**REPORT TITLE:** Health Scrutiny Panel of Enquiry into the closure of the Camden Rd Surgery

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**FOR SUBMISSION TO:** Camden Health Scrutiny Committee

**DATE:** 27 June 2012

**SUMMARY OF REPORT**

This report considers the evidence submitted, and makes recommendations about lessons to be learnt about the closure of the Camden Road surgery, and makes recommendations for future provision of GP premises.

**LOCAL GOVERNMENT ACT 1972 – ACCESS TO INFORMATION:**
All documents that require listing have been listed in the index of appendices to this report.

**CONTACT:** Councillor Angela Mason (Chair) of this scrutiny panel. Camden Town Hall, Judd Street, London WC1H 9JE

**RECOMMENDATIONS**

That the Health Scrutiny Committee endorses this report and recommendations of the Panel of Enquiry, and asks that a formal response is provided by NHS NCL to the relevant recommendations, at the next Health Scrutiny Committee meeting on 27 September 2012.

That the Camden Clinical Commissioning Board is also asked to comment on the implications of the report for their future work as health service Commissioners at the Health Scrutiny Committee meeting in September.

That a copy of the report is also sent to the Department of Health, and to the NHS Commissioning Board.
Health Scrutiny Panel of Enquiry into the closure of the Camden Rd Surgery

1. Introduction

1.1 The Health Scrutiny Committee was informed at their meeting on 9 February 2012 that the surgery at 142 Camden Rd was due to close on 13 April 2012. The Committee expressed considerable concern about the short notice of the closure and the impact on patients and whether the history of provision of GP services at 142 Camden Road had in any way led to the closure. The Committee were also conscious that the closure of the surgery was happening at a time of fundamental change in the NHS and, in particular, that there were fears that new commissioning arrangements might lead to increased privatisation of provision and a reduction in access to primary care in Camden.

1.2 The Committee therefore resolved at their meeting on 13 April to set up a panel of enquiry with Councillors Angela Mason, Paul Braithwaite and Peter Brayshaw as panel members.

1.3 The Enquiry Panel was set up to consider:

- the sequence of events that led to the closure;
- the terms of the contract between the Primary Care Trust (PCT) and United Health, including the circumstances in which United Health transferred the contract to The Practice;
- the circumstances in which the PCT took a lease on the premises at 142 Camden Road, including the length of the lease;
- whether satisfactory arrangements had been made for former patients including the possibility of alternative provision;
- the performance of United Health and The Practice since taking over the surgery at Camden Road and the performance of other NHS GP practices in the borough provided by private providers;
- future provision of primary care for residents in the area served by the Camden Road practice in Cantelowes, St Pancras and Somers Town and Kings Cross wards and the strategic provisioning of primary health care in Camden.

1.4 The Enquiry held two public meetings which took place in Camden Town Hall on 10 and 31 May 2012.

1.5 The full list of witnesses invited to give evidence to the Panel is set out in the appendices, together with correspondence and submissions to the Committee.

1.6 Oral submissions were received from

- Camden Keep Our NHS Public
- Dr Paddy Glackin, Medical Director of London Medical Councils
2. **Background**

2.1 The surgery at 142 Camden Road was run for many years by Dr. Silverman. When he retired in the early 1980s, it was taken over by Dr Harbord and his partners who provided primary care until 2008, when the contract for primary care was subject to an open tender under a new type of ‘Alternative Provider of Medical Services’ (APMS) contract that allows different types of organisations, not just general practitioners, to provide GP services.

2.2 A five year contract for this and two other practices was awarded to United Health UK (part of a United States based multinational company, United Health Care) following a competitive tendering process by Camden PCT. Dr Harbord retained ownership of the premises and agreed to provide a short five year lease to Camden PCT, backdated to 2007 and expiring in 2012.

2.3 There was considerable public concern about the granting of the contract to United Health UK, which was reflected in a number of discussions at the Camden Health Scrutiny Committee.

2.4 These concerns centred around the adequacy of public consultation, the price of the contract and the future performance of private providers with shareholders. We deal with the pricing of the contract at paragraphs 4.6-4.8 and with the issue of performance outcomes in section 5.

2.5 In April 2011, NHS North Central London (the successor organisation to Camden PCT and 4 other North London PCTs established from 1 April 2011) was informed by United Health UK who held the contract, that the three GP services Camden Road, Kings Cross Road and the Brunswick Medical Centre would be provided by The Practice instead of United Health Primary Care.

2.6 Both United Health UK and The Practice declined to give evidence to the Enquiry. In the absence of any evidence to the contrary we have no reason not to believe that the reason for United Health UK’s decision was their desire to concentrate on providing services to the GP Commissioner consortia being set up under the National Health and Social Care Act 2012.

2.7 On 6 February 2012, NHS North Central London began a consultation on their decision to close the Camden Road surgery on 13 April 2012 and to disperse or allocate patients registered at 142 Camden Rd to other local practices.
2.8 The reason for the closure was that, from May 2012, The Practice would no longer have access to the premises at 142 Camden Road, as the owner did not agree to renew the lease and neither The Practice nor NHS North Central London had found suitable alternative premises.

2.9 The Enquiry Panel considered issues arising from this chain of events, in line with its terms of reference at paragraph 1.3.

3. Issues arising from the closure –the search for alternative premises, the timing of the closure, the impact on patients and other practices

The search for alternative premises

3.1 The evidence of NHS North Central London was that negotiations began on the lease in the spring of 2011, approximately a year before the lease would expire. By the summer of 2011, it was apparent that these were unlikely to be successful. This left only nine months to find alternative accommodation. NHS North Central London had previously provided information to the Health Scrutiny Committee on their requirements for an alternative surgery, which were for premises of some 410.8 square metres.

3.2 There was no evidence from The Practice that they were involved in this search, although they were under a contractual obligation to provide premises, and NHS NCL understood that they sought premises. NHS North Central did seek to extend the lease, looked at other NHS premises and made enquiries to Camden Council’s property division.

3.3 The Panel are of the view that it was unlikely, given the history, that the owner would agree to renew the lease and, more significantly, that nine months was insufficient time for a search for new premises on this scale.

3.4 The Panel noted that, in 2008, when the contract was awarded to United Health for a five year term, there appeared to be some confidence that a solution to finding alternative premises could be found for the last year of the contract (see paragraph 6.1).

3.5 The significant changes in the intervening period were the major reorganisation of London PCTs into clusters, national reduction by 54% of management cost spending in the NHS and the instruction to all PCTs to transfer to the new government owned company ‘NHS Property Services Limited’ any PCT-owned GP premises in preparation for the introduction of the National Commissioning Board in 2013 and Clinical Commissioning Groups.

3.6 The Panel is of the view that all these factors contributed to inadequate planning to find alternative premises for the surgery at 142 Camden Rd and that there remains a need for a GP practice in the area formerly covered by the Camden Road surgery.
3.7 Representatives from Camden Keep Our NHS Public also suggested that Camden PCT and the successor body, NHS North Central London, thought that practices such as the Camden Road surgery were too small to operate efficiently and that the difficulty finding alternative premises was a chance to get rid of the Camden Road practice altogether.

3.8 We deal with these questions more fully in section 6 of this report.

Late Notice of the closure of the Camden Surgery

3.9 In evidence, NHS NCL said that they did not wish to destabilise the practice at 142 Camden Road, and early notice of the closure might have led to a ‘run’ on other practices. They continued to believe up until February 2012 that the search for alternative premises could be successful.

3.10 The Panel are nevertheless of the view that the delay in communicating the closure to patients and other GP practices did not lead to an orderly and planned transfer of patients. We note that the decision to disperse rather than allocate patients was based on a very small sample in their consultation.

3.11 We accept the evidence of representatives of Camden Keep NHS Public that the short notice of the closure caused considerable alarm among many patients and the evidence of Dr Amiel of the Caversham practice that there were considerable difficulties in transferring patient records in these short time scales or enabling practices receiving patients to make forward plans to cope with additional demands.

3.12 This evidence was corroborated by the written submission of the Biotech pharmacy.

3.13 A number of those who gave evidence to the Enquiry said they first found out about the closure from the Camden New Journal. We note that the reporting in the Camden New Journal by Tom Foot has been a consistent and reliable source of public information on what was happening at the Camden Road surgery.

3.14 At the end of May 2012, 1,500 patients from Camden Road surgery had still not registered at an alternative practice. NHS NCL state that they therefore allocated these patients to other practices. This is a large number, although we accept that some of these might be ex-students from the student halls opposite the Camden Road surgery, as the majority were aged 18-24.

The treatment of vulnerable patients
3.15 Approximately 450 out of a total of 4,709 registered patients were classified as ‘clinically’ vulnerable. In evidence, NHS North Central London stated that, in a practice of this size, the classification of 450 patients as clinically vulnerable was fairly representative. These patients were the first to be allocated a new surgery along with their carers. NHS NCL invited recipients to contact them with any concerns.

3.16 The Panel was of the view that there was a wider group of patients who whilst not clinically vulnerable would find moving to a new practice difficult. We were also concerned that age was not a criterion in assessing vulnerability and was disturbed by the evidence that some 90 year olds were not given special support, although we were pleased to learn that a translated letter was sent to Bengali patients (although not to Somali or other ethnic minority groups). More work could have been done with the local community centres and local councillors to alert their users to the closure of the surgery and what arrangements former patients needed to make.

Impact on other surgeries

3.17 Prior to the closure, NHS North Central London contacted local GP practices enquiring about their willingness and capacity to take on new patients, but not the reason for the enquiry nor their views on how best to deal with the imminent closure of the Camden Road surgery.

3.18 Dr Glackin also gave evidence that there was a legal requirement to notify the Medical Practitioners’ Committee of any closure of a GP practice. The purpose of this notification is to allow the Local Medical Committee (LMC) to try and find alternative solutions to closure. Dr Glackin said he was only notified in February, once the consultation on closure began.

3.19 Mr Hoolaghan stated that he had made contact with the interim Chair of the LMC while Dr Glackin had been on sabbatical, just before NHS NCL announced that the practice was closing.

3.20 The initial consultation by NHS North Central London on the closure took place between 6 February and 11 March 2012. A consultation document was sent to 20% of the patients and received 104 responses. Of these respondents, 80% preferred a dispersal option.

3.21 In the event, over half the patients at the surgery appeared to be unregistered immediately prior to the surgery closing and a major allocation exercise was undertaken in the week after closure on 13 April, including - at the suggestion of the Health Scrutiny Committee - a full page advert in the *Camden New Journal*.

3.22 In written evidence, Dr Amiel of the Caversham Practice said: ‘We believe that allocation from the start of a set number of Camden Road patients to willing local practices would have a more satisfactory way of
facilitating continuity and smooth transition for a practice that already had too many changes in their GP care over the past few years. NHS NCL stated that the majority of patients in their consultation expressed a preference for choosing their new practice themselves, but the Panel noted that the response was very small approximately 80 patients out of a list of 4,700.

3.23 Dr Amiel noted that the failure to follow a planned allocation did lead to a ‘run’ of patients who were actually unwell or had complex problems, which they feared would be destabilised during the running down of Camden Road, seeking alternative surgeries, and that the Caversham practice was therefore faced with an influx of complex patients, which added to the pressure of existing patients seeking appointments.

3.24 He also noted the difficulty of accessing patient records, which became more difficult when the surgery did close, after which point half of the registrations were actually made.

3.25 The Panel were pleased to note that practices taking on additional patients were given additional funding, in line with normal practice when numbers of patients move in a short space of time. Practices will receive the normal capitation rate for the continuing treatment of registered patients of between £23 and £25 per patient (depending on the number registered) as per the Rapid List Growth Local Enhanced Service agreement negotiated with the Local Medical Committee and confirmed by Dr Paddy Glackin’s testimony to this Panel. No additional capital funding was made available, and would not normally be.

3.26 In evidence, Caroline Taylor, the Chief Executive of NHS North Central, London accepted that the timing of the closure was a matter of ‘judgment’.

3.27 In the view of the Panel, the judgment on the timing of the closure and - we would add - the manner of the closure, particularly the lack of consultation with other GP practices, led to unnecessary anxiety for patients and increased pressure on ‘receiving’ GP surgeries.

4. The terms of the contract with United Health, transfer of the contract, contract pricing, weight given to local knowledge and sustainability, open tendering

4.1 The Panel were provided with a copy of the contract with United Health including the agreed pricing. This was supplied by Camden PCT to a patient at the Camden Road surgery, following a Freedom of Information request.

Transfer of the Contract from United Health to the Practice
4.2 The Panel was made aware that under the ‘APMS’ contract, which is set nationally, the contract holder could engage another suitable provider to lead on the delivery of services. The NHS could not object, provided that the proposed new provider was a suitable provider of primary medical services. As the contract remained with United Health, they were not required to consult the PCT on this change.

4.3 In evidence, NHS North London said that they had taken legal advice about the possibility of pursuing a claim against United Health when they transferred the contract to The Practice, but had been advised that they had no claim, and that to pursue a claim would not represent effective use of public funds.

4.4 The Chief Executive also stated that the form of the contract for Alternative Providers of Medical Services was decided nationally and there was little or no scope to depart from it. She pointed out that a similar situation would have arisen if a GP passed a contract to another GP partner.

4.5 The Panel were of the view that this was a serious loophole. In our view, primary care by GPs should not be a commodity traded in the private market and prompt action should be taken by the National Commissioning Board, which will be responsible for commissioning primary care, to remedy this.

Contract pricing

4.6 The Panel were provided with copies of the contract price agreed with Camden PCT in 2008. These are attached at Appendix 2c. Evidence from Dr. Glackin suggested that these prices were somewhat above those awarded for GP contracts, although payments appear to have been made on ‘uncleaned’ patient lists, which may have overestimated the number of patients actually being treated. NHS NCL noted that it is extremely difficult to compare APMS and GMS/PMS (“GP”) contracts; the funding is very different.

4.7 We noted that the PCT assumed responsibility for the payment of rent for the premises.

4.8 We welcome the decision of the Information Commissioner’s Office to order Camden PCT to disclose details of the contract with United Health, including the pricing, and believe further consideration needs to be given by the NHS Commissioning Board to the transparency of contractual arrangements as the market for alternative providers increases.

Weight given to local knowledge and sustainability
4.9 There is considerable concern on the part of the Panel that procurement rules give insufficient weight to local knowledge and the continuity and sustainability of the doctor-patient relationship.

4.10 It is concerning that the contract allowed the contract holder to transfer the contract to another suitable provider without any accountable processes.

4.11 The panel also heard some evidence about the quality of care at Camden Road surgery, provided by United Health Primary Care and subsequently The Practice. This was mentioned in evidence from patients at Camden Road, the Biotech Pharmacy, and Dr Amiel. This suggested that there was considerable use of locums, high turnover of GPs and lack of continuity of care.

4.12 Evidence given by NHS North Central London to the Health Scrutiny Committee confirmed that, prior to closure, there were the equivalent of 2.3 full time doctors working 21 sessions per week. This appears to be in compliance with the contract. Further evidence submitted by NHS NCL at appendix 3b was that that whilst high turnover of staff may be associated in some cases with low continuity of care, the two are not by any means correlated, nor is there any evidence in this particular practice to suggest it is the case.

4.13 The use of multiple locums contrasts sharply to the continuity of GP care provided by Dr Harbord and his colleagues at the surgery prior to 2008 and the letting of the contract to United Health.

4.14 The Panel would welcome further discussions with NHS North London Central and later with NHS Commissioning Board on how contract specifications can best ensure continuity of GP care and minimise the use of temporary locums. Contracts should promote the long term commitment to continuity of GP care, to counter the concerns expressed in evidence that large private providers have less commitment to a local population.

5. The performance of United Health and The Practice

5.1 Evidence from Dr Glackin indicated that there were problems at Camden Road before the surgery closed. Dr Glackin stated that a complaint about The Practice had been made to NHS North Central London six months before its closure. NHS NCL believe that this comment was in relation to a staff restructuring The Practice was undertaking, not on the quality of care.

5.2 He also pointed to QOF data that showed that, in 2007, when the Camden Road surgery was run by Dr Harbord, the prevalence of patients who had ‘depression ever’ was on the 69th centile, but that this dropped year on year and, by 2011, had risen to the 6th centile. Similarly, prevalence of atrial fibrillation (which prevents strokes) went from the 45th
centile in 2007 to the 17th centile. This, he suggested, indicated either a possible problem with under diagnosis, or poor recording of medical conditions.

5.3 A comparison of the three surgeries is attached at Appendix 3. The full data available at www.gpcontract.cu.uk demonstrates similar trends in relation to other conditions at the Camden Road Surgery.

5.4 However, in evidence, NHS North Central London said that the performance at Camden Road was ‘within the normal range for Camden’, which is confirmed by data from NHS Choices comparing the performance of practices in Camden. In a further letter submitted to the Panel, NHS North Central London clarified that they use a variety of information and data sources including the London Health Observatory (LHO) to benchmark GP performance. The LHO uses the same QOF data as the GP contracts website.

5.5 The “incidences of depression ever” recorded for the Camden Road practice in 2007 was 49. In 2011, this had risen to 98. This suggests a rise in recording of depression in the practice. The possible reasons for this rise include the Camden Road GPs actually doing more “case finding” of these patients among their list. In addition, depression as an illness became a quality indicator of QOF, which would encourage practices to ensure cases were being recorded on their systems. This does not necessarily mean that there has been an increase in the occurrence of depressive illness in this practice.

5.6 The register of patients with atrial fibrillation (AF) at the Camden Road surgery has decreased, but reasons for this could include movement of patients with AF within the PCT area (for example: registering with other local practices having moved home). Additionally, the percentage of patients with AF recorded at Camden Road appears to be within normal limits for the Camden area, as the actual numbers are so small, the change does not appear to be statistically significant.

5.7 The Panel were concerned that there does not appear to be an open and transparent protocol for monitoring performance in primary care, which is understood by the public and public agencies. We welcome the offer of Caroline Taylor to discuss this further with the Health Scrutiny Committee and the Council. The panel note that the Department of Health has this week also released new guidance on transparent GP performance data for use by patients.

6. The need for and provision of primary care in Cantelowes, Somers Town and Kings Cross – privatisation, the ‘one mile’ test, future provision in Kings Cross and Maiden Lane, transparency and disclosure of information

Practice Size
6.1 There was a running thread of concern in this Enquiry that Camden PCT regarded the practice at 142 Camden Road as simply too small to operate efficiently and provide best value for money. At the time of United Health taking on the contract in 2008, strategy was geared towards the creation of large polyclinics. However, Caroline Taylor confirmed that present thinking in NHS North Central London did recognise the need for a plurality of GP provision. She noted that research showed that patients preferred smaller surgeries, where they were more likely to know their doctor, and that it was important to offer patients such choice. But she also pointed out that smaller practices could be more expensive to run and may not offer as wide a range of services. Other models such as consortium arrangements between practices were also suggested as ways to provide a range of provision while keeping a choice of scale.

6.2 It appeared to the Panel that the previous GP practice at Camden Rd may have been a victim of political fashion for larger practices in 2008, but we welcome the offer to discuss the strategy for future provision and proposals for practices to work in larger networks or hubs which would make it easier to provide a wider range of care options.

Privatisation

6.3 The Panel were concerned about the long term changes in the provision of primary care that may be caused by the cumulative impact of open tendering for primary care services.

6.4 Camden Keep Our NHS Public also provided the Enquiry with a list of community services subject to competitive tendering at this date. See Appendix 2b.

6.5 In evidence, Caroline Taylor said that she was primarily concerned with patient outcome, rather than the character of the provider. However, it appears to the panel that the history of events at 142 Camden Road does raise some serious questions about the ability of large private providers to provide sustainable, high quality patient care that preserves a strong relationship between GPs and patients. We also note the concerns raised by Dr Glackin that large private care providers may have more resources to prepare tender bids, compared to local GPs.

6.6 These concerns are magnified by the imminent handover of responsibility for primary care to the new National Commissioning Board. We understand that there will be a London office of the Commissioning Board, but the trend will be to make the responsibility for GP commissioning more remote from local governance and local knowledge.

6.7 We recommend that this report is sent to the new NHS Commissioning Board highlighting, in particular, our concerns about the national contract for alternative providers and the need to reflect local knowledge and experience and patients’ experience.
The one mile test

6.8 The panel understand that, in a previous consultation exercise, 53% of respondents stated that 20 minutes was an acceptable distance to travel to a local surgery. This was based on an assumption that the average person can walk a mile in 20 minutes. This one mile test clearly does not take account of many unwell patients or those with limited mobility, nor of the ease of transport routes.

6.9 In considering future strategy for the siting of GP practices and new network hubs, we would urge that a more nuanced view is taken of accessibility, taking into account local transport and the varying capacities of patients to travel.

Future primary care provision in Kings Cross, Cantelowes and Somers Town.

6.10 NHS North Central London states that it is in a position to make investment in primary care in Camden, and intending to do so in 2012/13 as part of its Primary Care Strategy. It would welcome the opportunity to discuss its strategy with the Committee. As stated in Tony Hoolaghan’s letter to Clr Bryant of 23 February however, any proposals for a London cluster to bid for capital or take on a new lease requires a detailed business case to be produced which must be approved by the cluster joint Boards and then by NHS London. If these approvals are not granted then the capital or new lease cannot be secured. It is unlikely, in the circumstances of 142 Camden Road, that a business case would have been approved.

6.11 The Panel were disturbed to find out that, as of the time of the Enquiry, no business case had been prepared for the proposed Kings Cross surgery expected to open in the last phase of the Kings Cross development, despite the fact that the first tranche of new residents are about to move in. The Health Scrutiny Committee were particularly aggrieved when a s106 agreement for a GP surgery at the Stanley buildings did not go ahead last year due to changes in NHS priorities and organisation, and are keen to ensure that the move to an NHS Commissioning board does not leave the community bereft of a GP surgery at Kings Cross.

6.12 Consideration has not yet been given to proposals for a new surgery in the redevelopment of the Maiden Lane estate, which have been put forward as part of the discussion about the closure of Camden Road surgery.

6.13 The panel believes that there is an urgent need for primary care services in the area bounded by Camden Road, York Way and St
Pancras Way and note that the estates at Agar Grove and Maiden Lane and St Pancras Way are areas of particular deprivation. We recommend that the Council begin urgent discussions with NHS North Central London (and the London leads of the National Commissioning Board when they are appointed) on both the proposals for new practices in the Kings Cross development and Maiden Lane. The Panel welcome that NHS North Central London is keen to work with the Health Scrutiny Committee to secure appropriate primary care services which deliver high quality care and value for money in areas of demonstrable local need.

Transparency and future information

6.14 There is no doubt that there is period of immense upheaval in the NHS. The combination of cuts in management staffing and the introduction of the Health and Social Care Act 2012 have created considerable uncertainty about the future nature of primary care provision.

6.15 In this situation, the panel believes there is a particular need for transparency and clear information. Existing legislation provides that a Council’s Health Scrutiny Committee can require an officer of a local NHS body to attend before the Committee.

6.16 The panel appreciates in the case of this Enquiry that NHS North Central London wanted to clarify the terms of the Enquiry and were pleased that, as result of these clarifications, they did attend. However, it appeared to the Panel that an earlier letter from Mr Hoolaghan to a number of local GPs, which said ‘We are currently determining whether the scope of the inquiry may set a wider precedent in terms of local authority powers in relation to the Overview and Scrutiny regulations. I would like to request you to await further clarification from us.’ may have had a ‘chilling’ effect on the willingness of a number of GPs to give evidence to this Enquiry, which we regret.

6.17 We welcome new provisions, which will come into force next April, which will allow Council Health Scrutiny Committees to require evidence and attendance from NHS bodies and GP practitioners, and believe that it is essential that these provisions also apply to alternative private providers and all those holding contracts of any sort to provide primary care services.

CONCLUSIONS AND RECOMMENDATIONS

a. There was a lack of adequate planning in the attempt to find alternative premises for the surgery at 142 Camden Road. We believe that the reasons for this are primarily the major staffing cuts in the NHS, together with the major reorganisation accompanying the introduction of the Health and Social Care Act, and changes in National Health Service policy over how GP services should be provided, and that the surgery at
142 Camden Rd was a casualty of these changes.

b. The judgments made by NHS North Central London on the manner and timing of the closure of the surgery, particularly the lack of consultation with other GP practices, led to unnecessary anxiety for patients and increased pressure on the local practices to which patients migrated or were allocated.

c. There appears to be a serious loophole in the national contract for alternative providers, which allowed United Health to transfer the contract from The Practice to United Health.

d. We remain concerned about the remaining two contracts held by The Practice at the Brunswick Centre and Kings Cross, as contracts will end in 2013, at the same time that responsibility for GP commissioning is passed over to the National Commissioning Board. The panel recommend that a progress report on re-commissioning and continuity of these GP services is brought to the Health Scrutiny Committee's next meeting on 27 September 2012.

e. Existing procurement procedures give insufficient weight to the need to develop sustainable GP care and insufficient safeguards to prevent avoidable use of locum and temporary staff. We welcome further discussions on how continuity of care can be paramount in future GP contracts.

f. The criteria and arrangements for monitoring performance in the provision of primary care appear not to be commonly understood. We welcome the offer by NHS North Central London to have further discussions on the criteria used for monitoring primary care in the borough.

g. There is an urgent need for primary care services, particularly in the area bounded by Camden Road, York Way and St Pancras Way. This is an area of deprivation and comprises three large Council estates, Maiden Lane, Agar Grove and St. Pancras Way. We recommend the NHS begin discussions with the Council's regeneration division to consider the potential for a new practice in the Maiden Lane redevelopment.

h. The process for developing the business case for the planned surgery at Kings Cross as agreed under the s106 agreement is of immediate concern. We recommend that the Council and NHS North Central London initiate early discussions on the provision of a surgery in the Kings Cross development, and welcome the commitment of the NHS to discuss this issues with the Health Scrutiny Committee.

i. We welcome the prospect that, after April 2013, Health Scrutiny Committees will have enhanced power to require private health providers and GP Practices to come before us. A regrettable aspect of
this enquiry was the failure of United Health or The Practice to provide any evidence whatsoever.

j. The Committee recommends that NHS North Central London accept the need for a replacement surgery for 142 Camden Road (and Cliff Road) and agree to work proactively with local Councillors and Camden officers towards finding and funding a new provision – and, as a priority, explore the opportunity in the new housing development on the Maiden Lane Industrial Estate on York Way. The Panel welcomes the commitment from the NHS to discuss this further.