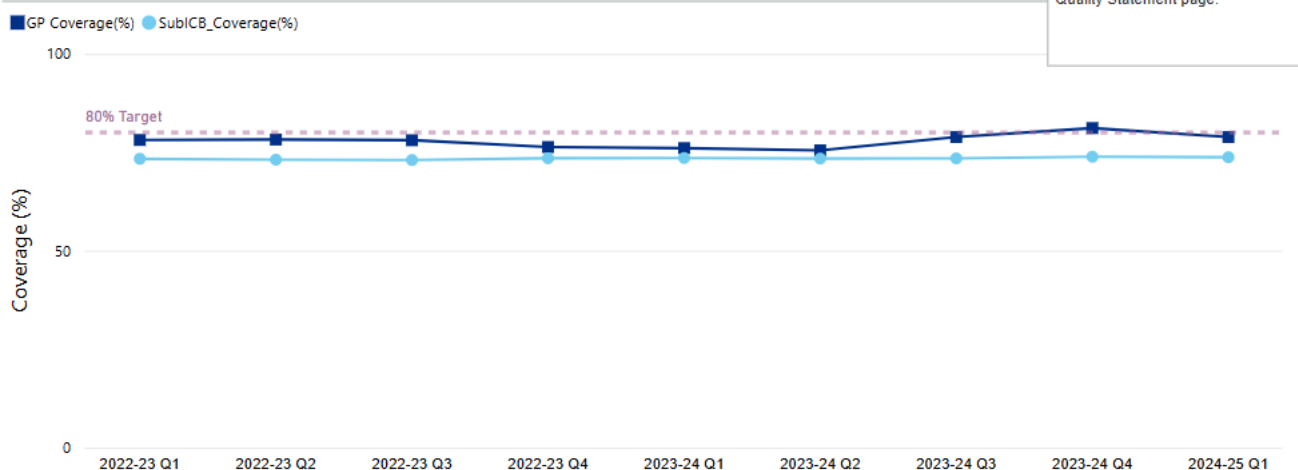
3.4 Newham Transitional Practice exceeded the North East London (NEL) average and surpassed the 80% target in Q4 of 2023/24. However, coverage tends to fluctuate and generally remains below the national target of 80%.

Eligible and Screened Population of GP Practice, by Quarter



(Source: NHS Digital)

GP Practice and Sub-ICB Coverage, by Quarter



(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 2024-25 the practice delivered 5,750 appointments per 1000 patients compared to the NEL average of 5,009 and national average of 5795.

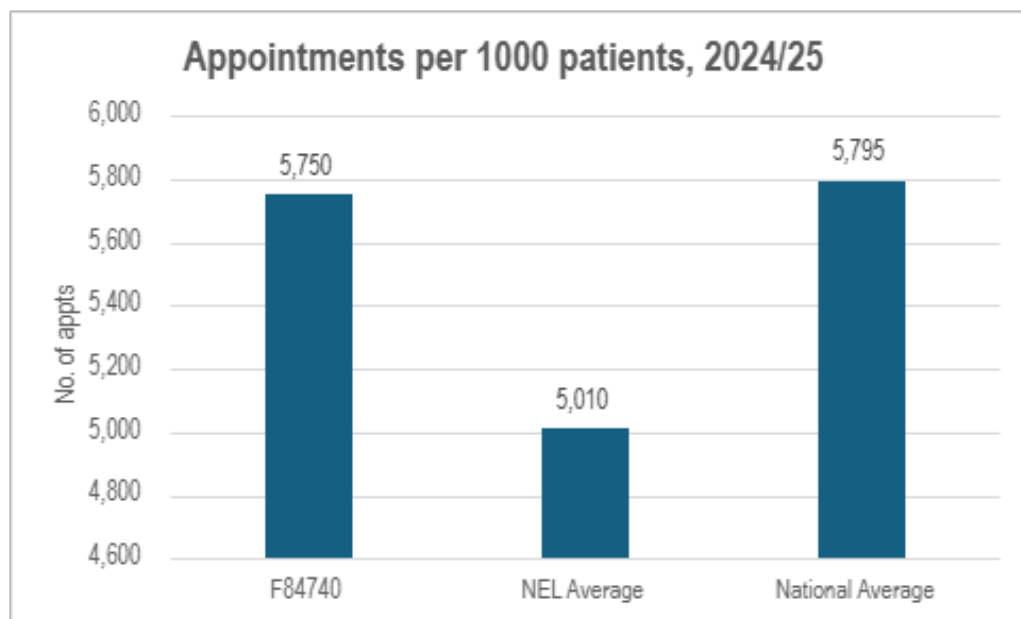
95% of appointments took place within 2 weeks of booking compared to 90% in NEL average and 81% national average. NHSE operational planning guidance indicates that a minimum of 85% of GP appointments should take place within 2 weeks of booking.

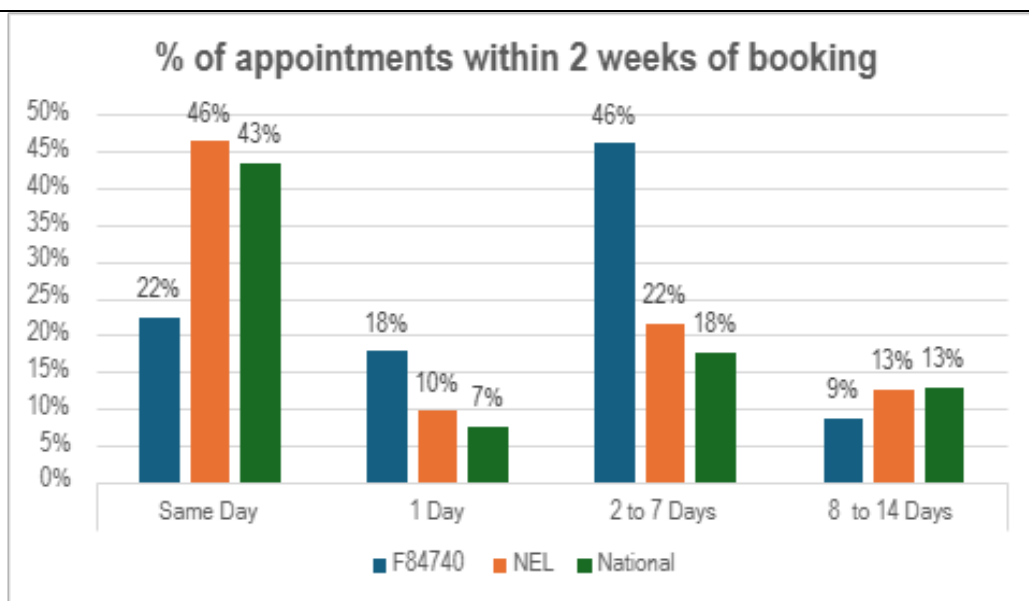
Newham Transitional practice offers more appointments per 1000 patients than the NEL average but slightly fewer than the national average. However, the majority of appointments took place within 2 weeks of booking.

### GPAD data 2024/25

	Appt rate p1000	Same Day	1 Day	2 to 7 Days	8 to 14 Days
Newham Transitional Practice	5750	22%	18%	46%	9%
NEL Average	5009	46%	10%	22%	13%
National Average	5795	43%	7%	18%	13%

(Source: NHSE Digital)





#### 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 – latest data available\* )

#### 4.3 Prescribing Quality and Efficiency

Service	Period	Number of referrals-Practice
Pharmacy First	January 2025	71 referrals per 10,000 patients

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 Efficiency Scheme (PES) is an initiative aimed at enhancing cost-effectiveness of medicines within Primary Care.

Indicator	Practice Output
% current recommended BGTS items	93.5% vs a target of 50%.
Selected Cost Improvement Plan Savings	£22,909 vs a target of £16.171

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 25 (12 months rolling data)	Proportion of co-amoxiclav, cephalosporin & quinolone items position March 25 (12 months rolling data)	Amoxicillin 500mg capsule: % of total items, 5 days (Quantity=15) March 245 (12 months rolling data)
≤0.871	≤10%	>40%
0.547	5.81%	62.5%

4.4 The contract under review was initially commissioned with the inclusion of Key Performance Indicators (KPIs), with KPI-related payments comprising 20% of the total contract value, amounting to £130,000. At the time of commissioning, which coincided with the peak of the Covid-19 pandemic, the practice was not required to deliver homeless-specific KPIs. Instead, it was commissioned to meet the Newham Outcome Measures (OMs), which apply to all GP practices across Newham.

Upon reaching the end of its original five-year term, the contract was extended for an additional 12 months. As part of this extension, the practice was required to implement a revised set of KPIs aligned with those in place for other homeless-specific contracts across North East London (NEL).

The practice’s submission for the 2024/25 KPIs demonstrated strong performance, achieving the top threshold in the majority of the indicators. However, two specific areas were identified where performance fell below expected standards were Diabetes Management and Breast Screening.

These areas of underperformance will be formally addressed in the upcoming contractual review meeting. The aim will be to understand the contributing factors and agree on remedial actions to ensure improvement in these key clinical domains.

The practice has shown a high level of compliance with the revised KPIs, reflecting strong overall performance. Focused attention on diabetes management and breast screening will be essential to maintain the quality and equity of care expected under this contract.

#### 4.5 Innovation

The practice runs outreach clinics within the community, including in hostels for vulnerable individuals and community centres. These clinics offer primary healthcare services and refer patients to appropriate support when needed. The team also collaborates closely with community mental health services and hostels that support people recently released from prison. Service users can access hot and cold meals, clothing, haircuts, and shower facilities.

### 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 next annual contract review for financial year 2024/25 is being undertaken soon as we have only recently had the KPIs.

### 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 establish 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 2024 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 2024

	Practice Result	ICB Result	Above / Below ICB Average
Describe their overall experience of this GP practice as good	92%	68%	Above
Felt their needs were met during their last general practice appointment	97%	87%	Above
Find it easy to get through to this GP practice by phone	79%	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)**

Considerations	Option 1 - Do nothing (Dispersal)	Option 2 – Procure a new contract via PSR Competitive Process	Option 3 – Offer 12-month contract extension
<b>Pros</b>	This is not a viable option as NEL ICB has a statutory duty to ensure suitable medical service provision is in place for its local population.	<ul style="list-style-type: none"> <li>Tendering a new contract will provide an opportunity to develop a new model and service specification.</li> </ul>	<ul style="list-style-type: none"> <li>Will ensure continuity of care for patients with minimum disruption to services</li> <li>Will ensure the least resistance backlash from patients and stakeholders</li> <li>Service delivery to this specialist population will not be disrupted. There are no significant performance concerns in relation to the delivery of the contract.</li> <li>Gives the ICB the opportunity to align this contract with the NEL Homeless Strategy that is being developed for 2026.</li> </ul>
<b>Cons</b>	Not applicable	<ul style="list-style-type: none"> <li>Disruption to services for this client group who already have challenging needs and are disengaged with local health services.</li> <li>Loss of a good provider with experience of working with the homeless population in Newham.</li> </ul>	None
<b>Risks</b>	Not applicable	<ul style="list-style-type: none"> <li>Limited providers in the market with a track record of delivering specialist homeless contracts</li> <li>Other providers may not have the resources to provide patient care in outreach services</li> </ul>	<ul style="list-style-type: none"> <li>Short length of contract extension may not be attractive to current provider</li> <li>NEL Homeless Strategy may not be ready in time for commissioning cycle 26/27.</li> </ul>
<b>Mitigation</b>	Not applicable	<ul style="list-style-type: none"> <li>Market testing will need to be undertaken and ensure a</li> </ul>	<ul style="list-style-type: none"> <li>Discuss with ELFT if there are issues with 12-month extension.</li> </ul>

		<p>sufficient timeframe for the tender process</p> <ul style="list-style-type: none"> <li>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</li> </ul>	<ul style="list-style-type: none"> <li>Offer a further extension if NEL Homeless Strategy is delayed.</li> </ul>
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**Preferred Option:**

The preferred option would be extending the contract for a further 12 months until 31 March 2027. This option carries the least amount of risk and will ensure continuity of patient care. It will also give the option to allow for the NEL Homeless strategy to be incorporated.

**10.0 Next steps**

- Issue provider with contract variation extension notice
- Continue with regular contract reviews

## Primary Care Contracts Sub-committee

8 July 2025

<b>Title of report</b>	Month 2 Primary Care Finance Report
<b>Author</b>	Rob Dickenson – Deputy Director of Finance
<b>Presented by</b>	Rob Dickenson – Deputy Director of Finance
<b>Contact for further information</b>	r.dickenson@nhs.net
<b>Executive summary</b>	Summary of the Month 2 reported financial position.
<b>Action / recommendation</b>	Note the content of the report
<b>Previous reporting</b>	N/A
<b>Next steps/ onward reporting</b>	N/A
<b>Conflicts of interest</b>	No decisions required therefore no conflicts to manage
<b>Strategic fit</b>	<ul style="list-style-type: none"> <li>To improve outcomes in population health and healthcare</li> <li>To tackle inequalities in outcomes, experience, and access</li> <li>To enhance productivity and value for money</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	Continual assessment of Value for Money (VfM) of current and future investments to reduce inequalities and provide a valuable service to the local people.
<b>Has an Equalities Impact Assessment been carried out?</b>	This is not required for this report.
<b>Impact on finance, performance and quality</b>	<p>Ongoing review of financial commitments against available resources.</p> <p>The total Primary Care budget, including Prescribing and DOPs is £1,106.4m.</p> <p>The Month 2 YTD position is £0.1m overspend with a FOT break-even to plan.</p>
<b>Risks</b>	The main risks to the position are Prescribing, Demographic Growth, ARRS, estates developments and SDF.

### 1.0 Introduction

1.1. This report provides the Primary Care Contracts Sub-Committee with a summary of the financial position and associated risks, both at a high-level (NHS NEL) but also providing some information at a Place level.

1.2. The report is being presented to the Sub-Committee for information only.

## 2.0 Month 2 Financial Overview

2.1. At Month 2, NHS NEL reported a YTD overspend of £0.1m and FOT of break-even to plan.

Month 2	YTD			Annual/Forecast		
	Budget	Actual	Variance	Budget	FOT	Variance
Area of spend	£m	£m	£m	£m	£m	£m
<b>Delegated Primary Medical Services</b>	80.5	80.5	0.0	483.2	483.2	0.0
Prescribing	54.0	54.0	0.0	323.7	323.7	0.0
Other ICB Funded Primary Care Services	9.2	9.3	0.1	55.2	55.2	0.0
<b>Total ICB Funded Primary Care Services</b>	<b>63.2</b>	<b>63.4</b>	<b>0.1</b>	<b>378.9</b>	<b>378.9</b>	<b>0.0</b>
SDF and other PC allocations	0.7	0.7	0.0	4.5	4.5	0.0
<b>Total Primary Care Position (excl. DOPs)</b>	<b>144.5</b>	<b>144.6</b>	<b>0.1</b>	<b>866.5</b>	<b>866.5</b>	<b>0.0</b>
Delegated Dentistry, Optometry and Pharmacy (DOPs)	40.0	40.0	0.0	239.9	239.9	0.0
<b>Total Primary Care Position (incl. DOPs)</b>	<b>184.5</b>	<b>184.6</b>	<b>0.1</b>	<b>1,106.4</b>	<b>1,106.4</b>	<b>0.0</b>

2.2. The total Primary Care reported position is a small YTD overspend of £0.1m across a range of spend categories but the current assumption is these will level out by year-end, thus the FOT being to plan. Month 2 reporting is always limited by a number of time lags in data e.g. Prescribing and Pharmacy are 2 months behind and Optometry is one month behind. Also at this stage, most of the contractual payments from Delegated are in line with budget. In the coming months, more information will be available to provide a more informed in-year position.

2.3. 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 break-even YTD and FOT:

Month 2	YTD			Annual/Forecast		
	Budget	Actual	Variance	Budget	FOT	Variance
Spend Category	£m	£m	£m	£m	£m	£m
<b>GMS/PMS/APMS Specific</b>						
GP Contractual Service	46.0	46.0	0.0	276.3	276.3	0.0
Enhanced Services	0.4	0.4	0.0	2.7	2.7	0.0
Quality Outcomes Framework (QOF)	3.8	3.8	0.0	22.9	22.9	0.0
Premises Reimbursements	7.6	7.6	0.0	45.4	45.4	0.0
Other Administered Funds	0.6	0.6	0.0	3.7	3.7	0.0
Personally Administered Drugs	0.2	0.2	0.0	0.9	0.9	0.0
<b>GMS/PMS/APMS Specific Total</b>	<b>58.6</b>	<b>58.6</b>	<b>0.0</b>	<b>351.8</b>	<b>351.8</b>	<b>0.0</b>
Primary Care Networks (PCN)	17.7	17.7	0.0	106.0	106.0	0.0
Other	4.2	4.2	0.0	25.3	25.3	0.0
<b>Total Delegated Primary Care Position</b>	<b>80.5</b>	<b>80.5</b>	<b>0.0</b>	<b>483.2</b>	<b>483.2</b>	<b>0.0</b>

- 3.2.2. The budgets for most of the categories of spend, such as GMS/PMS/APMS, have been calculated using initial payments in April and May. As such, the YTD spend is in line with YTD budget, and the assumption is that the forecast follows this trend.
- 3.2.3. There are risks to this position, as referred to in the risk section of this paper, however at this early stage it is not possible to quantify or validate any of these risks.
- 3.2.4. Variances will be reflected in the reported position at a later date, if/when these risks give rise to probable cost pressure.

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

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

Month 2	YTD			Annual/Forecast		
	Budget	Actual	Variance	Budget	FOT	Variance
<b>Spend Category</b>	£m	£m	£m	£m	£m	£m
Prescribing	53.6	53.6	0.0	321.3	321.3	0.0
Oxygen	0.4	0.4	0.0	2.3	2.3	0.0
Out of hours	0.3	0.3	0.0	1.7	1.7	0.0
LES and Other	6.4	6.5	0.1	38.7	38.7	0.0
GPIT	1.1	1.1	0.0	6.3	6.3	0.0
SDF - Primary Care Transformation	0.7	0.7	0.0	4.5	4.5	0.0
Access Hubs / Same Day Access	1.4	1.4	0.0	8.5	8.5	0.0
<b>ICB Funded Primary Care Services</b>	<b>64.0</b>	<b>64.1</b>	<b>0.1</b>	<b>383.4</b>	<b>383.4</b>	<b>0.0</b>

- 3.3.2. The largest budget in this section is Prescribing. The budget has been set at a higher rate than the 2024-25 outturn (increase of c3.6% after applying a £10m CIP). This is with a view that increasing volumes (which was the predominant reason for an overspend in 2024-25) will continue to be the trend in this financial year.
- 3.3.3. At month 2 there is no in-year data, although even 2 months of data would be insufficient to rely upon to calculate a meaningful forecast. A break-even position was therefore reported until there is sufficient evidence is available.
- 3.3.4. Commissioner reviews of contractual commitments are continuing this year which may give rise to realignment of budgets, increased VfM and may make funding available for use in a different way. For now, it is assumed that the full available budget will be spent.

### 3.4. Delegated Dentistry, Optometry and Pharmacy Services

- 3.4.1. At month 2, the DOPs position is break-even YTD and FOT. The table below provides a breakdown of the relative categories of spend:

Month 2	YTD			Annual/Forecast		
	Budget	Actual	Variance	Budget	FOT	Variance
<b>Spend Category</b>	£m	£m	£m	£m	£m	£m
Delegated Dental	28.8	28.8	0.0	172.6	172.6	0.0
Delegated Optometry	4.2	4.2	0.0	25.2	25.2	0.0
Delegated Pharmacy	7.0	7.0	0.0	41.7	41.7	0.0
Delegated Property Costs	0.1	0.1	0.0	0.3	0.3	0.0
<b>DOPs Total</b>	<b>40.0</b>	<b>40.0</b>	<b>0.0</b>	<b>239.9</b>	<b>239.9</b>	<b>0.0</b>

- 3.4.2. Final guidance regarding the final contractual uplifts for each of the DOPs elements. There may be some realignment required between Pharmacy and Optometry because of finalised guidance and contractual negotiations.
- 3.4.3. There is a possibility that there will be some availability to make a relatively small non-recurrent investment into Dental, in a similar vein to what was commissioned in the last two years. Once final guidance is received the finance and contracting teams will be able to ascertain the value of investment available.
- 3.4.4. As such, and with Dental performance in NEL being more than 97%, there is no assumption of any resulting underspends at this stage.

#### **4.0 2025-26 Budgets**

- 4.1. The total Primary Care budgets are confirmed at £1,106.4m. Finance team are continuing to work with commissioning colleagues to ensure the ICB funded elements are allocated correctly to align to contractual commitments for the coming financial year. The following gives a high-level overview of the key funding components for the 2025-26 financial year.

##### **Delegated Primary Medical Services**

- 4.2. The recurrent baseline has been confirmed at £483.2m which represents funding growth of c.7.9% (net of convergence factor of 0.17%). This is to reflect the nationally agreed contractual uplifts e.g. Global Sum has increased from £112.50 to £121.79).
- 4.3. This excludes any final DDRB funding assumptions, which will be confirmed later in the year.
- 4.4. The Operating Plan submitted by the ICB assumes all Delegated Primary Care funds are utilised in full in 2025-26.

##### **Delegated DOPs**

- 4.5. The notified allocation for DOPs is c.£239.5m which reflects c.3.5% growth. Detailed guidance is outstanding, similar to Delegated Primary Medical Services, the DDRB uplift is yet to be agreed, and any associated increase in funding will be notified when available.

##### **Prescribing**

- 4.6. Prescribing budgets have increased by c.3.6% above 2024-25 outturn, after applying a £10m CIP target.

##### **SDF/PCT**

- 4.7. The funding flows for Primary Care Transformation have changed in 2025/26. Rather than a separate allocation for Primary Care Transformation, it has been included within the ICB Baseline funding. £4.1m for this, along with £0.4m for GPIT Infrastructure and Resilience. Separate allocations have been confirmed (although values and timing are to be confirmed for additional programmes, such as GP Fellows. Further information on this will be made available when further guidance is published.

## **Other**

- 4.8. Some funding streams have ceased, such as PCARP Digital Tools (c£1.9m). In 2025-26 the costs for this will be accommodated within the SDF allocation.
- 4.9. Despite this, the current annual budget for Primary Care is still c.£40m (c3.8%) higher than 2024-25 outturn, with potential additional funding still to be confirmed.

## **5.0 Risks**

- 5.1. The risks associated with the Primary Care budgets for 2025-26 remain consistent with previous years e.g. Demographic Growth, Prescribing and Premises increases.

### **Demographic Growth**

- 5.2. Within the budget setting process, the budgets were set based on 1 April list sizes/ contract values, with an allocation of 1% for growth in the remaining 9 months. There is a risk this will not be enough but will be closely monitored throughout the year, as will all costs. The mitigation being that any budgets reviewed to be above what is required will be made available to accommodate these key risks at the earliest opportunity.

### **Prescribing**

- 5.3. Volume was the big driver for overspends in 2024-25. Despite a CIP target of £10m being applied, Prescribing budgets have increased by a net c3.6% when compared with 2024-25 outturn. This should go some way to mitigating any risk of continued increase in volumes (or in fact price increases).
- 5.4. At month 2, we have no in-year data of prescribing costs and volumes. At the time of the next sub-committee meeting, we will have some in-year data, to help with forecasting, but that will still be c.2 months at best.

### **Premises**

- 5.5. Premises budgets have been set based upon the most up to date information available. It's not clear how many properties will be revalued during the year, so a nominal revaluation reserve has been set within the budget. Similar to the Demographic growth allocation, this will be closely monitored and adjusted accordingly at the earliest opportunity, if/when required.

## **6.0 Conclusion / Recommendations**

- 6.1. The Primary Care Contracts Sub-Committee is asked to note the content of the report.

Author: Rob Dickenson, Deputy Director of Finance

Date: 25 June 2025

## Primary Care Contracts Sub Committee

8 July 2025

<b>Title of report</b>	Primary Care Risk Report
<b>Author</b>	Daniel Hodgson
<b>Presented by</b>	Head of Primary Care Partnership Development
<b>Contact for further information</b>	<a href="mailto:Daniel.Hodgson12@nhs.net">Daniel.Hodgson12@nhs.net</a>
<b>Executive summary</b>	<p>All risks related to the Primary Care Contracts (totalling six risks) are attached, of which three are rated 12 or over, and three are rated below 12.</p> <p>Since last report:</p> <ul style="list-style-type: none"> <li>• one risk closed</li> <li>• no change to scores for remaining risks</li> </ul> <p>The ICB reorganisation will likely impact multiple risks on the register, however risks associated with the reorganisation are being managed separately and until further information is known the impact on the primary risks is still uncertain.</p>
<b>Action / recommendation</b>	The sub-committee is asked to note the risk report.
<b>Previous reporting</b>	Primary Care Directorate Senior Management Team reviews risk monthly. Similar reports are received by the Primary Care Collaborative.
<b>Next steps/ onward reporting</b>	Updates will be received at each meeting.
<b>Conflicts of interest</b>	Not applicable
<b>Strategic fit</b>	<ul style="list-style-type: none"> <li>• To improve outcomes in population health and healthcare</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To enhance productivity and value for money</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	N/A
<b>Has an Equalities Impact Assessment been carried out?</b>	N/A
<b>Impact on finance, performance and quality</b>	There are no additional resource implications/revenue or capital costs arising from this report
<b>Risks</b>	This paper outlines the risks on the current NEL Primary Care Risk Register.

## 1.0 Risk management

- 1.1 Risks included in this report are relevant to the Primary Care Contracts Sub Committee.
- 1.2 Risks with a score of 12 or higher are listed below.
- 1.3 All risks are reviewed at least monthly, or more frequently if required and/or as approaching deadlines.
- 1.4 As a reminder, primary care transformation risks are now held in the same register; these are owned by the programmes directly but might have an impact on risks owned by this Sub Committee. For example, a risk to a transformation programme might threaten the viability of that programme; that programme might be one of the mitigating actions for a risk owned by this Sub Committee.

## 2.0 All risks

- 2.1 There are five risks on the primary care risk register under the remit of the primary care contracts subcommittee. The remainder of the risks fall under the remit of the primary care collaborative subcommittee or the Chief Medical Officer directly.
- 2.2 Three risks have a risk score of 12 or above (requiring reporting to the relevant subcommittee); three risks have a risk score below 12.

## 3.0 Risks scored 12 or above

**PC12: General practice workforce, demand, quality and financial pressures combined: Risk score 12.** There is a risk that the reduced workforce, increased demand, quality issues and financial pressures could result in morale deteriorating (therefore a lack of buy-in to specific initiatives eg SDA), premises becoming unaffordable/unviable, practices becoming unsustainable/unviable and ultimately practices closing, leading to inability to deliver transformation and/or lack of service provision.

**PC18: GP Premises issues: Risk score: 12.** There is a risk that current premises issues become unsustainable and lead to lack of viability of general practice, leading to handing back of core contracts and lack of service provision. (Premises issues include service debt variability, practice debt and the impact on practice viability, planned increase in rents at NELFT properties, quality of property management, rent review backlog and impact on ICB finance, variation in support given to practices when relocating and having significant premises developments, moving to a standard NEL offer)

**PC24: Corrective action: Risk score 12:** There is a risk that if GPs continue to take actions that were part of collective action (eg no new shared care arrangements, reduced clinical interactions, and other non-contract breach activity) that patients will not be able to access appropriate care.

## 4.0 Risks scored below 12

**PC01: Prioritisation and allocation of resource: Risk score 9.** There is a risk that if there is continued lack of clarity around prioritisation processes and how/where funding and resources are allocated, this may result in delays to, or inadequacy in, allocation of resources (and lack of alignment of national-NEL-Place priorities). This

may negatively impact GP Primary care services, investment in new services and investment in transformation, leading to reduced access to quality primary care services and continuity of care.

**PC09: GP practice coding: Risk score 9.** There is a risk that the quality and variation of coding in practices being of an insufficient standard will result in loss of income for GP practices and the inability of the ICB to effectively monitor impact/outcomes or planning, leading to investment in services that are not delivering the required outcome.

**PC19: Access to NHS dental services: Risk score 9.** There is a risk that if the system is unable to provide additional capacity to meet the oral health needs of the population due to limited or unavailable resource this will result in wider consequences in terms of chronic health issues for adults and impact on children's education. (There is significant evidence to suggest that those in the most deprived groups are the most adversely affected)

## 5.0 Change since last report

5.1 There have been no changes to the likelihood and impact scores for the risks that remain on the register.

5.2 One risk has been closed:

**PC23: Pharmacy collective action: Risk score 6.** There is a risk that if pharmacies take collective action, patient access to community pharmacy, medications and care will be limited, leading to worsening health outcomes and patient dissatisfaction, and putting pressure on other parts of the system (general practice, secondary care etc).

5.3 Following the publication of the 24/25 and 25/26 CPCF settlement which has dealt with significant issues in respect of the financial viability of community pharmacies, the prospect of collective action has diminished significantly and there is no imminent risk that this will happen.

Daniel Hodgson, June 2025

Primary Care Risk Register

ID	Priority	Area	Initial risk score	Corporate Objectives 2024/25 (Those will be deleted end of May 2025)	Corporate Objectives 2025/26	Primary Care Objective 2025/26	Risk description	Previous rating	Current rating			Target rating	Target completion date	Completed mitigating actions	Mitigating actions in progress	Risk owner	Action Owner	Response for completion of group	Escalation requirement	Updates/ comments (please insert date of update/comment)
									Likelihood	Impact	Risk Score (1-25)									
PC01	High	Primary Care Directorate	9	Inequalities in outcomes, experience and access	Financial stability through transformation, productivity and digital	All	Prioritisation and allocation of resources There is a risk that if there is continued lack of clarity around prioritisation processes and how/where funding and resources are allocated, this may result in delays to, or inadequacy in, allocation of resources (and lack of alignment of rational-NEL Place priorities). This may negatively impact GP Primary care services, investment in new services and investment in transformation, leading to reduced access to quality primary care services and continuity of care.	9	3	3	9	6	31-Dec-25	<ul style="list-style-type: none"> <li>- This Primary Care Strategy stocktake took place in May/June 2024.</li> <li>- Review of 2024 primary care budgets, as part of the Financial Recovery Process.</li> <li>- 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.</li> <li>- LSL/ES review process commenced with detailed financial analysis (including differential funding), specification review for value for money, and duplication of core and scheme overlap being the initial areas of priority.</li> <li>- Business cases demonstrate value and good outcomes and ability of primary care to react quickly, be accessible to the local population, have a strong impact and provide continuity of care. Ensure this is backed up with good data.</li> </ul>	<ul style="list-style-type: none"> <li>- Primary care operating plan, NEL business planning, BAU priorities, transformation priorities, and individual objectives all being aligned and prioritisation exercise being undertaken - review alignment with and understanding of Place teams and others - by end July 2025.</li> <li>- Development of primary care transformation delivery plan provides opportunity for long term prioritisation alignment through agreement of target outcomes at NEL level with delivery decisions at Place - by end Aug 2025.</li> <li>- The announcement of financial cuts for ICSs provides an opportunity to ensure improved prioritisation and resource allocation, as well as understanding thereof - by end Dec 2025.</li> <li>- Communication with stakeholders to manage expectations - Ongoing.</li> <li>- Consider use of technology/automation to maximise productivity - by end Dec 2025.</li> </ul>	Sarah See	Daniel Hodgson	Primary Care Contracting Sub Committee	N	19 June 25 - This risk has been compounded by the ICB reorganisation, reduction of staff resources and changes to ICB responsibilities. This risk, and its scores, are unchanged as the overarching risk related to the reorganisation are being managed separately
PC09	High	Primary Care Directorate	9	To improve outcomes in population health and healthcare	Financial stability through transformation, productivity and digital	All	GP practice coding There is a risk that the quality and variation of coding in practices being of an insufficient standard will result in loss of income for GP practices and the inability of the ICB to effectively monitor impact/outcomes or planning, leading to investment in services that are not delivering the required outcome.	9	3	3	9	6	31-Mar-25	<ul style="list-style-type: none"> <li>- All PCNs had produced plans to improve accuracy of recording in app books as part of their capacity and access improvement plans. These have been reviewed and PCNs paid - COMPLETED</li> <li>- An incentive scheme has been developed to encourage practices to adopt standardised methods of clinical coding.</li> </ul>	<ul style="list-style-type: none"> <li>- PCN/ICS review and Commissioning review considering how to embed 'coding' requirements and benefits thereof - by March 2026.</li> </ul>	William Curran gham-Davis	Heads of Primary Care	Primary Care Contracting Sub Committee	N	
PC12	High	Primary Care Directorate	16	Deliver High quality service for patients	Working as a system to deliver improvements and priorities	Developing the primary care workforce	General practice workforce, demand, quality and financial pressures combined There is a risk that if general practice workforce continues to contract, demand continues to increase, quality issues arise and financial pressures increase, then general practice morale will deteriorate (therefore a lack of buy-in to specific initiatives e.g. SDA), premises will become unaffordable/unusable, practices will become unsustainable and ultimately practices will close, leading to inability to provide a general practice service and lack of transformation.	12	3	3	12	9	31-Mar-26	<ul style="list-style-type: none"> <li>- Surge planning guidance in place that can be applied by local systems to support their business continuity and preparedness plans.</li> <li>- Expanded locum bank in place.</li> <li>- Additional access and capacity funding has been made available to PCNs.</li> <li>- CPICs in place and well established.</li> <li>- Roll out of cloud-based telephony</li> <li>- Support being given to practices identified as being most at risk, through SDF Resilience, workforce and Digital funding</li> <li>- Primary Care Recovery Plan to support practices in managing demand and capacity.</li> </ul>	<ul style="list-style-type: none"> <li>- Development of primary care improvement dashboard to consider multiple measures that might combine to impact practices - primary care, PHM, Places all to review the dashboard and consider targeted support - by end July 2025.</li> <li>- Increase the take up of online consultations, develop ehub and move towards implementation of 'modern general practice' which will help to improve efficiency and release capacity - by March 2026.</li> </ul>	Sarah See	Deputy Directors of Primary Care	Primary Care Contracting Sub Committee	Y	
PC18	High	Primary Care Directorate	12	Deliver High quality service for patients	Financial stability through transformation, productivity and digital	Ensuring effective primary care contract oversight and management	GP Premises issues There is a risk that if current premises issues become unsustainable and lead to lack of viability of general practice, then practices might hand back core contracts, leading to inability to provide a general practice service. (Premises issues include service debt, variability, practice debt and the impact on practice viability, planned increases in rents at NEL/T properties, quality of property management, rent review backlog and impact on ICB finance, variation in support given to practices when relocating and having significant premises developments, moving to a standard NEL offer)	12	3	3	12	8	31-Mar-26	<ul style="list-style-type: none"> <li>- Fixed term postholder commenced work in July 24 to undertake work to clear the backlog of rent reviews.</li> <li>- Work being undertaken to further develop the premises portal to help manage and monitor the rent review process.</li> <li>- Proposal to support a GP Infrastructure Review to support the transformation programme underway.</li> <li>- Develop a 10 year estate strategy for general practice.</li> <li>- Clarity on standardised decision-making and metrics to support by March 2025</li> </ul>	<ul style="list-style-type: none"> <li>- 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.</li> <li>- 4 workstreams have been established:                             <ol style="list-style-type: none"> <li>Service charge variability</li> <li>Quality of property management</li> <li>Rent review backlog</li> <li>Standardisation of NEL offer to practices going through relocation or other development.</li> </ol> </li> </ul>	Sarah See	William Curran ham-Davis	Primary Care Delivery Group, Primary Care Contracting Sub Committee	Y	<p><b>Support for Lease Agreements</b> We continue to support practices in negotiating and finalising lease agreements. However, significant delays at the District Valuer Office (DVO), due to workload and backlog, has created challenges. Unofficial reports suggest rent reviews and value-for-money (VFM) assessments could be delayed by up to 12 months, impacting the ability to progress lease negotiations for Primary Care.</p> <p><b>Management of Historic Debt and Settlement Plans</b> We are working closely with NHSPG and CHP to manage historic debt and implement structured settlement plans. Regular engagement meetings are in place to review outstanding balances, agree on realistic repayment terms, and help prevent further financial pressure on practices.</p> <p><b>Policy Development and Implementation</b> Draft policies are currently under internal review. Once approved, these will offer clearer guidance on financial management, lease processes, and support for practices facing premises-related challenges.</p> <p><b>Quality Issues</b> Most urgent quality concerns have been addressed. However, some long-term issues remain and will require sustained planning and investment. We are continuing discussions with NHSPG and CHP to explore solutions.</p>
PC19	High	Primary Care Directorate	16	Inequalities in outcomes, experience and access	Working as a system to deliver improvements and priorities	Improving patient access and experience	Access to NHS dental services: There is a risk that if the system is unable to provide additional capacity to meet the oral health needs of the population due to limited or unavailable resources this will result in wider consequences in terms of chronic health issues for adults and impact on children's education. (There is significant evidence to suggest that those in the most deprived groups are the most adversely affected.)	9	3	3	9	6	31-Mar-26	<ul style="list-style-type: none"> <li>- 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.</li> <li>- Urgent Care Requirement completed - new permanent delivery in place from April 2024.</li> <li>- Inclusion of Dentistry as part of place based discussions within NEL.</li> <li>- Dental inclusion in operation plan at same level as 2024/25</li> <li>- Development of DOP specific provider groups</li> <li>- Paper submitted to PCG and endorsed in May 2025 detailing approach to commissioning</li> </ul>	<ul style="list-style-type: none"> <li>- 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</li> <li>- Forensic review of all dental contracts to ensure consistency and value for money.</li> </ul>	Sarah See	Jeremy Walman	Primary Care Contracting Sub Committee and Commissioning	N	
PC24	High	Primary Care Directorate	12	Deliver High quality service for patients	Tackle inequalities in outcomes, experience and access	Improving patient access and experience	GP corrective action There is a risk that if GPs continue to take actions that were part of collective action (eg no new shared care arrangements, reduced clinical interactions, and other non-contrast breach activity) that patients will not be able to access appropriate care.	12	3	3	12	6	31-Mar-26	<ul style="list-style-type: none"> <li>- Close liaison with London wide LMCs to understand the potential actions practices could continue and the impact this might have on patients and the system - ONGOING</li> <li>- Working with colleagues across the ICS to minimise risks and ensure continuation of patient care in a safe manner - ONGOING</li> </ul>	<ul style="list-style-type: none"> <li>- Close liaison with London wide LMCs to understand the potential actions practices could continue and the impact this might have on patients and the system - ONGOING</li> <li>- Working with colleagues across the ICS to minimise risks and ensure continuation of patient care in a safe manner - ONGOING</li> </ul>	Sarah See	William Curran ham-Davis	Primary Care Contracting Sub Committee	Y	

## Primary Care Contracts Sub-Committee

8 July 2025

<b>Title of report</b>	GP Contracts Update Report
<b>Author</b>	Adeel Aksar, Primary Care Commissioning Manager
<b>Presented by</b>	Benjamin Smith, Senior Primary Care Commissioning Manager
<b>Contact for further information</b>	<a href="mailto:Adeel.aksar@nhs.net">Adeel.aksar@nhs.net</a> <a href="mailto:benjamin.smith10@nhs.net">benjamin.smith10@nhs.net</a>
<b>Executive summary</b>	The purpose of this report is to provide the Primary Care Contracting Sub Committee with updates on the contract changes that have been agreed; contractual actions taken, and the progress of practices making improvements in response to remedial notices.
<b>Action / recommendation</b>	For noting
<b>Previous reporting</b>	None
<b>Next steps/ onward reporting</b>	None, presented for sub-committee information
<b>Conflicts of interest</b>	N/A
<b>Strategic fit</b>	N/A
<b>Impact on local people, health inequalities and sustainability</b>	N/A
<b>Impact on finance, performance and quality</b>	N/A
<b>Risks</b>	N/A
<b>Appendices</b>	

<b>1.0</b>	<b>Addition/removal of partners</b>
1.1	<b>Woodgrange Medical Practice – Newham</b> Addition of two partners on the contract with effect from 1 April 2025. There are a total of four partners on the contract following this change. Contract variation complete
1.2	<b>Churchill Medical Centre – Waltham Forest</b> Removal of partner from the contract with effect from 31 March 2025. There are a total of eight partners on the contract following this change. Contract variation complete
1.3	<b>Higham Hill Medical Centre – Waltham Forest</b> Addition of three partners on the contract with effect from 15 April 2025 There are a total of five partners on the contract following this change. Contract variation complete
1.4	<b>High Road Surgery – Waltham Forest</b> Addition of partner to the contract with effect from 1 May 2025 There are a total of three partners on the contract following this change. Contract variation complete
1.5	<b>Nightingale Practice – City &amp; Hackney</b> 24 hr retirement of GP with effect 1 April 2025 Contract variation complete
1.8	<b>Balfour Road Surgery – Redbridge</b> Addition of partner to the contract with effect from 1 April 2025 Contract variation complete
1.9	<b>First Avenue Surgery – B&amp;D</b> Retirement of partner with effect from 31 May 2025 Contract variation complete
<b>2.0</b>	<b>Mergers</b>
	N/A
<b>3.0</b>	<b>Remedial &amp; Breach Notices</b>
3.1	<b>The Ecclesbourne Practice – Waltham Forest</b> A second remedial notice was served in May 2025 following the CQC inspection findings. The remedial requires the practice to fully comply with requirements and work with the ICB in remediation.  Practice is committed to this and are currently working and cooperating with the ICB and appointed SMEs. First meeting held on 16 June and the practice is demonstrating good progress on the remedial action plan.
<b>4.0</b>	<b>Extensions</b>
	<b>Island Medical &amp; Wood Wharf Practices – Tower Hamlets</b> Following the sub-committee’s approval to award a new 5-year (with a further 2-year extension) APMS contract to Hurley Clinic Partnership, via PSR Direct Award Route C in April 2025, the NEL ICB Procurement Oversight Group approved this decision and an Intention to award notice was submitted in May 2025. After a 14-day period, no challenges were received and the ICB has issued the provider with the contract and awaits its signature.