NHS HWE ICB Primary Care Board meeting held in Public

Thursday 25 May 2023

09:30 - 13:00

Focolare Centre for Unity, 69 Parkway, Welwyn Garden City / via MS Teams

Meeting Book - NHS HWE ICB Primary Care Board meeting held in Public

AGENDA

09:30	1. Welcome, apologies and housekeeping		Chair
	2. Declarations of Interest		Chair
09:30	3. Minutes of last meeting held on Thursday 23 March 2023	Approval	Chair
	4. Action Tracker	Approval	Chair
09:40	5. Questions from public		Chair
09:45	6. Primary Care Board Governance	Discuss / Information	Iram Khan
10:00	7. Directorate Highlight Report - Verbal	Assurance/information	Avni Shah
10:20	8. Primary Care Finance Report	Approval	Alan Pond
10:35	9. Update from Healthwatch	Information	Neil Tester/Sam Glover
	Hertfordshire		
	West Essex		
10:45 - 11:00	Comfort Break		
11:00	10. Primary Care Access Recovery Plan	Discussion	Rachel/Michelle
11:20	11. Primary Care Transformation		
	11A. Draft Strategic Delivery Plan	Information	James / Emily
	11B. Primary Care Digital Roadmap – Strategy	Approval	Gopesh/ Parul/ Cathy
12:00	12. Update on Primary Care Delegated functions	Information	
	A. Delegation of Pharmacy, Optometry and Dental Commissioning - Update		Rachel Halksworth
	B. Update on dental services including areas of priority		Michelle Campbell
	C. Delegation of Primary Care Complaints function		Chris Harvey
12:50	13. Minutes from Subgroups – attached for information	Information	Chair

12:10	Primary Care Digital Primary Care workforce	Information	Chair
12:50	14. Reflections and feedback from the meeting		Chair
13:00	Close of meeting		

Herts & West Essex Strategic Framework- 2022-2027

Our mission

Better, healthier and longer lives for all

We will achieve this by

- **Improving physical and mental health across our population**
- **Tackling unequal access, experience and outcomes**
- **Enhancing productivity and value for money**
- **Ensuring the NHS supports broader social and economic development.**

In the first 3-5 years we will

- Increase healthy life expectancy, and reduce inequality
- Give every child the best start in life
- Improve access to health and care services
- Increase the numbers of citizens taking steps to improve their wellbeing
- Achieve a balanced financial position annually

The ICB will deliver this by:

- Setting direction for the NHS in Hertfordshire and West Essex
- Allocating NHS resources fairly and effectively
- Supporting, equipping, and empowering our people
- Working with and pooling resources with our partners
- Enabling improvement and driving change, with a focus on quality
- Using data and evidence to generate insight and assess impact

Hertfordshire and West Essex Integrated Care System

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DRAFT MINUTES

Meeting:	**HWE ICB Primary Care Board meeting held in Public**			
	Meeting in public	☒	*Meeting in private (confidential)*	☐
Date:	**Thursday 24 March 2023**			
Time:	**09:30 – 12:30**			
Venue:	**The Forum, Hemel Hempstead HP1 1DN and Via MS Teams**			

MINUTES

Name	Title	Organisation
Members present:		
Nicolas Small (NS) **(Meeting Chair)**	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Gurch Randhawa (GR) Via MS Teams	Non-Executive Member	Herts and West Essex ICB
Ian Perry (IP)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Avni Shah (AS)	Director of Primary Care Transformation	Herts and West Essex ICB
Rami Eliad (RE) Via MS Teams	Primary Care leads (SWH)	Herts and West Essex ICB
Amik Ameja (AA) Via MS Teams	Primary Care Locality Lead – WE	Herts and West Essex ICB
In attendance:		
Michelle Campbell (MC)	Head of Primary Care Contracting	Herts and West Essex ICB
James Gleed (JD)	Associate Director Commissioning Primary Care	Herts and West Essex ICB
Michael Harrison (MH)	LMC Representative	Bedfordshire and Hertfordshire LMC
Iram Khan (IK)	Corporate Governance Manager	Herts and West Essex ICB
Tracey Norris (TN)	Meeting Clerk	Herts for Learning Education
Annette Pullen (AP)	EA to Avni Shah	Herts and West Essex ICB
Joined via MS Teams		

Ruth Disney (RD)		Herts and West Essex ICB
Ashish Dwivedi (AD)	Director	Health Integration Partners
Cathy Galione (CG)	Head of Primary Care Transformation and Integration - ENH	Herts and West Essex ICB
Sam Glover (SG)	Chief Executive	HealthWatch Essex
Sue Fogden (SF)	Assistant Director – Premises	Herts and West Essex ICB
Rachel Halksworth (RH)	Assistant Director for Primary Care Contracting	Herts and West Essex ICB
Alison Jackson (AJ)		Herts and West Essex ICB
Roshina Khan (RK)	Head of Primary Care Transformation and Integration - SWH	Herts and West Essex ICB
Gemma McKelvey (GM)	Senior Communications and Engagement Manager	Herts and West Essex ICB
Vanessa Moon (VM)	Senior Communications and Engagement Manager	Herts and West Essex ICB
Helen Musson (HM)	Chief Officer	Hertfordshire Local Pharmaceutical Committee
Emily Perry (EP)	Primary Care Manager – Strategy and Transformation	Herts and West Essex ICB
Rehan Qureshi (RQ)	Programme Lead	Health Integration Partners
Dr Raja Vaiyapuri (RV)	LMC Representative	Essex LMC
Nicole Rich (NR) (Deputy for Elliot Howard-Jones)	Director West Essex for Community Health Services	Essex Partnership University NHS Foundation Trust
Anurita Rohilla (AR)	Chief Pharmacist and Associate Director for Allied Health Professions	Herts and West Essex ICB
Neil Tester (NT)	Vice Chair	Healthwatch Hertfordshire
Apologies received		
Joanna Marovitch (JM)	VCSFE Representative	Herts and West Essex ICB
Rob Mayson (RM)	Primary Care Locality Lead – ENH	Herts and West Essex ICB
Prag Moodley (PM)	Partner Member (Primary Medical Services)	Herts and West Essex ICB

PCB/15/23	**Welcome, apologies and housekeeping**
15.1	The Chair welcomed all to the meeting. He confirmed that this was not a public meeting but a meeting being held in public (members of the public were welcome to attend but were not permitted to participate). Questions from the public were welcomed in advance and there were instructions on the website how to do this.
15.2	Apologies for absence had been received from: • Rob Mayson • Prag Moodley • Joanna Marovitch The meeting was declared quorate.
PCB/16/23	**Declarations of interest**
16.1	The Chair invited members to declare any declarations relating to matters on the agenda: • None declared. All members declarations are accurate and up to date with the register available on the website: Declaration of interests – Hertfordshire and West Essex NHS ICB
PCB/17/23	**Minutes from the previous meeting**
17.1	**The minutes of the last meeting held on 26 January 2023 were agreed as an accurate record.**
PCB/18/23	**Action tracker**
18.1	The action tracker was reviewed, and the current status of the following actions noted: • Item PCB 21.7/22: Digital strategy deep dive: this item would come to the May meeting.
18.2	**The Primary Care Board noted the updates to the action tracker**
PCB/19/22	**Questions from the public**
19.1	A statement from Mr Woodcock had been received (part of an ongoing dialogue with the PCB) relating to the provision of a community pharmacy in Stansted Mountfitchet. This matter would be considered at the end of Q1 (post delegation of community pharmacy to the ICB). No other questions had been raised.
PCB/20/23	**Primary Care Board Governance**
20.1	Iram Khan (IK) introduced this item (see pages 16-34 of the document pack) and highlighted the proposed changes to the Term of Reference for the Primary Care Board: • Paragraph 1.2: Definition of primary care to include all primary care independent providers. • Paragraph 4.1: Revised governance chart. • Paragraph 7.1: Addition of Independent Dental Adviser as approved at Primary Care Commissioning Committee and Chief Pharmacist to the membership. • Paragraph 7.1: Addition of the Local Dental Network Chairs, representatives from adult social care to the invitee list.
20.2	Questions and comments were invited: • The Chair noted that the incoming dental, optometry and pharmacy services represented a big change in operations and was aware that there was a lot of work going on behind the scenes to ensure a smooth transition. This matter would be discussed at the ICB Board meeting to be held on 24 March 2023. • Paragraph 7.2 should be changed to adult social **care** (not adult social services).
20.3	**Appendix 2: Template for committee effectiveness survey**

	Avni Shah (AS) explained that the survey would be issued w/c 3 April and asked that all committee members take the time to complete the survey. The questions were in draft format (changes could and would still be made in the coming week, committee members were asked to send comments to NS/AS/IK). AS invited questions and comments: • It was clarified that the survey would be sent to the **current** membership of all committees and boards. • Feedback would be collated and shared at the May PCB meeting. • A question on understanding committee members' views on the interdependency between committees and working parties within the context of the ICB would be welcomed. • The knock on effects of a decision made in one committee into other areas of the system had been discussed previously but it was agreed that it would be useful if this could be captured in the survey.
20.4	**Appendix 3: Draft work plan 2023/24:** noted. The Chair invited all clinical leads to engage with this process to ensure all reports that were in the pipeline were captured.
20.5	**The Primary Care Board approved the proposed changes to the terms of reference**
20.6	**The Primary Care Board noted the timeline for the committee effectiveness survey**
20.7	**The Primary Care Board noted the draft work plan for 2023/24.**
20.8	***Action: To add a question on inter-dependencies to the committee effectiveness survey – I Khan / A Shah***
PCB/21/23	**Directorate Highlight Report**
21.1	AS introduced the Directorate report (see pages 35-42 of the document pack) highlighting the following points: • Delegation was a key area of focus for the directorate working with NHSE colleagues. • Dentistry, optometry and community pharmacy contracts will be delegated from from 1 April; staff would be TUPE transferred and various meet and greet welcome sessions had been arranged for w/c 27 March. Note HWE is hosting Community Pharmacy and Optometry contracting team on behalf on the East of England ICBs • Risks associated with this phase of delegation included: ○ Staffing resources transferring into the ICB would not be ringfenced/protected and would be considered as part of the running costs allowance of the ICB. ○ Finance envelope for dentistry: the Y1 envelope would be ringfenced as the transformation in this sector has not progressed as much Teams are working through the detail and identifying the gaps in current provision. ○ There were gaps in community pharmacy contract funding (this is tied up with the national negotiations). ○ This delegation would result in addition of over 700 more contracts across HWE. In total we are looking at 870 contracts for primary care to be managed across Primary care Directorate. • Work continued to support Ukraine refugees and asylum seekers. GPs have completed more than 2,800 health care assessments (this is a national specification but was funded locally as approved by Primary Care Commissioning Committee in February 2023). • Population Health Management have developed and shared a detailed pack for each PCN on their population identifying the areas to focus on working in partnership with partners at PCN/locality/Place level. These dashboard will be support delivery of our ICB objectives and priorities as mirror them.

	• A national review of GP IT services is underway; this was an opportunity to learn from others and share best practice (9 x practices and 2 x PCNs had been selected across HWE to particate in this review which is led by region and delivered through an external independent company). • Spring covid vaccination programme; a smaller cohort of patients would be eligible for this, and it would be delivered by community pharmacies, PCNs and HCT outreach teams.
21.2	Questions and comments were invited: • Q What is the the next stage of Population Health Management being discussed at the place level with system partners? • AS updated on the packs shared at each place with a view these discussions will be underway through PCN/locality and place transformation/local delivery boards meetings to ensure the plans are aligned. • It was hoped that the 2023/24 delivery plans being drafted now by health care partnerships would include these priorities or a commitment from a place holder to promote/champion it. • There was agreement that population health data was crucial; how it was used, how it informed decision making re the allocation of resources. NB identifying areas of deprivation and addressing the levelling up agenda. This would mean that some areas would receive more (resources/funding/staffing/initiatives etc) than other according to need. All partners (not just clinical) needed to commit to an integrated approach. • It was hoped that the integrated neighbourhood teams would begin to make a real difference (joining up system partners and understanding specific issue to make the most appropriate decisions), following the lead of the development of the neighbourhood teams in West Essex. • Priorities would need to be agreed at a system level so that potentially conflicting pressures could be overcome: e.g. general practice was rewarded for meeting targets relating to access/appointments vs the need to spend time reaching vulnerable cohorts/hard to reach patients. • Q What was the position re the national 10% claw-back of dental contracts? AS explained that the team had been working closely NHSE regional staff in relation to this however work is underway locally to initially understand our gaps and then putting a plan in place. Progress on this will be shared at May meeting •
21.3	**The PCB noted the Directorate update**
PCB/22/23	**Primary Care Board Updates**

22.1	**Estates update**
	Sue Fogden (SF) introduced the estates update report (see pages 43-56 of the document pack) highlighting the following points and providing some pertinent background:
	• A rolling programme had been in place since 2012.
	• Robust data sets were collected and monitored under a single platform covering such items as:
	  ○ Tenure information
	  ○ Measurement
	  ○ Revenue costs
	  ○ Capital funding
	• This information was used to inform the “heatmap”; a systematic, data driven, assessment process to guide and inform infrastructure prioritisation having reference to housing growth and projections, population growth and projections, list size, practice performance and surveys.
	• Funding could not support all needs and practices were ranked in order of priority (see pages 48-49 for top 19 and top 10 priorities).
	• There were 26 projects currently underway.

	• Creative approaches have been taken to create more space, eg repurposing storage space into workstations/consulting areas (this had been possible due to digital archiving/the off-site storage of files). • The annual rent reimbursement was £23million (£17m rent + £6m rates). This was expected to rise to £29m by 2036. • NHS capital investment was infrequent and insufficient to meet demand, the most recent NHS capital programme, Estates Technology Transformation Fund would end on 31 March 2023. • Work would commence in April 2023 to create an estates infrastructure strategy with population health outcomes/workforce and digital all taking priority. • The team would also have regard to the NHS zero carbon commitment.
22.2	Questions and comments were invited: • The list size information for each practice was updated twice a year and was accurate. Some practices with two sites eg Schopwick, had a split list. • SF and team had helped practices identify and utilise all spare space. • A plan was needed to ensure all available spaces within the wider community was also utilised. • Q How did investment decisions re estates link to population health management data – was there enough investment in areas of deprivation? Population health needs together with clinical priorities and the method of care would define the space needed. • Not all community spaces were being used to capacity. A system-wide understanding of estates was needed; this should include the voluntary sector. • Community pharmacy also faced estate constraints in some areas; which would impact their ability to widen their remit, eg lack of consultation space. • The lack of funding combined with rising inflation and rental income opportunities was a barrier to expanding care delivery at many practices. • Poor quality estates and infrastructure was a barrier to recruitment and retention. • The lack of treatment rooms impacted every aspect of a practice's provision, not just GP capacity; eg staff training and the ability to expand nursing, trainees and ARRS roles. • The team would collect data from community care and secondary care to add to the primary care database. This would identify pockets of pressure and pockets of slack within the system. • Following discussion with NHSE colleagues, SF was hopeful that it would be possible to value engineer some projects to make them viable; practice income would need to be expanded to include QOF payments and residual value. • Risks identified: the core general practice 5-year contract did not include adequate provision for current inflation levels, wage demands and energy costs. • Similar pressures were noted in dentistry, optometry and community pharmacy.

22.3	**Update on the Development of PCN Clinical Strategies**
	Dr Anushree Jagadambe and Dr Ashish Dwivedi from the Health Integration Partnership presented the report (see pages 57-81 of the document pack) and highlighted the following points:
	• NHSEI launched a national programme to provide a framework with practical tools for use to support PCNs develop clinical strategies.
	• Meetings with PCNs have taken place to understand pressures/limitations and interdependencies and population health needs; how system partners can support each other and how to integrate the voluntary sector into primary care.
	• Engagement has been high:
	  ○ West Essex – 6 x PCNs: 5 strategies have been delivered and work had commenced with the one remaining PCN.
	  ○ South West Herts – 17 x PCNs: 15 strategies have been delivered.
	  ○ East North Herts – 12 PCNs: 11 strategies have been drafted and work has commenced with the remaining PCN.

	• Strategic priorities related to GP sustainability (workforce, estate, operations) and the role of people/population within the NHS framework with a focus on the need for population education awareness, prevention and inequality
	• Multiple enablers had been identified eg digital, workforce, recruitment and retention.
	• The PCN vision would align to the national direction of travel and address such issues as:
	  ○ Inequality
	  ○ Mental health, wellbeing and prevention
	  ○ Access
	  ○ Recruitment and retention

22.4	Questions and comments were invited: • The linkage and overlap between this presentation and others shared at today's meeting were noted, NB estates, digital and workforce. • Q How would this abstract strategy be articulated in practice and differentiated according to local neighbourhood need? • The volume of different strategies being worked on at different levels was potentially overwhelming. The overlap meant there was also a lot of repetition with not necessarily any new insight. • AS acknowledged that different areas were at different stages in this process, for example in West Essex some integrated neighbourhood teams were already well established. The ICB would establish clinical priorities which would be implemented in different ways in different neighbourhoods depending on local population need. The purpose of the PCN strategy was to give the PCNs the time and space to think about primary care development in a joined-up way. • The work around community diagnostics was a key area. • Infrastructure needs would have to follow priorities, these might be different in different areas depending on the local footprint. • The local operating model within each neighbourhood would need to be responsive to local demand and capacity and need.
22.5	**The Primary Care Board noted the Estates update and the update on PCN clinical strategies**
PCB/23/23	**GMS Contract Changes 2023/24**
23.1	Michelle Campbell (MC) introduced this agenda item (see pages 82-99 of the document pack) and highlighted the following points: • The paper provided the Board with a summary of the key changes to the GP Contract and Regulations for 2023-24. • The changes were aimed at supporting improvements to patient experience and satisfaction with a focus on improving access to general practice by significantly reducing the Impact and Investment Fund indicators and changes to some of the QOF indicators. • Changes would be made to the PCN Additional Roles Reimbursement Scheme (ARRS) to support recruitment and retention within PCNs to further increase capacity. • These changes have not been agreed with the BMA GP Committee; this was the last year of the 5-year framework and NHSE would engage with the profession to agree a new contract which would support the next steps of integrated primary care. • The full letter from Dr Amanda Doyle could be found at Appendix 1 for the report • The development of an access dashboard was underway to identify the right metrics to track. • Key developments in the GMS contract related to:

	○ Advanced telephony; framework was now in place following the NHSE funded pilot. ○ Digital front door, e-consult and text messaging (evaluation would take place to track the impact of these tools on patients). ○ New pathways being considered for community pharmacy to deliver which would support general practice. Currently this is being negotiated. ○ Engaging with Patients/Codesign ○ Education and train primary care workforce as a whole including front line reception staff • Key enablers were estates, digital, population health data.
23.2	Questions and comments were invited: • The four-page letter from Amanda Doyle outlined the intention only, the contract had not yet been released. • MC was aware of this delay; however, her team had been working on the known operational changes in the build-up to the contract release and was confident that by working together with all partners this matter could progress smoothly. • A video on use of Community pharmacy consultation service and impact on practice has been captured as a good case study which will be shared after the meeting. Unfortunate due to IT issues we have not been able to share. • No uplift in ARRs funding was expected in 2023/24. • The capacity challenges within community pharmacy were noted – the desire to provide advanced services was there but this needed to be fully funded. • The reaction of GPs to an, as yet, unknown contract, represented a significant risk to the system.
23.3	**The PCB noted the current position in relation to the GMS contract changes**
PCB/24/23	**Primary Care Transformation**
24.1	**Engagement plan** James Gleed presented this agenda item (see pages 100-102 of the document pack) and highlighted the following points: • There were two main objectives re primary care transformation: ○ Establish integrated neighbourhood teams; and ○ Simplify and enhance access. • Consistency in outcomes would be demanded, but how this was achieved was up to the local team and would depend on the local demography. • The ICB would work with PCNs and GP practices to enhance/create workstreams under each of the objectives covering: ○ Workforce ○ Premises ○ Communications ○ Patient empowerment and education ○ Investment ○ IT/digital ○ Interdependencies • Generic MOUs would be established for integrated neighbourhood teams (INT) to ensure proper governance, responsibility and accountability, building on the work already underway in West Essex. • Simplification and enhancement of access/signposting was needed; there were other ways to improve access without increasing GP appointments for example. • Service redesign would need to be considered, eg following the success of respiratory hubs. • The system should be easy to navigate and should not create further inequality.

	• The system should aim to reduce the number of instances a patient could be seen more than once for the same health need with no benefit; the multiple points of access at the moment did not necessarily improve/impact outcomes. • If the model of same day access could be improved, then there would be more time to devote to the management of long-term conditions.
24.2	Questions and comments were invited: • Colleagues from West Essex noted that the INT had taken 5 years to build the relationships with partners (without any extra funding for any organisation); Primary Care Clinical Leadership (PCN leads) met regularly and were working closely with community care colleagues and the voluntary sector. • The development has now led to monthly MDT in each practice/PCN with attendance from adult community services, mental health and social care which has allowed to enhance the relationships at practice and PCN level but also where patients can be discussed in an MDT. The next step is to really use the PHM PCN data packs and identify groups of patients and make a difference through MDT approach • Greater emphasis was needed on the continuity of care and care ownership; the current system often saw patients being bounced between different services, this was not helpful and was evidence of the fragmented model of care. This might require a complete re-design of the current model/architecture. • Same day access did not always mean an appointment with a GP. • Community pharmacy had not been included in the engagement plan; this was an opportunity and a challenge. • Health inequalities needed to have a higher profile. • Contractual levers needed to be applied; for example, there was different levels of provision within care homes across Herts and West Essex. • The driver for change should be linked to population need and there should always be a review of the care provided – was it appropriate? • The transformation strategy focused on two objectives; this did not mean that work had been halted on other areas that had been identified as requiring improvement. • Population education was essential; it was noted that changes to access had not been adequately communicated to the public in the past. • There was commitment from all parties for the transformation agenda.
24.3	**Update on Enhanced Commissioning Framework (ECF)** Anurita Rohilla presented this agenda item on behalf of Sam Williamson (see pages 103-108 of the document pack) and highlighted the following points: • The ECF has had a significant impact on patient care, supporting the restoration of core services that provide proactive management of long-term conditions, including frailty and mental health conditions, as well as restoration of primary care procedures. • The implementation of the ECF has had several challenges, coming at a time of sustained pressure across health and care services and limited capacity. • The learning from the 2022/23 ECF has been incorporated into the plans for 2023/24 and there will be ongoing work to further develop and support practices to deliver high quality care. This forms the foundation of care upon which the ICB can commission and develop further services that meet the needs of the local population.
24.5	Questions and comments were invited: • There needs to be more engagement with community providers re long-term conditions. Whilst a condition might start with a diagnosis from within primary care it was typically treated in the community. There had been some interdependencies

	which need to be shared with community partners. AS to pick this up outside the meeting • GP targets have been simplified and adjusted; extra income (above the core contract) must result in a corresponding activity.
25.6	**Evaluation of Respiratory Hubs** Roshina Khan presented this agenda item (see pages 109-134 of the document pack) and highlighted the following points: • The Acute Respiratory hubs in Hertfordshire and west Essex (HWE) were set up mid-December 2022 as a response to increased winter pressures, initially for Strep A, activity presenting via NHS 111 and Emergency departments. • NHS England had offered funding to Integrated Care Boards (ICBs) to facilitate Acute Respiratory Infection hubs to help manage these pressures. • In HWE, four community-based hubs had been set up, initially for children with suspected Strep A only. As the problem spread to adults, and as part of the system response to winter, the Urgent and Emergency Care board advised to broaden the criteria to allow patients of all ages with non-life-threatening respiratory conditions or exacerbated chronic respiratory conditions, to be referred into the respiratory hubs. • Feedback from 83 patients and 14 practices had been collated, some key metrics included: ○ 80% rated the service as excellent. ○ 43% experienced barriers when attempting to book. ○ 100% of practices were given information to upload to patient records. ○ 78% said the hub helped reduced GP pressure. ○ 83% of referrals were from GP ○ Zero referrals were made via A&E • Funding for respiratory hubs would cease on 31 March and a plan would be drawn up for the best model for the coming winter and shared with a future meeting.
24.7	Questions and comments were invited: • Q What value for money did the Hubs offer? How much had each appointment cost and how did this compare to the cost of an appointment at a GP surgery? • Capacity had been built in at a certain level, but demand had not been as high as had been anticipated. The peak of demand was in late December. • The establishment of the respiratory hubs for 200,000 patients was a “must do” from NHSE; in periods of low demand, the hubs could be utilised for the management of other long-term conditions. • Community care partners needed to be involved in discussions about what future models should look like. • It was noted that the hubs were established at a time of surging demand within general practice and had been welcomed. • It was acknowledged that it would take time for a new service to be established.
24.8	**The Primary Care Board noted the Primary Care Transformation updates**
PCB/25/23	**Primary Care Risk Register**
25.1	James Gleed (JG) presented this agenda item (see pages135-145 of the document pack) and highlighted the following points: • The three areas of risks around the commissioning of dentistry, optometry and community pharmacy were being worked on currently. • The provision of dental services had been noted as a separate risk. • Risk 538: related to COVID-19 Mass vaccination centres – NHSE had announced the Spring Booster campaign which was focused initially on care homes and housebound patients. Given that this risk specifically concerned mass vaccination

	centres, the current risk rating remained appropriate. However, a wider review of the scope of this risk would be undertaken. • Risk 617: related to the growth in the placement of asylum seekers in local hotels – this risk has been updated in light of discussions at the February PCCC and identification of the need to develop alternative models of service provision. • Additional control measures and updates had been added to risk numbers 320, 321, 323, 327 and 537. • All changes have been highlighted in the document in RED. • Premises risks would be included in the register for the next meeting.
25.2	Questions and comments were invited: • The board noted that the register was dynamic. • The review date (in the last column) of the risk register needed to be updated to record that the risk register was reviewed at each meeting.
25.3	**The Primary Care Board noted the updated risk register**
PCB/26/23	**Reports/minutes from sub-groups**
26.1	The following reports were noted for information: • Primary care digital: 9 February 2023 (pages 146-150 of the document pack) • Primary care workforce: 23 February 2023 (pages 151-155 of the document pack)
PCB/27/23	**New Risks Identified**
27.1	The following new risks were identified: • Industrial action by junior doctors (announced on 24 March). • Lack of detail re the GMS Contract
PCB/28/23	**Reflections and Feedback from the Meeting including items to disseminate**
28.1	• Interrelationships and inter-dependencies within the system. • The meeting was fast paced, and discussions were rich and focused. • Strategic plans all needed to remain focus on achieving improved patient outcomes as a goal and address inequality.
28.2	The appendix from Healthwatch was noted.
PCB/29/23	**Date and Time of next meeting**
29.1	Thursday 25 May 2023, at 09.30
The meeting closed at 12.30	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Herts and West Essex Integrated Care Board PRIMARY CARE BOARD Action Tracker Last updated on 16 May 2023								
Private / Public	**Action Tracker Ref No**	**Date of Meeting**	**Subject**	**Action**	**Responsible Lead**	**Deadline Date**	**Comments and Updates**	**Status**
Public	PCB/21.7/22	24/11/2022	ICS Digital strategy	**Deep dive into digital exclusion to come to a future PCB meeting**	A Shah	~~**23/03/2023**~~ **24/05/2023**	On May Agenda	**Closed**
Public	PCB/20.3/23	23/03/2023	Governance - Appendix 2: Template for committee effectiveness survey	**Add question on interdependencies to the committee effectiveness survey**	I Khan/A Shah	**24/05/2023**	Completed	**Completed**

RAG Rating Key:	
Red	**Open (overdue)**
Amber	**Open (on-going)**
Green	**Completed / Action Closed**

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NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Primary Care Board				**Meeting Date:**	**25/05/2023**	
Report Title:	**Governance Update – Committee Effectiveness Survey Results**				**Agenda Item:**	**06**	
Report Author(s):	Iram Khan - Corporate Governance Manager						
Report Presented by:	Iram Khan - Corporate Governance Manager						
Report Signed off by:	Simone Surgenor, Deputy Chief of Staff, Governance and Policies						
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☒	**Information** ☒
Which Strategic Objectives are relevant to this report **[Please list]**	▪ Increase healthy life expectancy, and reduce inequality ▪ Give every child the best start in life ▪ Improve access to health and care services ▪ Increase the numbers of citizens taking steps to improve their wellbeing ▪ Achieve a balanced financial position annually						
Key questions for the Committee:	N/A						
Report History:	▪ The Effectiveness of Committees is assessed on an annual basis. ▪ The Primary Care Board workplan is reported at each Committee meeting.						
Executive Summary:	This report brings Governance updates to the attention of the Primary Care Board members, for discussion and information: 1. Committee Effectiveness Survey Results **(Appendix 1)** Please refer to the main body of this paper 2. Committee Workplan 2023-24 **(Appendix 2)** The Primary Care Board Workplan template has been drafted for 2023-24, the committee is asked to advise the Committee EA or the Governance lead of items to be added to the schedule of business.						

<table>
<tr><td>Recommendations:</td><td colspan="4">The Committee is asked to:

▪ Note that the Committee Effectiveness Survey results.
▪ Note the work plan for 2023-24.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">[Consider the impact of the paper on patient safety, e.g. Does the paper support improvement in patient safety and mitigate risks to patient safety]</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">[Refer to latest Risk Register when completing]</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="3">Impact Assessments:
(Completed and attached)</td><td colspan="2">Equality Impact Assessment:</td><td colspan="2">An EQIA will be undertaken on the method adopted for the release of this survey to ensure there are no concerns in particular surrounding access and approach</td></tr>
<tr><td colspan="2">Quality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Data Protection Impact Assessment:</td><td colspan="2">A DPIA would be connected to the platform used concerning release of the survey via a virtual route. It will be ensured checks are made to ensure a DPIA is in place.</td></tr>
</table>

1. Committee Effectiveness Survey Results (Appendix 1)

2.1 The committee should monitor the [company's] risk management and internal control systems and, at least annually, carry out a review of their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls" Paragraph 29, section 4, UK Corporate Governance Code (2018).

The committee effectiveness survey has been developed as part of the ICBs due diligence as part of a programme to evidence the above.

2.2 The first Primary Care Board effectiveness self-assessment survey was circulated to all members and attendees on Monday 17 April 2023 via MS Teams Forms in line with all HWE Board sub-committees' self-assessment surveys, annually at Q1.

2.3 Purpose of the review –

The annual review is designed to:

- Provide the Board with robust assurance of the committee's functioning and effectiveness;
- Form the basis of the Board's own effectiveness review;
- For the committee to examine its expectations of its members, and they are reminded of their duties;
- Provide an anonymous platform to enable individuals to have a safe environment to offer constructive feedback for the organisation to reflect on.
- Provide evidence of relevant achievements and development needs.

2.4 Methodology

The questionnaire has been designed around six main areas:

- Committee Focus
- Committee Team Working
- Committee Effectiveness
- Committee Engagement
- Committee Leadership
- Enhancing the Committee

2.5 Results:

The questionnaire was circulated to all members and attendees via MS Teams Forms, with a two-week timeframe to complete and submit. All responses are anonymous and have been collated into a feedback report for the committee to review and discuss (Appendix 1).

2. Committee Work Plan 2023-24

Primary Care Board work plan for 2023 – 24 (Appendix 2). The board is asked to review the contents of the work plan and advise of any items to be added.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Primary Care Board Effectiveness Survey Results
April – May 2023

The committee effectiveness survey is an annual activity to gain and evaluate feedback from the members of the Primary Care Board regarding their thoughts relating to six key topics:

1. Committee Focus (Q1 to 4)
2. Committee Team Working (Q5 to 8)
3. Committee Effectiveness (Q9 to 13)
4. Committee Engagement (Q14 to 16)
5. Committee Leadership (Q17 to 20)
6. Enhancing the Committee (Q21)

The survey was distributed to 36 individuals who are members and attendees of the Primary Care Board. The survey was designed on MS Teams Forms to be anonymous to enable individuals to have a safe environment to offer constructive feedback for the organisation to reflect on. It was completed by 10 individuals.

Findings:

The charts attached summarise the responses received for each question.

Topic 1 – Committee Focus

- 9 out of 10 members that responded strongly agreed/agreed that the committee is clear about its purpose and role and understands its duties as set out in the Terms of Reference.
- 8 out 10 members agreed that the agenda is appropriately set in relation to the balance of the range of issues including quality, performance targets, governance and financial controls where relevant whilst two members neither agreed nor disagreed.
- Seven members agreed that the committee and its members have adequate authority as set out in the committee Terms of Reference whilst two members felt neutral, and one member disagreed with this statement.
- Half of those that responded agreed that the committee has a clear programme of work to ensure the ICB discharges NHSE statutory functions effectively, to provide assurance to NHSE and demonstrate improvement' received a varied response indicating that the there is work required to further discuss the remit of this committee, whilst three members felt neutral, and one member disagreed with this statement.

Topic 2 – Committee Team Working

- 70% of those that responded strongly agreed/agreed that the Committee has the right balance of experience, knowledge, skills and resources to deliver its role effectively.
  One response was received: *could benefit from more user voice*

- Majority of those that responded agreed that the Committee ensures that the right levels and balance of attendance or contributions from the ICB and is maintained to enable it to secure the required level of understanding of the papers / information it receives, whilst one member disagreed with this statement.
  One response was received: *Could benefit from more user voice*

- Majority of those that responded agreed that when a decision has been made or action agreed I feel confident that it will be implemented as agreed and to the agreed timescale, whilst two members neither agreed nor disagreed.
- One response was received: *Too soon to assess*

- Once a decision has been made the Committee supports it irrespective of personal views and opinions – seven members strongly agreed/agreed with this statement, two felt neutral and one member disagreed.

Topic 3 – Committee Effectiveness

- Majority of those that responded agreed that the quality of committee papers received, and committee administration allow me to perform my role effectively i.e agenda/papers delivered on time ahead of meetings, whilst two members disagreed.

- Majority of those that responded agreed that they were able to provide real and genuine challenge and contribute to problem solving, whilst one member felt neutral, and one member disagreed.

- 4 out of 10 members agreed that the Committee has established a work plan for the year which drives the business of the Committee and is linked back to the objectives of the Committee, whilst four members felt neutral, and one member disagreed.

- The Committee meets sufficiently frequently to deal with planned matters and enough time is allowed for questions and discussions – responses received were majority in agreement with this statement with two respondents neither agreeing nor disagreeing.

- Seven members responded in agreement that they felt the topics covered in the agendas and workplan allow the Committee to seek appropriate assurance in relation to equality and diversity, with three members neither agreeing nor disagreeing with this statement.

Topic 4 – Committee Engagement

- *Committee members challenge the executive team and other assurance providers to gain clear understanding of their findings* – seven members strongly agreed/agreed with this statement whilst two members felt neutral, and one member disagreed.

- *The committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality, and risk management* – five members agreed with this statement with two members feeling neutral and two disagreeing.

- How effectively do you think the work of the PCB is integrated with other broader areas of ICB programme areas and place agendas for transformation – a varied response was noted from four members agreeing, two members neither agreeing nor disagreeing, one member disagreeing and other not able to respond to this question.

Topic 5 - Committee Leadership

- There was unanimous agreement to the below statements, with one member disagreeing:
- The committee meetings are chaired effectively and with clarity of purpose and outcome.
- The Chair allows debate to flow freely and does not assert their own views too strongly onto the debate.
- The Chair has a positive impact on the performance of the Committee.
- The Chair is visible within the organisation and is considered approachable.

- Overall, the responses to this section show a high level of strong satisfaction with the Chair.

Topic 6 – Enhancing the Committee

4 respondents provided additional comments;

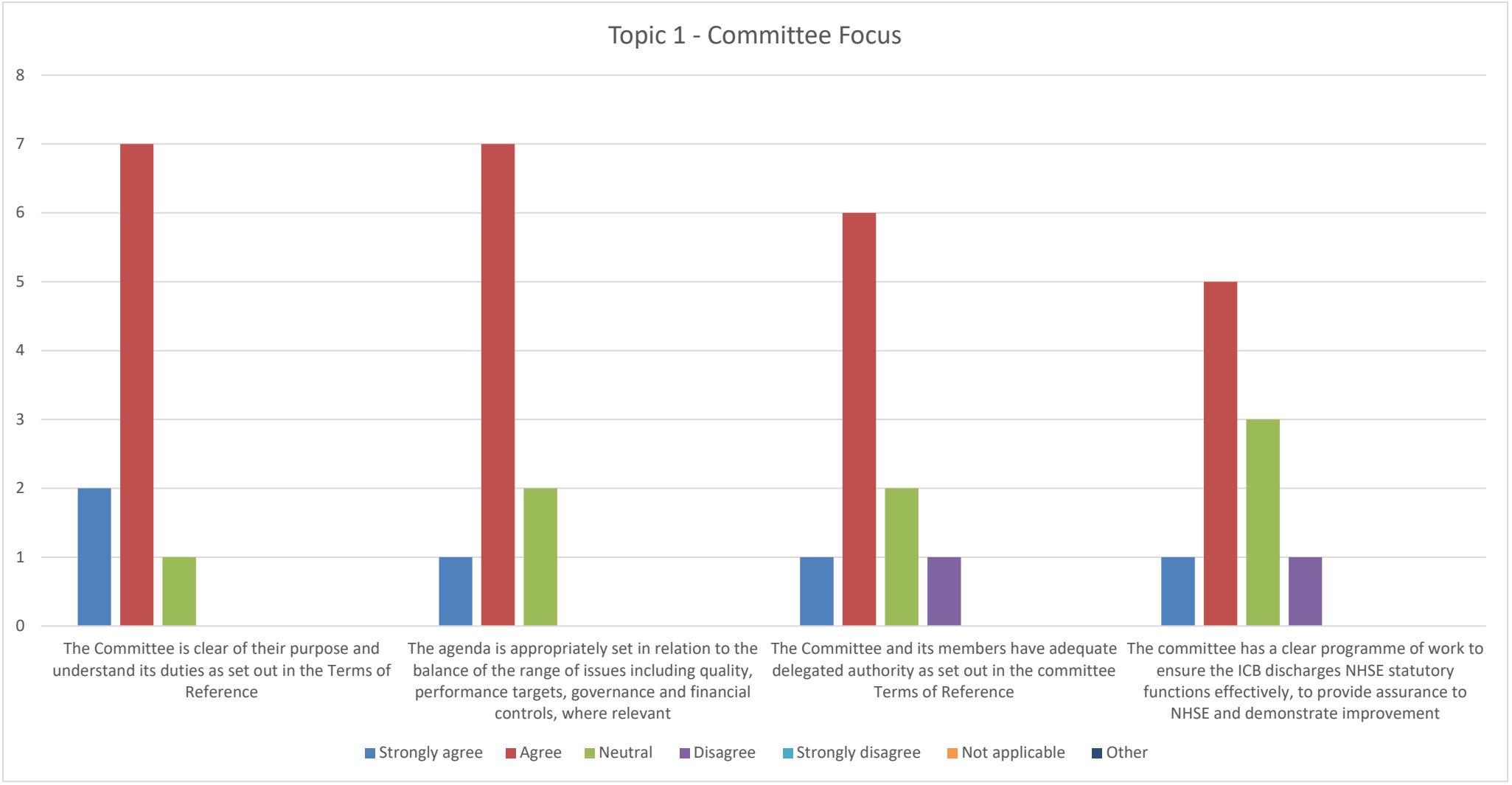
- *Committee papers are large and unwilling, this could be reduced*
- *The committee is evolving and with POD responsibilities taken on since the start of April we will need to get to know each other. I am also looking forward to the addition of Citizen involvement on our Board.*
- *This is a new committee of the ICB which formed in July and started to meet in August. It meets in Public but not a public meeting. With the changes to primary care and further delegation, the work plan of the board will be evolving as it takes on POD delegation. However the board is on the path of developing the strategic delivery plan across the ICB and needs to do further work to ensure how this is not silo and aligned to all other transformation programmes across the ICB to show the matrix working an interconnectivity, Further work outside the board to make those connections stronger which will happen with the portfolio working of senior primary care management too.*
- *Primary care board has evolved to encompass broader range of primary care services - will need to review time allocated to meetings to reflect the broadening agenda*

Next Steps:

Overall, these results show that there is a high level of general satisfaction with the operation and effectiveness of the board. Some suggestions have been put forward to improve the arrangements and these will be discussed at the meeting to ensure the appropriate balance between the effectiveness of the board.

A full discussion will take place at the next meeting and in addition members are welcome to contact the Chair directly if they wish to discuss further.

We thank you for your support and feedback.


Topic 1 - Committee Focus
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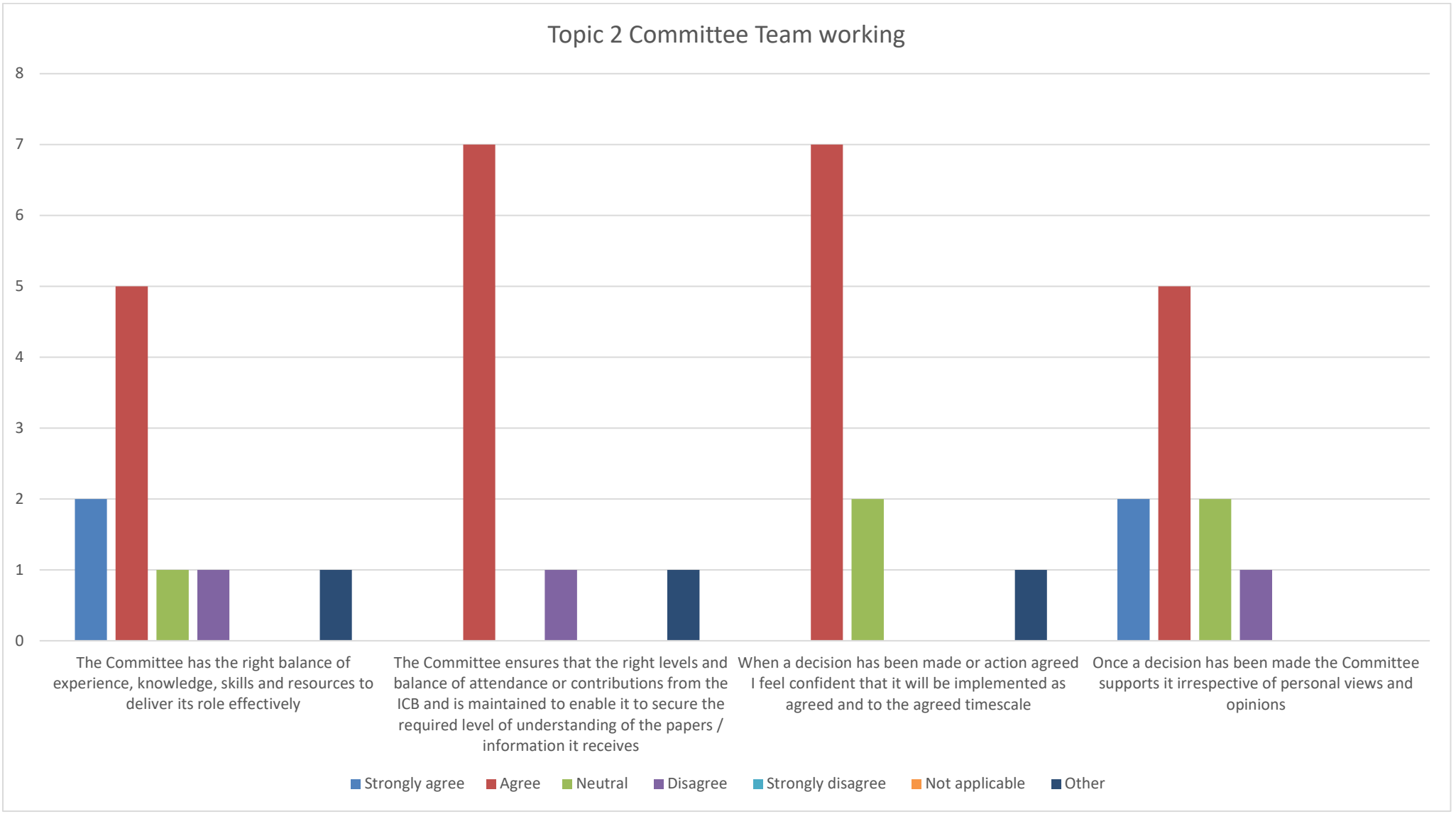
The Committee is clear of their purpose and understand its duties as set out in the Terms of Reference
The agenda is appropriately set in relation to the balance of the range of issues including quality, performance targets, governance and financial controls, where relevant
The Committee and its members have adequate delegated authority as set out in the committee Terms of Reference
The committee has a clear programme of work to ensure the ICB discharges NHSE statutory functions effectively, to provide assurance to NHSE and demonstrate improvement
Strongly agree
Agree
Neutral
Disagree
Strongly disagree
Not applicable
Other


Topic 2 Committee Team working
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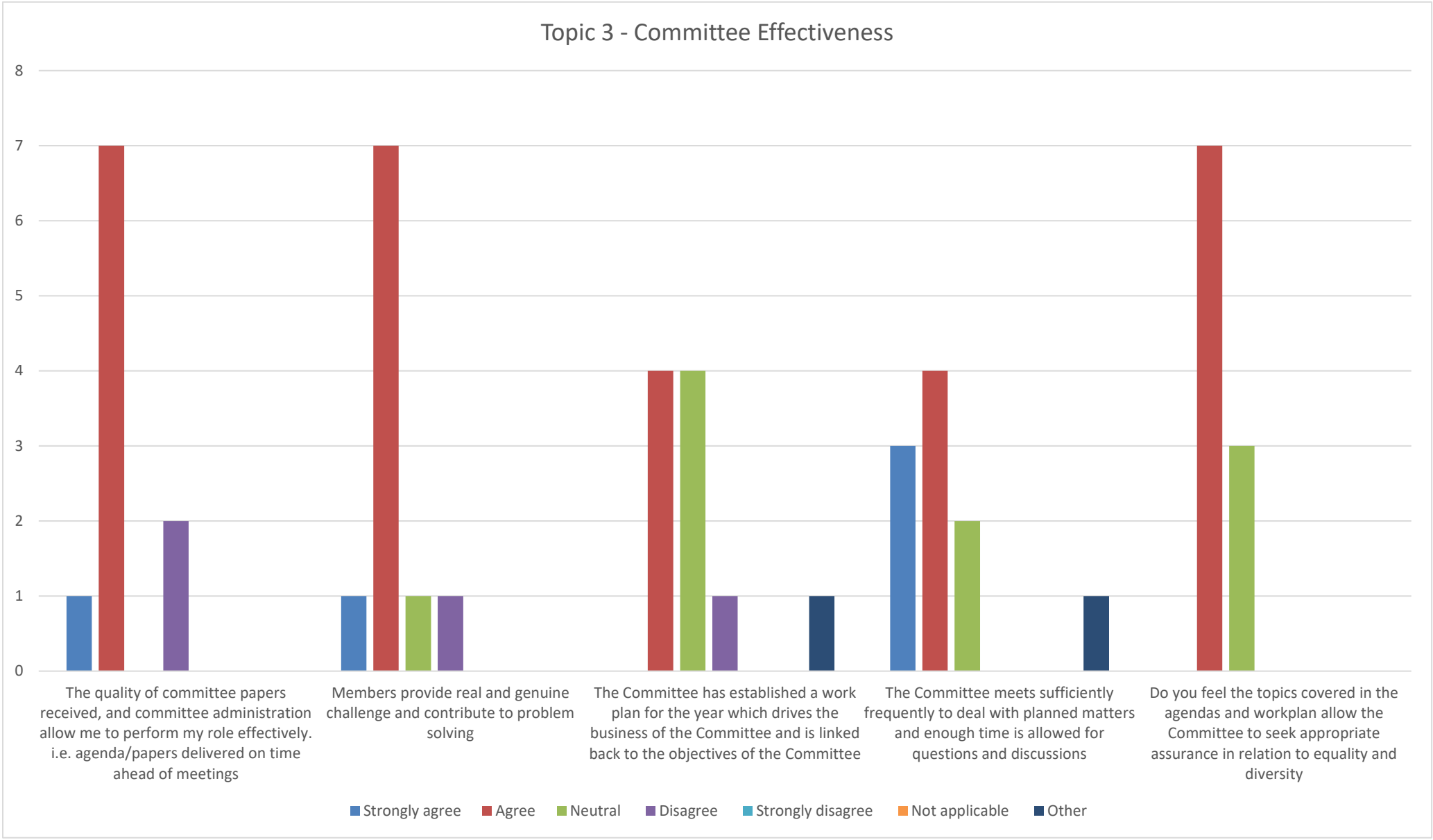
The Committee has the right balance of experience, knowledge, skills and resources to deliver its role effectively
The Committee ensures that the right levels and balance of attendance or contributions from the ICB and is maintained to enable it to secure the required level of understanding of the papers / information it receives
When a decision has been made or action agreed I feel confident that it will be implemented as agreed and to the agreed timescale
Once a decision has been made the Committee supports it irrespective of personal views and opinions
Strongly agree
Agree
Neutral
Disagree
Strongly disagree
Not applicable
Other


Topic 3 - Committee Effectiveness
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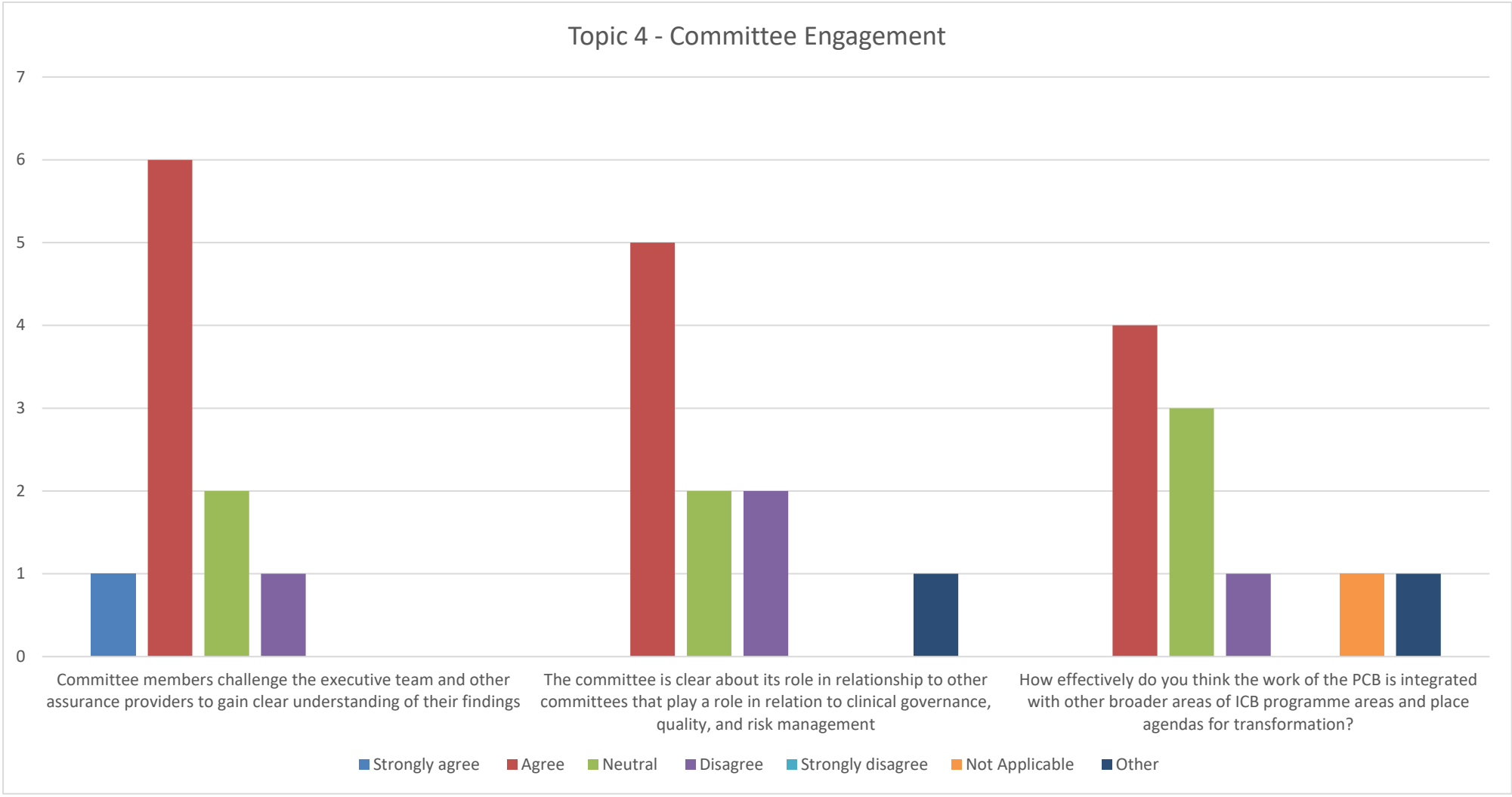
The quality of committee papers received, and committee administration allow me to perform my role effectively. i.e. agenda/papers delivered on time ahead of meetings
Members provide real and genuine challenge and contribute to problem solving
The Committee has established a work plan for the year which drives the business of the Committee and is linked back to the objectives of the Committee
The Committee meets sufficiently frequently to deal with planned matters and enough time is allowed for questions and discussions
Do you feel the topics covered in the agendas and workplan allow the Committee to seek appropriate assurance in relation to equality and diversity
Strongly agree
Agree
Neutral
Disagree
Strongly disagree
Not applicable
Other


Topic 4 - Committee Engagement
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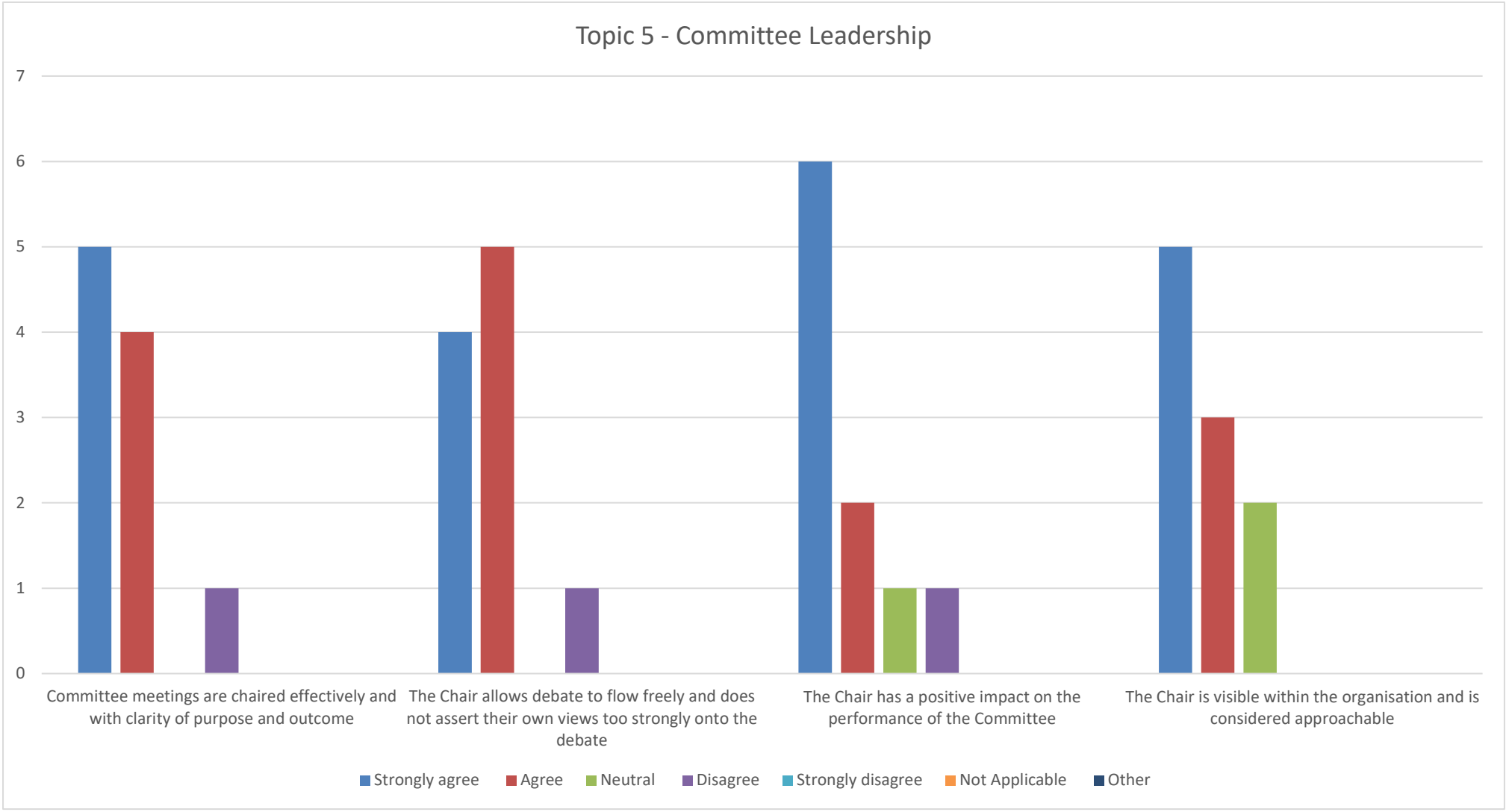
Committee members challenge the executive team and other assurance providers to gain clear understanding of their findings
The committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality, and risk management
How effectively do you think the work of the PCB is integrated with other broader areas of ICB programme areas and place agendas for transformation?
Strongly agree
Agree
Neutral
Disagree
Strongly disagree
Not Applicable
Other


Topic 5 - Committee Leadership
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Committee meetings are chaired effectively and with clarity of purpose and outcome
The Chair allows debate to flow freely and does not assert their own views too strongly onto the debate
The Chair has a positive impact on the performance of the Committee
The Chair is visible within the organisation and is considered approachable
Strongly agree
Agree
Neutral
Disagree
Strongly disagree
Not Applicable
Other

21. Please could you take some time to share any views or suggestions about what could be done to enhance the Committee

4 Responses

ID ↑	Name	Responses
1	anonymous	Committee papers are large and unwilling, this could be reduced
2	anonymous	The commitee is evolving and with POD responsibilities taken on since the start of April we will need to get to know eachother. I am also looking forward to the addition of Citizen involvement on our Board .
3	anonymous	This is a new committee of the ICB which formed in July and started to meet in August. It meets in Public but not a public meeting. With the changes to primary care and further delegation, the work plan of the board will be evolving as it takes on POD delegation. However the board is on the path of developing the strategic delivery plan across the ICB and needs to do further work to ensure how this is not silo and aligned to all other transformation programmes across the ICB to show the matrix working an interconnectivity, Further work outside the board to make those connections stronger which will happen with the portfolio working of senior primary care management too
4	anonymous	Primary care board has evolved to encompass broader range of primary care services - will need to review time allocated to meetings to reflect the broadening agenda

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Primary Care Board

Work Plan and Deadlines for Papers 2023/24

Deadlines for Papers *(Unless alternative arrangements have been agreed with the Chair and Exec Lead)*	**2023**				**2024**	
Date of Meeting	**Thursday 25 May**	**Thursday 27 July**	**Thursday 28 September**	**Thursday 23 November**	**Thursday 25 January**	**Thursday 28 March**
Final Papers to Corporate Governance by 5pm (9 days before the meeting)	**16 May**	**18 July**	**18 September**	**14 November**	**16 January**	**19 March**
Final Papers to Committee Members (7 days before the meeting)	**18 May**	**20 July**	**21 September**	**16 November**	**18 January**	**21 March**
Planning meetings with Chair and Executive Lead						
- **Agenda setting (6 weeks before meeting date)**	**6 April**	**15 June**	**10 August (early due to Avni a/l)**	**12 October**	**14 December**	**15 February**
- **Pre-meet (1 week before meeting date)**	**18 May**	**20 July**	**14 Sept (early due to no avail wk after)**	**16 November**	**18 January**	**21 March**
- **Post-meeting review (within 1 week following the meeting)**	**1 June**	**3 August**	**5 October**	**30 November**	**1 February**	**4 April**
Committee Work Plan	√	√	√	√	√	√
Committee Terms of Reference	√	√	√	√	√	√
Committee Self-assessment of Effectiveness (2023-24)	√					
Committee Summary for escalation to the Board	√	√	√	√	√	√
Session in Public						
1. Welcome & Apologies	√	√	√	√	√	√
2. Declarations of Interest inc. Register of Committee Members	√	√	√	√	√	√
3. Impact assessments for reports: Equality Impact Assessment (EQIA) / Quality Impact Assessment (QIA) / Data Protection Impact Assessment (DPIA)	√	√	√	√	√	√
4. Minutes of previous meeting & Action Log	√	√	√	√	√	√
5. Questions from the public	√	√	√	√	√	√
6. Risk Register	√	√	√	√	√	√
7. Primary Care Transformation Reports	√	√	√	√	√	√
8. Primary Care Board Workplan each place – Roshina/Cathy/Philip		√				

9. ICS Digital Strategy			√	√	√	√
10. Healthwatch Herts / Essex Reports	√	√	√	√	√	√
11. GP Patient Survey results and action plans						
12. Primary Care Workforce Delivery Plan						
13. Development of Patient groups						
14. Deep Dive Sessions	**Digital** √					

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐				
	NHS HWE ICB Primary Care Board meeting held in Public				**Meeting Date:**	**25/05/2023**		
Report Title:	**HWE ICB Primary Care Finance Report** **Section 1 – 2022/23 Month 12 Finance Report** **Section 2 – 2023/24 Primary Care Medical Service Financial Plan** **Section 3 – 2023/24 Primary Care POD Services Financial Plan**				**Agenda Item:**	**08**		
Report Author(s):	Philip O'Meara, Head of Finance – Primary Care Services, HWEICB							
Report Presented by:	Alan Pond, Chief Financial Officer, HWEICB							
Report Signed off by:	Alan Pond, Chief Financial Officer, HWEICB							
Purpose:	**Approval / Decision**	☒	**Assurance**	☐	**Discussion**	☐	**Information**	☒
Which Strategic Objectives are relevant to this report **[Please list]**	▪ Mandatory Duty of Achieving Financial Balance across the ICB							
Key questions for the ICB Board / Committee:	N/A							
Report History:	N/A							
Executive Summary:	This paper is set out in 3 Sections. Section 1 of the paper provides a summary of the Primary Care Devolved Commissioning and Locally Commissioned Services finance position for the year ended 31st March 2023. At year end Primary Care budgets reported an overspend of £9.25m. However, this overspend was entirely associated with primary care prescribing which was overspent by £9.638m. There was an underspend on commissioned primary care medical services (including delegated budgets) of £0.398m.							

	Section 2 of this paper sets out proposed budgets for Primary Medical Services Delegated and Locally Commissioned for the year April 2023 to March 24. Section 3 of this paper presents a high level summary of the newly Delegated Services Budgets for Pharmacy, Optometry and Dental Services for the year April 2023 to March 2024.			
Recommendations:	To note the month 12 position and to approve the CCG Primary Care Commissioning plans for the year April 2023 to March 24.			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A			
Implications / Impact:				
Patient Safety:	*N/A*			
Risk: *Link to Risk Register*	*N/A*			
Financial Implications:	*N/A*			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***		N/A	
	Quality Impact Assessment:		N/A	
	Data Protection Impact Assessment:		N/A	

1. Executive summary

This paper is set out in 3 Sections.

Section 1 of the paper provides a summary of the Primary Care Devolved Commissioning and Locally Commissioned Services finance position for the year ended 31st March 2023.

At year end Primary Care budgets reported an overspend of £9.25m. However, this overspend was entirely associated with primary care prescribing which was overspent by £9.638m. There was an underspend on commissioned primary care medical services (including delegated budgets) of £0.398m.

Section 2 of this paper sets out proposed budgets for Primary Medical Services Delegated and Locally Commissioned for the year April 2023 to March 24.

Section 3 of this paper presents a high level summary of the newly Delegated Services Budgets for Pharmacy, Optometry and Dental Services for the year April 2023 to March 2024.

SECTION 1 ICB EXPENDITURE OVERVIEW ALL SERVICES

ICB Primary Care Services as at March 2023			
Service Description	**Annual Budget (£000)**	**Actual (£000)**	**Variance (£000)**
DELEGATED GP			
General Practice - GMS	£127,245	£124,497	(£2,748)
General Practice - PMS	£1,207	£1,367	£160
Other List-Based Services (APMS incl.)	£8,487	£8,437	(£50)
Premises cost reimbursements	£15,054	£14,966	(£88)
Primary Care NHS Property Services Costs - GP	£542	£578	£37
Other premises costs	£969	£845	(£124)
*Enhanced services	£6,191	£8,169	£1,977
QOF	£15,479	£15,601	£122
£1.50 per head PCN Development Investment	£1,617	£1,226	(£391)
Other - GP Services	£7,705	£6,294	(£1,411)
Total Delegated GP	£184,496	£181,979	(£2,517)
Other Primary Care Allocations			
Prescribing	£175,504	£185,142	£9,638
Community Base Services	£8,336	£8,306	(£30)
Out of Hours	£13,070	£13,346	£276
*Other Primary Care Services	£8,820	£9,879	£1,060
GP IT Costs	£4,548	£5,363	£814
Total Other Funded Local Services	£210,278	£222,036	£11,758
Total (Under/Overspend	£394,774	£404,015	£9,240

*Includes cross Charge for Enhanced Access

The allocation and budget were increased by NHSE to reflect the actual costs for ARRS.

The main variances on the delegated budget were associated with lower than forecast population growth leading to an underspend on GMS; and on Enhanced services partly due to the new Capacity and Access payments which were funded through repurposing of the Investment and Impact Fund (shown as an underspend on Other – GP Services.

The GPIT budget had a significant overspend as new services were brought on stream or were no longer centrally funded. Additionally changes in operating models since COVID, with more remote working and/or non-face to face consultations, has led to significant increase in software licences and SMS Messaging costs.

On other budgets the main area of increased spend was on the Enhanced Commissioning Framework where the previous CCGs' schemes were brought together and relaunched with an overall increase in payment per patient being made. This increase was offset by headroom that had been held in the

On prescribing there was a significant overspend of £9.638m with the breakdown shown in the table below. The overspend is largely driven by:

- Price concessions – through stock outages of essential medication causing costs to rise. While this happens to some extent every year the cost pressures in 2022/3 were considerably more than is usual.
- Appliances – cost increases due to increased use of Continuous Glucose Monitoring (CGM) to monitor diabetes in line with NHSE guidance.
- Cardiovascular – increased use of sacubitril valsartan in line with NICE recommendations, prolonging lives; and increased use of DOACs, although increased use of edoxaban as 1st choice DOAC reduced the overall cost increased.
- Endocrine – costs rising due to increased use of newer diabetes medicines taken orally becoming 1st choice in line with NICE guidance
- Gastroenterology- five low cost high volume medicines have had significant price increases namely lansoprazole, pantoprazole and three commonly used laxatives.
- Respiratory – more use of combined inhalers to improve compliance and dry powder inhalers which have lower carbon emissions and therefore better for the environment, but often at a higher financial cost. The use of dry powder inhalers instead of pressurised metered dose inhalers was incentivised in the Impact and Investment Fund indicators and is the right thing to do on sustainability grounds.

ICB Prescribing, Central Drugs & Oxygen as at March 2023			
Service Description	**Annual Budget (£000)**	**Actual Expenditure (£000)**	**Variance (£000)**
Prescribing	£165,590	£174,538	£8,949
Oxygen	£1,252	£1,387	£135
Medicines Management - Clinical	£3,729	£3,335	(£394)
Central Drugs	£4,933	£5,881	£948
Total Prescribing Costs	£175,504	£185,142	£9,638

SECTION 2

2023/24 Draft Primary Care Medical Services Financial Plan

NHS England published ICB core and delegated primary medical allocations just before Christmas alongside planning priorities and guidance for 2023/24. Subsequently further information on allocations and on recovery plans has been published.

This paper confirms the 2023/24 allocations to primary care medical services, from both the core allocation, delegated allocation and System Development Funding. The paper sets out draft budgets having modelled changes in service requirements, population and allowing for inflation.

The starting point for core allocation funding has been the 2023/23 recurrent outturn expenditure, which builds in the significant overspend on prescribing. Whilst the budget set has built in some savings in 2023/24, the final budget still consumes significantly increased resources compared to the 2022/23 budget. For this reason, if the prescribing budget underspends in 2023/24, this amount will be clawed back centrally and will not be available for spending elsewhere in primary care services.

The total allocation for primary care services and prescribing are set out in the table below.

CC Category	Cost Centre Description - ICB	2022/23 Recurrent Expenditure £000	Inflation £000	Efficiencies £000	Demographic Growth £000	Convergence £000	PIES (Efficiencies) £000	Other £000	2023/24 Proposed Allocation £000
PRESCRIBING	MEDICINES MANAGEMENT - CLINICAL	4,605	0	0	0	0	0	0	4,605
	PRESCRIBING	218,332	6,332	(2,402)	4,367	(1,629)	(2,842)	0	222,158
	CENTRAL DRUGS	7,127	207	(78)	143	(53)	0	0	7,344
	OXYGEN	1,689	49	(19)	34	(13)	0	0	1,741
PRESCRIBING Total		231,753	6,587	(2,499)	4,543	(1,695)	(2,842)	0	235,848
PRIMARY CARE	DELEGATED ALLOCATION	246,625	7,152	(2,713)	9,062	(937)	0	0	259,189
	CORE ALLOCATION	43,990	1,276	(484)	840	(328)	(53)	0	45,241
	SDF TRANSFORMATION	0	0	0	0	0	0	5,508	5,508
PRIMARY CARE Total		£290,615	£8,428	(£3,197)	£9,902	(£1,265)	(£53)	£5,508	£309,938
Grand Total		£522,368	£15,015	(£5,695)	£14,445	(£2,961)	(£2,895)	£5,508	£545,786

Budgets have been developed based on the following:

- Weighted list sizes have been updated to January 2023 as published and list size growth is assumed for each of subsequent quarters, 2% overall which is prudent.
- Global Sum price per weighted patient is £102.28. Out of Hours Opt Out deduction remains at 4.75% but changes from £4.74 in 2022/23 to £4.86 in 2023/24. The net global sum price is therefore £97.42 per weighted patient.
- APMS budget updated to maintain existing contract agreements with a 20% premium on the Global Sum, with the exception of Sollershott at 28%.
- The value of Quality and Outcomes Framework (QOF) points moves from £207.56 to £213.43. The budget is based on 21/22 achievement.
- Premises budget has been uplifted for market rent average annual uplift and for new schemes in the pipeline.
- Directed Enhanced Services have been uplifted by 5.09%.

- Other Delegated services have been uplifted by 5.09%
- PCN ARRS costs have been uplifted based on the new PCN entitlement with 60% funded within the delegated budget and the other 40% held centrally by NHSE and claimed if spent.
- Enhanced Commissioning Framework budget is asset assuming 93% achievement.
- A local transformation budget of £2m is included. This is in addition to the SDF allocation.
- A contingency reserve of 0.5% is held.
- With these assumptions there remains £2.155m unallocated creating headroom on the budget.

Service Description	Proposed Budget £000
Related Contractual/QOF	171,424
PCN and DES	50,095
Premises	22,371
Prescribing	3,515
Locum Support	3,997
Practice Support Costs	643
Online Consultation Support	689
Local Commissioning / Incentive	21,213
Out of Hours	16,972
Primary Care IT	7,330
Other	476
Local Transformation Funding	2,000
SDF - Transformation	4,122
SDF - Fellowships	867
SDF - Mentors	204
SDF - GPIT infrastructure and resilience	315
Contingency Reserve	1,550
Unallocated Headroom	2,155
Primary Medical Care Services	**309,938**
Pharmacy and Medicines Optimisation Team	4,605
Primary care Prescribing	222,158
Central Drugs	7,344
Oxygen	1,741
Prescribing	**235,848**
Total Budget	**545,786**

SECTION 3

2023-24 Draft Pharmacy , Optometry and Dentistry Financial Plan

Commissioning responsibility for Pharmacy, Optometry and Dentistry (POD) services transferred to Hertfordshire and West Essex ICB from 1st April 2023. Unlike primary care medical services where there is patient registration and the ICB is responsible for the registered patients of its associated GP Practices, POD services have no such registration. The ICB is therefore responsible for the cost of services commissioned from and delivered by POD providers within the boundaries of the ICB.

NHS England published POD allocations by ICB before Christmas and has developed a draft financial plan for each ICB using the information and intelligence they have.

The 2023-24 allocation to the ICB is £ £133.8m as set out in the table below.

2022/23 Allocation	dental £000	ophth £000	pharmacy £000	other £000	total £000
Recurrent baseline	85,707	15,163	29,083	214	**130,166**
Base growth %	4.0%	4.3%	-0.3%	0.0%	**3.1%**
Base growth	3,445	640	(102)	0	**3,984**
Subtotal	**89,153**	**15,803**	**28,981**	**214**	**134,151**
convergence	(253)	(45)	(86)	(1)	**-384**
Recurrent Allocation 23/24	**88,900**	**15,758**	**28,895**	**213**	**133,767**

Pharmacy and Optometry services costs are largely variable being based on significant elements of cost per case services, e.g. dispensing fees and also prescription charges received from patients. This makes controlling spending difficult.

Primary and community dental services were largely commissioned through block contracts or contracts with a maximum level of activity. Secondary dental services through COVID were largely contracted for on a block contract basis and in 2023/24 will continue so, except for elective activity associated with the elective recovery fund which will effectively be paid for on a cost per case basis. Funding from NHSE for this care will also be variable and matched to the tariff value of activity.

The plan, in the table below, was constructed by NHSE using known contract and price changes, assumptions on growth in services; and known commitments on dentistry.

The plan currently has significant headroom of nearly £6m which is largely consistent with the financial outturn in 2022/23 forecast at month 11 (see lower table). The increased headroom over 2022/23 is related to pharmacy services where nationally agreed transitional payments being made in 2022/23 cease in 2023/24.

The dental allocation is ringfenced and ICBs have been encouraged to use funding available to increase activity through additional and/or increased contracts.

POD Delegation Summary 2023/24 DRAFT PLAN

Summary	PLAN	ALLOCATION	VARIANCE
Pharmacy	28,193	28,908	716
Primary dental	65,631	66,314	684
Community dental	2,576	2,726	150
Secondary dental	18,440	20,001	1,561
Optometry	12,911	15,767	2,856
			0
Total	**127,751**	**133,717**	**5,966**
Property Costs	222	222	0
Uncommitted allocation	5,794	(172)	(5,966)
Grand Total	**133,767**	**133,767**	**0**

POD Delegation Summary 2022/23 FOT

Summary	M11 FOT	ALLOCATION	VARIANCE
Pharmacy	30,064	29,083	(981)
Primary dental	63,845	64,595	751
Community dental	2,481	2,618	137
Secondary dental	16,460	17,924	1,464
Optometry	12,379	15,138	2,759
Grand Total	**125,228**	**129,358**	**4,129**

RECOMMENDATIONS

To note the 2022/23 financial outturn and to approve the Primary Care Commissioning budgets for 2023/24.

Alan Pond

Chief Financial Officer

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS HWE ICB Primary Care Board meeting held in Public		**Meeting Date:**	**25/05/2023**
Report Title:	**Update from Healthwatch Hertfordshire –** **a. Early Findings on Adults with Learning Disabilities' Experiences of Accessing GP Services, and Support in Living a Healthy Lifestyle** **b. Early Findings on Public Understanding on Cardiovascular Disease, and Self-Management.**		**Agenda Item:**	**9A**
Report Author(s):	Geoff Brown, Chief Executive, Healthwatch Hertfordshire Chloe Carson, Senior Research Manager, Healthwatch Hertfordshire Miriam Blom-Smith, Research Officer, Healthwatch Hertfordshire Asha McDonagh, Research Officer, Healthwatch Hertfordshire			
Report Presented by:	Neil Tester, Vice-Chair, Healthwatch Hertfordshire			
Report Signed off by:	Avni Shah, Director of Primary Care Transformation			

Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☒	**Information**	☐

Which Strategic Objectives are relevant to this report **[Please list]**	▪ Improve access to health and care services ▪ Increase the numbers of citizens taking steps to improve their wellbeing ▪ Increase healthy life expectancy and reduce inequality
Key questions for the ICB Board / Committee:	**Adults with Learning Disabilities Engagement:** ▪ Based on the findings so far, are there recommendations the Primary Care Board could suggest to improve experiences for people with learning disabilities and to address their needs? **Cardiovascular Disease Engagement:** ▪ Does the Primary Care Board feel these are positive results? The findings also highlight differences in experiences, particularly in regards to age, gender, ethnicity and income. Are there opportunities

	for the Primary Care Board to do targeted work with particular groups?
Report History:	N/A
Executive Summary:	**The full reports and recommendations will be presented at the Primary Care Board meeting in July. Here we have used the Executive Summary to cover early findings. The final reports will provide more detail on the background, methodology and propose recommendations for the Primary Care Board to take forward.** **<u>Engagement with Adults with Learning Disabilities</u>** Through a focus group and one-to-one interviews, we spoke to adults with learning disabilities, carers and support workers about their experiences of accessing GP services, and how GP practices support them to live a healthy lifestyle. Key findings include: <u>Accessing an appointment</u> • All respondents contact their GP practice by telephone, with many experiencing long delays when contacting and difficulties in getting an appointment. For some, difficulties in access has made them reluctant to contact their GP practice unless their concern is urgent. • Almost all respondents contact their GP practice with the help of their carer or support worker. Respondents shared that it can be difficult to contact their GP practice during opening hours, as this is outside of their support worker's working hours. • Three respondents have a Care Coordinator at their GP practice who they can contact to organise appointments. They have found this to be invaluable and has improved their experience of accessing GP services. • Some respondents had difficulty communicating with receptionists and in some cases, were treated poorly. <u>Choice</u> • All respondents prefer to see the same nurse or GP. This continuity helps them to build trust and communication, and avoids having to repeat their needs and medical history. However, most have to wait several weeks to see the clinician of their choice. • All respondents prefer to speak to a clinician face-to-face, and have found video and/or telephone appointments inaccessible, including difficulties hearing, communicating and using online technology. • Most respondents are given a date and time when making an appointment, which they can find difficult to work around their own schedule and their support worker's working hours.

Communication

- Some respondents felt that clinicians and receptionists can speak too quickly and use words and terminology that they find difficult to understand. Many do not receive information in Easy Read.
- Some respondents have had very positive experiences with clinicians, emphasising that they are kind, helpful and accommodating.
- However, a few respondents felt that clinicians speak to their carer or support worker, rather than addressing them directly, which they find upsetting and disrespectful.

Healthy Lifestyle

- Most respondents have had a clinician discuss healthy eating and exercise which they have found useful. However, they would like more regular conversations about this, as well as more practical support and information.
- Most respondents have not had a clinician talk about mental health and/or their social life. Although not important to most, it was very important to respondents experiencing depression and social isolation.
- Most respondents have not had a clinician discuss drugs, alcohol and smoking, although most felt they did not need this information.
- Most respondents have not had a clinician discuss cancer screenings, and some lacked awareness about what cancer screenings are and why they are important.

Annual Health Checks

- Some respondents had a very positive experience, emphasising that they received a thorough examination of their physical and mental health.
- Some had a more negative experience, only receiving a basic examination and a short appointment.
- A few respondents have never been offered an Annual Health Check, or have not been contacted about their Annual Health Check for a couple of years.

Engagement on Cardiovascular Disease

Through an online survey, we engaged with people with a diagnosis of cardiovascular disease - about how they self-manage their condition, and those without a diagnosis – about their understanding of the symptoms and risk factors.

Key themes for people **with a diagnosis** include:

Identification and Diagnosis

- 25% recognised their own symptoms of heart disease, after which most visited their GP and some contacted emergency services. Under 65s were more likely than those over 65 to recognise their own symptoms.

	• 72% said their symptoms were recognised by a clinician. Men and those under 65 were more likely to be diagnosed in hospital, rather than by a GP or practice nurse. • Only 14% experienced barriers in identifying and diagnosing their condition, these included waiting times for an appointment and/or delays in referral. <u>Understanding and Self-Management</u> • 74% felt that their condition was explained properly and understood the information given. However, some respondents felt they could have been better informed and supported. Women in particular were more likely to feel that their condition was not adequately explained to them. • Only 13% do not feel confident in managing their condition. Men, people from an Asian ethnic background, those on a lower income and people aged over 65 were least confident. <u>Measuring</u> • 64% knew their blood pressure readings. People of an Asian background, men and those on a lower income were less likely to know their blood pressure readings. • 38% knew their cholesterol levels. Again, those on a lower income people from an Asian or Black ethnic background and those under 65 were the least aware. Key themes for people **<u>without a diagnosis</u>** include: <u>Awareness</u> • Awareness of risk factors was generally good. Gender as a risk factor had the lowest awareness at 42% followed by ethnicity (54%) and age (69%). People of an Asian background had far higher awareness of all the risk factors listed. • Chest pain and breathlessness were most commonly identified as symptoms of heart disease. 11% did not know any symptoms. <u>Prevention</u> • 81% consider their heart health “a lot” or “a little” in their everyday choices. • Women, people from Black and Asian ethnic backgrounds, those aged 45-64 and those aged over 75 were far more likely to consider their heart health. • Men, those aged 18-44 and people on a lower income were far less likely to consider their heart health. <u>Interacting with clinicians</u> • Only 35% have interacted with a clinician about their heart health, however 91% would not have any concerns in doing so. Men and

<table>
<tr><td></td><td colspan="4">people from Black and Asian ethnic backgrounds were less likely to have spoken to a clinician.
• 69% would see their GP if they had concerns about their heart health, 13% would visit a pharmacy and 17% would use NHS 111 or NHS 111 Online.
• Although eligible for an NHS Health Check, only 41% of those aged over 45 have interacted with a clinician about their heart health.
<u>Measuring</u>
• 40% knew their blood pressure readings. people on lower incomes and those aged 18-44 were less likely to know their blood pressure.
• 19% knew their cholesterol levels. Men, people from Asian ethnic backgrounds, and those aged 64-75 were the least likely to know their cholesterol levels.
• If they wanted to check their blood pressure, 58% would check at home, 37% would visit their GP, 18% would visit a pharmacy and 14% would purchase a blood pressure monitor.
• If they wanted to check their cholesterol levels, 79% would visit their GP and 21% would visit a pharmacy. Some were not sure or not aware how to do this.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">To note the contents of the report.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">N/A</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">N/A</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="3">Impact Assessments:
(Completed and attached)</td><td colspan="2">Equality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Quality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Data Protection Impact Assessment:</td><td colspan="2">N/A</td></tr>
</table>

Engagement on Cardiovascular Disease: Healthwatch Hertfordshire

Key Findings:

Identification and Awareness

With a Diagnosis:

- 25% recognised their own symptoms and 72% said their symptoms were recognised by a clinician. Men and those under 65 were more likely to be diagnosed in hospital.
- Only 14% experienced barriers in having their condition diagnosed, these included waiting times for an appointment and/or delays in referral.

Without a Diagnosis:

- Awareness of risk factors was generally good, especially amongst Black and Asian respondents.
- 81% consider their heart health in their everyday activities. Men, those aged 18-34 and those on a lower income were less likely to consider their heart health.
- Women, Asian and Black respondents, those aged 45-64 and those aged over 75 were more likely to consider their heart health.

Support

With a Diagnosis:

- 74% felt that their condition was explained properly. Some, especially women, felt they could have been better supported and informed.
- Only 13% do not feel confident in managing their condition. Men, Asian respondents, those on a lower income and people aged over 65 were the least confident.

Without a Diagnosis:

- Only 35% have spoken to a clinician about their heart health, however 91% would not have any concerns in doing so.
- 69% would see their GP if they had concerns, 13% would visit a pharmacy and 17% would use NHS 111.

Measurements

With a Diagnosis:

- 64% knew their blood pressure reading. Asian respondents and people on lower incomes were the least likely to know.
- 38% knew their cholesterol level. Again, Asian respondents, people on a lower income and those aged under 65 were the least likely to know.

Without a Diagnosis:

- 40% knew their blood pressure reading. Asian respondents, people on lower incomes, and those aged 18-44 were the least likely to know.
- 19% knew their cholesterol level. Men, Asian respondents and those aged 64-75 were the least likely to know.
- 58% would check their blood pressure at home, 37% would visit their GP, 18% would visit a pharmacy and 14% would buy a blood pressure monitor.
- 79% would check their cholesterol level by visiting their GP and 21% would visit a pharmacy.

Engagement with Adults with Learning Disabilities: Healthwatch Hertfordshire & Essex

Key Findings:

Access

- Long delays when contacting by telephone and difficulties in getting an appointment. For some, this has made them reluctant to contact their GP practice unless their concern is urgent.
- Difficulty contacting their GP practice during opening hours as this is outside their support worker's working hours.
- Difficulty communicating with receptionists and treated poorly.
- Care Coordinators are GP practices provide invaluable support.

Choice

- Face-to-face is preferred, with many finding telephone and/or video appointments inaccessible.
- Seeing the same GP or nurse is very important. However, respondents have to wait several weeks to see the clinician of their choice.
- Lack of flexibility around appointment dates and times which respondents find difficult to work around their own schedule and their support worker's working hours.

Communication

- Clinicians and receptionists can speak too quickly and use complicated language.
- Information is often not provided in Easy Read.
- Some respondents had very positive experiences, emphasising that clinicians are kind, helpful and accommodating.
- Clinicians can speak to carers and support workers, rather than addressing respondents directly which respondents find upsetting and disrespectful.

Healthy lifestyle

- Clinicians have discussed healthy eating and exercise with respondents. However, they would like more regular conversations about this, as well as more practical support and information.
- Clinicians were less likely to have discussed mental health, social life, drugs and alcohol, smoking and sexual health. Although some of these issues were not important to most respondents.
- Cancer screenings need to be discussed more, with most respondents lacking awareness about what they are and why they are important.

Annual Health Checks

- Some had a very positive experience, receiving a thorough examination of their physical and mental health.
- Some had a more negative experience, only receiving a short appointment and a basic examination.
- A few respondents have never been offered an Annual Health Check or have not been contacted about their Annual Health Check for a couple of years.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*		☐		
	NHS HWE ICB Primary Care Board meeting held in Public			**Meeting Date:**	**25/05/2023**		
Report Title:	**Access to health and care, including self-care, for adults with a learning disability**			**Agenda Item:**	**9B**		
Report Author(s):	Sara Poole-Information and Guidance Officer-Healthwatch Essex						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	N/A						
Executive Summary:	Healthwatch Essex has been commissioned by the Hertfordshire and West Essex Integrated Care System (ICS) Primary Care Workstream to undertake a series of engagement projects. This report is focusing on-Access to health and care, including self-care, for adults with a learning disability-gathering feedback and lived experience. Key Findings: **Support** Adults with LD who still live with family can rely heavily on family members to manage their health appointments and medication. **Communication** Difficult to make a GP appointment via the phone. The 8am phoning process is not easy for many people with LD. This can increase feelings of anxiety. Medical professionals not talking directly to the patient with LD but to their carer or family member in face-to face appointments. Very disempowering. **Complex needs** Many adults with LD also have other health issues and numerous diagnoses. This can lead to families struggling to find the right services that meet the need of the person. **Consistency**							

	Having one point of contact for the adult and their support network can help to build relationships and confidence with a medical professional. This will also reduce the number of times that the persons situation/needs have be repeated.			
Recommendations:	To note the contents of the report			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	
	Quality Impact Assessment:	
	Data Protection Impact Assessment:	
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒

Healthwatch Hertfordshire and Essex: Access to Health and Care for Adults with a Learning Disability

Explored experiences of accessing primary healthcare for adults with LD:

- **Residents living in west Essex**

Key Findings:

Support

- Adults with LD who still live with family can rely heavily on family members to manage their health appointments and medication.
- Some adults are able and confident enough to manage their own medical appointments with little or no support from family/support workers.

Communication

- Difficult to make a GP appointment via the phone. The 8am phoning process is not easy for many people with LD. This can increase feelings of anxiety.
- Medical professionals not talking directly to the patient with LD but to their carer or family member in face-to-face appointments. Very disempowering.

Complex needs

- Many adults with LD also have other health issues and numerous diagnoses etc. This can lead to families struggling to find the right services that meet the need of the person.

Consistency

- Having one point of contact for the adult and their support network can help to build relationships and confidence with a medical professional. This will also reduce the number of times that the persons situation/needs have be repeated.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*		☐		
	NHS HWE ICB Primary Care Board Meeting held in Public			**Meeting Date:**	**25/05/2023**		
Report Title:	**COPD and other Respiratory Conditions in West Essex**			**Agenda Item:**	**11B**		
Report Author(s):	Fergus Bird-Information and Guidance Officer-Healthwatch Essex						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☐
Report History:	N/A						

Executive Summary:

Healthwatch Essex has been commissioned by the Hertfordshire and West Essex Integrated Care System (ICS) Primary Care Workstream to undertake a series of engagement projects.

This report is focusing on-lived experiences of COPD and other respiratory condition in west Essex.

Key Findings:

Support

- Adults with LD who still live with family can rely heavily on family members to manage their health appointments and medication.
- Some adults are able and confident enough to manage their own medical appointments with little or no support from family/support workers.

Communication

- Difficult to make a GP appointment via the phone. The 8am phoning process is not easy for many people with LD. This can increase feelings of anxiety.
- Medical professionals not talking directly to the patient with LD but to their carer or family member in face-to-face appointments. Very disempowering.

Complex needs

- Many adults with LD also have other health issues and numerous diagnoses etc. This can lead to families struggling to find the right services that meet the need of the person

Consistency

	• Having one point of contact for the adult and their support network can help to build relationships and confidence with a medical professional. This will also reduce the number of times that the persons situation/needs have be repeated.			
Recommendations:	To note the contents of the report			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☐

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	
	Quality Impact Assessment:	
	Data Protection Impact Assessment:	
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒

Healthwatch Essex: COPD and Respiratory Conditions Report

Explored experiences of accessing treatment and support for COPD and other respiratory & lung conditions amongst:

- **People in West Essex**

Key Findings:

Diagnosis

- Respondents often had to make multiple presentations to their GP surgery before getting a referral and subsequent diagnosis.
- Many people were diagnosed by chance when being assessed for separate ailments by medical staff.
- 30% are diagnosed within 6 months of visiting their GP

Management

- Written self-management plans are not being offered to the vast majority
- Many respondents have not had an annual review since covid.
- A large proportion of respondents have not been offered Pulmonary Rehabilitation treatment

Technology

- Patients are very open to having technology help them self-manage their condition.
- Activity trackers and apps popular
- Opportunity to roll out an online Pulmonary Rehabilitation tutorial

Mental Health

- Long term nature of the condition and the slow ‘inevitable’ decline in health is leaving respondents anxious and depressed
- Many respondents feel worried about the future

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	NHS HWE ICB Primary Care Board meeting held in Public				**Meeting Date:**	**25/05/2023**	
Report Title:	**Primary Care Access Recovery Plan**				**Agenda Item:**	**10**	
Report Author(s):	Michelle Campbell, Head of Primary Care Contracting						
Report Signed off by:	Avni Shah, Director of Primary Care						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☐
Report History:	N/A						
Executive Summary:	0n 9th May, the National Delivery Plan for Recovering Access to Primary Care was published (**Appendix 1).** This is the first step in delivering the vision set out in Fuller Stocktake and more importantly our local ICB wide plan for Primary Care integrating into our system with alignment of the priorities as a system and through each place. The need for a plan to recover access to Primary Care is to address the following problems: • Increase in contacts – 20-40% increase since pre-pandemic • Increase in older patients (70+) with multiple long-term conditions • Increase of 12% more appointments being delivered since pre-pandemic • Increase in workforce does not match demand (only circa 7% increase in GPs since pre-pandemic) • Reduction inpatient satisfaction – Over 85% of practices nationally saw a fall in patient satisfaction (average fell from 83% to 72% in 22-23) • Patients not getting through to the practice Under this plan, Primary Care Networks (PCNs) are asked to develop an "Access Improvement Plan" by 30th of June 2023. Primary Care place teams are having a facilitated and supportive discussion with the PCNs to develop this plan to ensure there is some consistency across our ICB						

	but also identify gaps which will be incorporated development of the Primary Care Strategic Delivery Plan due to be presented in July to the Board. It is expected that there will also be a Dental Access Recovery Plan however this has not been yet been published. As outlined in recently published access recovery plan. At a high level the plan seeks to support recovery by focusing this year on four areas: • **Empower patients** to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice. Whilst a range of services are available such as self-referrals to IAPT/counselling, antenatal, Herts Help; sexual health, oral contraception etc there is opportunity to enhance this as outlined in the operating plan for 2023/24 and access recovery plan to services such as physiotherapy, range of services delivered via community pharmacy. Some of these services through community pharmacy are awaiting negotiation of their national contract. • **Implement Modern General Practice Access** to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment. 70 of out of 131 practices have cloud based telephony and the aim is to implement the remaining practices utilising the national funding that is on offer. There is a pilot of a new GP practice website with five practices in North Hertfordshire. These sites will be launched by the end of May and will have a major focus on promoting online access to services as well as helping patients to understand the wider variety of appointments in general practice. • **Build capacity** to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed. Continued progress on recruitment of ARRS roles across PCN with written confirmation from national team that ARRS funding will continue beyond 2024. In addition, good progress has been made on the Community Pharmacy PCN Clinical lead role. By end of May

<table>
<tr><td></td><td colspan="4">these community pharmacists will be appointed to take on the role of PCN lead for 2 days a month. This will support how we integrate community pharmacy further in the network not just with general practice in the PCN but also with wider partners which will support role of community play with vulnerable groups such as end of life care, care homes etc.

• Cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.
Ongoing work via the interface groups with HPFT, WHTH, PAH and ENHT to work collaborative and ensure no unintended consequence of workload shift through pathway/transformation work.

The Delivery Plan is also supported by a programme of support such as:
• funding release through the repurposing funding from the reduction of indicators in the Investment and Impact Fund (IIF) and the protection of Quality Outcomes Framework clinical indicators; National funding available to support implementing cloud-based telephony
• Support for training in care navigation or participating in the national Access Improvement Programme

A schedule of webinars throughout May are planned to support general practice, PCNs and Commissioners on how the plan can be implemented.

The Board will receive a presentation as an update on the ICB work to date to support recover and the delivery of the access improvement plan.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">▪ The Board is asked to note the content of the paper</td></tr>
<tr><td rowspan="3">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☒</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☐</td></tr>
</table>

	GP members on the Board are conflicted; however as the paper is not seeking a decision, input into the discussion on the plan will be managed appropriately within the meeting.

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☒
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☒

Department of Health & Social Care

NHS England

Delivery plan for recovering access to primary care

May 2023

Contents

Our commitment is to tackle the 8am rush and make it easier and quicker for patients to get the help they need from primary care. We will:

Empower patients by rolling out tools they can use to manage their own health, and invest up to £645 million over two years to expand services offered by community pharmacy.

1. Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024.
2. Ensure integrated care boards (ICBs) expand self-referral pathways by September 2023, as set out in the 2023/24 Operational Planning Guidance.
3. Expand pharmacy oral contraception (OC) and blood pressure (BP) services this year, to increase access and convenience for millions of patients, subject to consultation.
4. Launch Pharmacy First so that by end of 2023 community pharmacies can supply prescription-only medicines for seven common conditions. This, together with OC and BP expansion, could save 10 million appointments in general practice a year once scaled, subject to consultation.

Implement 'Modern General Practice Access' so patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message. We are re-targeting £240 million – for a practice still on analogue phones this could mean ~£60,000 of support over 2 years.

5. Support all practices on analogue lines to move to digital telephony, including call back functionality, if they sign up by July 2023.
6. Provide all practices with the digital tools and care navigation training for Modern General Practice Access and fund transition cover for those that commit to adopt this approach before March 2025.
7. Deliver training and transformation support to all practices from May 2023 through a new National General Practice Improvement Programme.

Build capacity so practices can offer more appointments from more staff than ever before.

8. Make available an extra £385 million in 2023/24 to employ 26,000 more direct patient care staff and deliver 50 million more appointments by March 2024 (compared to 2019).
9. Further expand GP specialty training – and make it easier for newly trained GPs who require a visa to remain in England.
10. Encourage experienced GPs to stay in practice through the pension reforms announced in the Budget and create simpler routes back to practice for the recently retired.
11. Change local authority planning guidance this year to raise the priority of primary care facilities when considering how funds from new housing developments are allocated.

Cut bureaucracy to give practice teams more time to focus on their patients' clinical needs.

12. Reduce time spent liaising with hospitals – by requiring ICBs to report progress on improving the interface with primary care, especially the four areas we highlight from the Academy of Medical Royal Colleges report, in a public board update this autumn.
13. Reduce requests to GPs to verify medical evidence, including by increasing self-certification, by continuing to advance the Bureaucracy Busting Concordat.
14. Streamline the Investment and Impact Fund (IIF) from 36 to five indicators – retarget £246 million – and protect 25% of Quality and Outcomes Framework (QOF) clinical indicators.

Summary

Primary care is one of the most dynamic and innovative parts of the health service. We saw this in the rapid and comprehensive rollout of the NHS COVID-19 vaccination programme.

General practice is delivering more than a million appointments every day and half a million more every week than pre-pandemic.[1] This has been possible because of the hard work of staff and through significant investment since 2019, which has grown the general practice workforce by 27% to meet rising demand and the needs of an ageing population. The number of people in England aged 70 or over is up around a third on 2010, from 6.1 million to 8.1 million, and this group has on average five times more GP appointments than young people.[2]

However, the pandemic has changed the landscape, and the increase in practice capacity needs to keep pace with growing demand. Primary care, like many parts of the NHS and health systems globally,[3] is under tremendous pressure – one in five people report they did not get through or get a reply when they last attempted to contact their practice.[4] The Fuller Stocktake stated, "there are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it".

The Fuller Stocktake built a broad consensus on the vision for integrating primary care with three essential elements: streamlining access to care and advice; providing more proactive, personalised care from a multidisciplinary team of professionals; and helping people stay well for longer. This remains our intent.

But before we can fully implement the wider reforms necessary to achieve this vision, we need to take the pressure off general practice and tackle the 8am rush. Although this plan supports all three elements of the Fuller Stocktake vision, it makes no excuses for focusing on the first.

This plan has two central ambitions:

[1] Appointments in general practice, January 2023 (excludes COVID-19 vaccinations).
[2] NHS Digital Clinical Practice Research Datalink (~10 per year for 70+ and 2 per year for 11–19).
[3] Burnout and commitment after 18 months of the C-19 pandemic: A follow-up qualitative study with primary care teams (in the US); Why health-care services are in chaos everywhere. Economist, 15 January 2023.
[4] DHSC pulse-check survey, December 2022.

1. **To tackle the 8am rush and reduce the number of people struggling to contact their practice.** Patients should no longer be asked to call back another day to book an appointment, and we will invest in general practice to enable this.
2. **For patients to know on the day they contact their practice how their request will be managed.**
    a. If their need is clinically urgent it should be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.
    b. If their need is not urgent, but it requires a telephone or face-to-face appointment, this should be scheduled within two weeks.
    c. Where appropriate, patients will be signposted to self-care or other local services (eg community pharmacy or self-referral services).

The first part of this plan describes how we will empower people by investing in tools they can use to stay healthy and manage their care without needing to see their GP. This includes funding technology so practices can monitor long-term conditions from readings patients take in their own homes; enabling patients to self-refer to specialists for certain conditions; and rolling out existing NHS App functionality to 90% of practices by March 2024.

NHS England and the Department of Health and Social Care (DHSC) will expand the role of community pharmacy by supporting seven further common conditions through delivering Pharmacy First and expanding pharmacy oral contraception and blood pressure services. DHSC will consult the sector on this proposed expanded role, which we estimate could alleviate pressure by saving up to 10 million appointments a year, once scaled up, equivalent to around 3% of all appointments, and give the public more choice in where and how they access care.

NHS England will lead the implementation of a modern approach to general practice that makes it easier for patients to contact their practices by phone or online and supports practices to rapidly assess the nature and urgency of requests by involving the whole practice team. This dynamic approach builds on what hundreds of innovative practices are already doing to improve access and patient experience. We have spoken to and received feedback from these practices, and they say such changes have been a ‘game-changer.’ We call it ‘Modern General Practice Access’.

This approach is a major change to how many practices have traditionally worked. Patients may be asked to provide more information about their issue when they make a request, but in return the practice team can better assess their need and tell them on the day how their request will be handled, based on clinical need and respecting their preference for a call, face-to-face appointment or online message.

Patients will always be able to choose to contact their practice by telephone, in person, or online, and should be asked how they prefer to get a response.[5] But practices that have implemented this new approach say most patients find it more convenient to go online to make a request and are often happy to get a response the same way. These practices find that far fewer patients request face-to-face appointments, and even though for clinical reasons more face-to-face appointments are delivered than requested, the number is well below the national average for all appointment types.[6] It also means many requests can be dealt with without an appointment, which can be quicker for patients and practices, and means those patients who need an appointment get one sooner.

When more people go online, this frees up the phones for those who prefer to call and spreads work across the day. To further improve the experience for those who do prefer to call we will invest in high-quality digital phone systems so calls are not met by an engaged tone. Implementing this approach takes planning, resources, training and leadership, and this plan addresses each of these. We will invest in care navigation training to help teams direct patients to the right person. Effective care navigation could direct over 15% of patients to teams that could better help them: administrative teams, self-care, community pharmacy or another local service.[7] Other patients can be directed to the most appropriate practice staff member for assessment and response, without first being seen by a GP. We will also fund the digital tools that make it easier for practices to receive, navigate, assess and respond to requests in this way.

We can also do more to build capacity, reduce workload and cut bureaucracy. We will deliver on the commitment of 26,000 more direct patient care staff and 50 million more appointments in general practice by March 2024. The NHS Long Term Workforce Plan, which will be published shortly, will set out our plans to expand GP training and ensure the NHS can recruit and retain the GP workforce it needs in the future, alongside an

[5] The NHS Choice Framework: what choices are available to me in the NHS?
[6] Around 10% of patients request, and around 20% need, a face-to-face appointment.
[7] Malby B, Downham N, Hufflett T (2018) Organisational development is essential to support systems change in primary care. Lessons from London's primary care quality academies. London Southbank University.

expanded and empowered wider primary care team. The Chancellor has also announced significant pension changes to encourage experienced GPs to remain in practice.[8]

Published alongside this plan is a report from the Academy of Medical Royal Colleges (AoMRC) on how bureaucracy and workload can be cut by improving the interface between primary and secondary care. NHS England will ask integrated care boards (ICBs) to report on their progress at their public boards in October or November 2023.

DHSC will also cut unnecessary burdens on GPs through the Bureaucracy Busting Concordat, which is increasing self-certification to cut requests to GPs to provide medical evidence. For 2023/24 we are streamlining the Investment and Impact Fund (IIF) from 36 to five indicators. We will also consult on the future of QOF this summer.

This plan seeks to support recovery by focusing this year on four areas:

1. **Empower patients** to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice.
2. **Implement Modern General Practice Access** to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment.
3. **Build capacity** to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.
4. **Cut bureaucracy** and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

To support this plan, NHS England and DHSC have retargeted over £1 billion and committed to:

1. Retarget over £240 million of funding in 2023/24 for new technologies and support offers for primary care networks (PCNs) and practices that help them plan and implement Modern General Practice Access, including online tools, digital telephony, care navigation training and transformation support.
2. Invest up to £645 million over the next two years to expand community pharmacy services, subject to consultation.

[8] Spring Budget 2023

3. Redirect £246 million of the streamlined IIF towards improving access; 70% will be given to PCNs unconditionally to support driving change (~£11,500 per month for the average PCN), with the remaining 30% awarded by ICBs conditional on PCNs achieving agreed improvement in access and patient experience.
4. Delivering on our commitment to make a further £385 million available in 2023/24 to reach the existing target of 26,000 more direct patient care staff and 50 million more appointments in general practice by March 2024.[9]
5. Continue to allocate System Development Funding (SDF) to ICBs, which for 2023/24 totals ~£170 million. NHS England expects systems to use a large part of this to support primary care transformation.
6. Given the scale of proposed change, NHS England will launch a major communications campaign to explain the evolving nature of primary care to the public and how they can best use the NHS.

For a practice on analogue telephony that implements Modern General Practice Access, this plan provides an average of ~£60,000 to support the move to digital telephony, digital tools, and transition support over the next two years. This is in addition to training and transformation offers from NHS England, and the IIF and ARRS funding outlined above.

Delivery will require national and regional teams to work flexibly with ICBs, while reinforcing their accountability as commissioners of primary care. NHS England wants ICBs to lead the change that is right for their system. We will measure progress from ICB public board reporting and offer support to any ICBs that are falling behind.

This plan represents the first steps towards the vision described in the Fuller Stocktake; it is not the whole implementation path. So, we will also engage widely in 2023/24 on the contract and programme changes needed to deliver the longer-term vision of more streamlined access, more proactive and personalised care, a more joined-up approach to prevention, and again making primary care an attractive place to work for all staff.

NHS England has engaged with a wide range of stakeholders to develop this plan – thank you to everyone who has contributed.

[9] Commitment to grow from March 2019 baseline.

Why we need a plan to recover access to primary care

Pressures in primary care

The NHS is focused on recovering core services from the significant and ongoing impact of the pandemic, and this plan sits alongside our delivery plans for recovery of elective[10] and urgent and emergency care services.[11]

General practice is one part of primary care, the others being community pharmacy, optometry and dentistry,[12] which together support more patients every working day than any other single part of the health system. General practice, comprised of 6,500 individual practices, delivers over 330 million appointments a year (excluding those for Covid vaccinations). It delivers, from cradle to grave, across the spectrum of prevention, urgent, and long-term condition care for millions of people. Our last annual survey showed the public's satisfaction with the care provided remains extremely high; for example, scores for 'were your needs met in your last appointment?' were over 90% nationally.

Like many parts of the NHS, general practice is under intense pressure. Where demand is greater than capacity it means general practice cannot always be effective, and patient experience and access are negatively impacted. It also means that stresses appear in other parts of the health system as patients seek alternative routes to get NHS care.

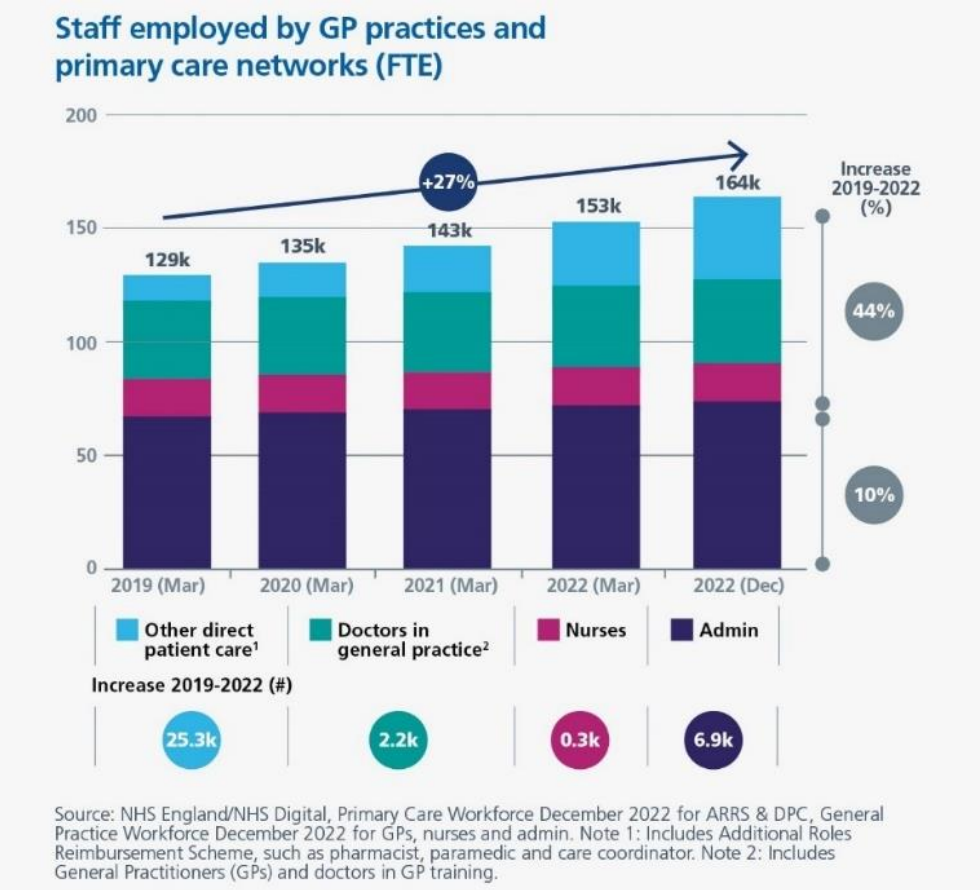
One key driver of growth in demand is the ageing population. Most of those over 70 live with one or more long-term condition and have five times more GP appointments on average than teenagers.[13]

In 2019 the NHS Long Term Plan[14] recognised this growing pressure, the benefits of moving more care closer to home and the value of more preventative and proactive care. It outlined three changes for general practice: increased funding; a major expansion of

[10] Delivery plan for tackling the COVID-19 backlog of elective care
[11] Delivery plan for recovering urgent and emergency care services
[12] DHSC and NHS England will publish actions to support the recovery of dentistry access later this year
[13] NHS Digital Clinical Practice Research Datalink (~10 per year for 70+, and 2 per year for 11–19); General Practice Patient Survey 2022.
[14] NHS Long Term Plan

staff roles; and the development of primary care networks (PCNs) as a way practices can work together for their communities.

Government prioritised health and social care in the Autumn Statement by announcing a funding increase of £14.1 billion over two years. Core entitlements for general practices and PCNs will be a record £11.5 billion in 2023/24, an increase of ~£700 million over 2022/23 and 38% (£3.2 billion) higher than in 2018/19.[15] Additional funding in previous years amounted to more than £3 billion.[16] Practice funding continues to be allocated according to need, with consideration of patient demographics, deprivation and rurality.



Overall general practice staffing is 27% higher and the number of staff delivering direct patient care is 44% higher than March 2019.

[15] Contractual, PCN and improving access funding.
[16] Finalised in-year for supporting training, indemnity costs, employer pension contributions, IT and wider transformation, as well as ICB SDF and ICB locally commissioned services.

Separately, community pharmacies receive ~£2.6 billion per year[17] through the Community Pharmacy Contractual Framework: 2019 to 2024, and we have expanded the services they offer as another step to strengthen the overall primary care offer.

The pandemic has changed the nature of demand. Patient contacts with general practices are estimated to have grown faster than demographic pressures, at between 20% and 40% since pre-pandemic,[18] in part as COVID-19 backlogs have increased workload. Local practice surveys tell us administrative tasks outside a consultation, measured by entries to medical records, are up 50% since 2019.[19] Practices tell us they have never been as busy.

Over the same period, growth in the number of GPs has lagged behind that of total practice staff employed. Although government has increased GP specialty training numbers from 2,671 in 2014 to over 4,000 today, and increased medical school places by 25% (from 2018), training fully qualified GPs takes time. Importantly, the pressure in general practice is felt strongly by these experienced GPs, who today are managing larger practices, with more patients, and supervising more doctors in GP training, more practice staff, and more clinical roles, yet remain critical to assessing the on-the-day urgent clinical need. While there is significant variation, we estimate induction, training and clinical supervision of the expanding practice team can take 10% to 20% of GP time.[20] In May 2023, NHS England will publish guidance for PCNs and practices on different models of supervision for roles new to general practice.

The problem for patients and practices

As demand rises, many practices are struggling to meet all the needs of their patients. Overall patient satisfaction with practices fell 10% in 2022, with falls in 99% of PCNs and over 85% of practices.[21]

This appears to be related to a drop in scores for ‘experience of making an appointment’, which strongly correlates with the ‘ease of getting through’. Variation between practices is a large part of the problem: only 1% of those who said it is ‘very easy to get through to their practice’ rate their practice overall as poor, whereas 43% give a poor rating when

[17] Does not include local services, Covid vaccines and flu vaccines.
[18] Based on NHS England survey via Institute of General Practice Management (February 2023) (n=68).
[19] Berkshire, Buckinghamshire and Oxfordshire LMC Secretariat (unpublished). Situation report for general practice in BBO, 2020–2022.
[20] NHS England clinician experience and clinician roundtables.
[21] GP Patient Survey 2022.

they say it is ‘not at all easy to get through’. Difficulties with access were also highlighted in a recent survey where one in five of the public said they either did not get through or get a reply when they last tried to contact their practice.[22] Good access is central to general practice being effective at meeting the reasonable needs of patients.

As demand rises, the number of calls is challenging for reception staff. For those practices still on analogue lines, patients find repeated engaged tones frustrating. Retaining staff in this environment can be difficult.

In the model described in this plan, the receptionist role expands. Receptionists become more skilled and empowered as care navigators who gather patient information to match patients to the right member of an increasingly multidisciplinary practice team.

While many practices have implemented this new model, others feel it is out of reach because they lack the time and bandwidth to change practice workflows. We recognise this and the need for PCNs and practices to carefully plan change and we are offering them a broad range of support.

What we will deliver for patients, the public and staff

We need a sustained focus on the four areas described in this plan to deliver our central ambitions:

- empowering patients
- implementing Modern General Practice Access
- building capacity
- cutting bureaucracy.

This plan also describes accountability for delivery, transformation support, and how we will ensure choice and equity of access. It outlines the actions for ICBs, PCNs and practices, and how to make the most of the funding and support offers to reduce unwarranted variation in patient experience.

This plan focuses on access to make it easier for the public to contact practices when they are open and get a timely response. The 2023/24 contract requires practices to assess patient requests on the day – they should not normally be asking patients to call NHS 111

[22] DHSC pulse-check survey, December 2022.

when the practice is open.[23] As this plan delivers, we expect it to relieve pressures on 111 during the day.

We have also invested in enhanced access through PCNs. Since 1 October 2022, a PCN must provide network appointments between the hours of 6.30pm and 8pm Mondays to Fridays, and between 9am and 5pm on Saturdays. In 2023/24, ~£470 million is available for PCNs to deliver this.

NHS England will continue to explore how to better integrate out-of-hours and urgent care services and, as set out in the delivery plan for recovering urgent and emergency care services, is undertaking an extensive review of 111 services. This will consider the impact of delivering this plan, as well as the actions needed to create the single integrated urgent care system described in the Fuller Stocktake. In the meantime, when practices are closed, the public should call 111.

Empowering patients

Increasingly sophisticated technology continues to change many aspects of our daily lives. Technology can empower us with information to make decisions, make processes more efficient, give staff more flexibility and reduce costs.

To help the public do more for themselves, we want to make information and easy-to-use tools available by:

A. improving information and NHS App functionality
B. increasing self-directed care where clinically appropriate
C. expanding community pharmacy services.

A. Improving information and NHS App functionality

Ambition

We want the public to have access to health information they can trust, find local services, and use the NHS App where this is their preference to see their medical

[23] Practices should inform their local commissioner (ICB primary care team) when they need to divert patients to 111, which should only be in exceptional circumstances.

records, order repeat prescriptions, manage routine appointments with their practice or local hospital and see messages from their practice.

The NHS App ambitions are already a reality for people registered with around 20% of practices, so this plan focuses on how to increase that to over 90% by March 2024.

How we will deliver

Information

The NHS.uk website receives around 75 million visits a month,[24] the highest for any UK health website. It is continually updated and refreshed: in 2023/24 NHS England will expand information on local services and women's health and refresh content to support new parents. It will also improve the heart age and blood pressure monitoring tools.

NHS App

The NHS App has over 15 million log-ins a month, and over 31 million people have signed up. NHS England is working to give more of the public access to four existing functions: (i) to view their prospective clinical records (including test results); (ii) order repeat prescriptions; (iii) see messages from their practices as an alternative to text messaging; and (iv) manage routine appointments.

Over 20%[25] of practices offer patients the ability to see their prospective clinical records online and over 99% of practices offer patients the ability to order repeat prescriptions online, with 22 million prescriptions ordered through the NHS App in 2022 (see Solihull case study).[26] Over 3,800 (58%) practices have enabled secure messaging through the NHS App and nearly 2 million messages have now been sent. Over 90% of practices have enabled patients to book and manage appointments, such as vaccination clinics, online, with over 250,000 managed in the NHS App each month.[27]

The 2023/24 contract asks all practices to enable prospective record access for patients by November 2023. This will allow patients to see prospective entries in their medical records such as immunisations, test results and consultations in their NHS App. NHS England published directly bookable appointments guidance and practices should make

[24] Internal management information (November 2022).
[25] Programme dashboard (GPIT supplier data, not publicly available) – automatic prospective record access to patients.
[26] Patient Online Management Information (at December 2022).
[27] December 2022 National Digital Channels Report.

online booking of routine appointments available, such as for smear tests, B12 injections or vaccination clinics.

Case study – promoting NHS App functionality

Solihull Healthcare Partnership PCN has promoted the use of the NHS App's repeat prescription functionality. Previously it regularly received phone calls from patients wanting to order their repeat medications, ask to change pharmacy nominations and/or check if the GP had signed their prescriptions and sent them to the pharmacy.

The app is helping to ease the pressure on primary care services in the area. Over 31,000 of 56,000 patients are registered to use it and 650 to 700 repeat prescriptions a week are made through the app.

Patients appreciate they can also change their nominated pharmacy using the app, ensuring they can pick up their prescription from a pharmacy of their choice.

B. Increasing self-directed care

Ambition

For some conditions general practice involvement is not necessary if it is clear to patients where to get care and it is clinically safe to do so directly. This is more convenient for patients and frees up valuable practice time. This is already a reality for some conditions, but we will increase the number of self-refer options, guided by clinical advice.

We also want to help patients care for themselves. We want to make it easier for them to monitor certain long-term conditions at home, such as high blood pressure, where it is clinically safe, and make it easier for practices to review their patients' self-monitoring. 20% of patients consult their GPs for problems that are non-clinical or social in nature,[28, 29] and NHS England will continue to support social prescribing link workers who improve patient outcomes and reduce pressure on primary care.

How we will deliver

Already more than 30,000 people self-refer each month, and in the 2023/24 operational planning guidance NHS England asks systems to expand this for certain carefully

[28] Torjesen I (2016) Social prescribing could help alleviate pressure on GPs. BMJ 352: 1436.
[29] National Academy for Social Prescribing (2022) The economic impact of social prescribing

considered community-based services from September 2023.[30] These include selected community musculoskeletal services,[31] audiology for older people including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services. We estimate up to 50% more patients could be self-referring by March 2024. NHS England will monitor this to ensure opening these self-referral pathways does not lead to inappropriate demand.

Home monitoring can substantially improve health outcomes and reduce the need for regular and urgent appointments. A good example is blood pressure control through home monitoring, reducing heart attacks and strokes. To make home monitoring easier for patients and practices, we are funding the digital tools for patients to send their readings to their practice, where staff can review and add them to their clinical record with 'one click'.

As of December 2022, there were over 3,000 full-time equivalent (FTE) link workers in general practice managing over 1.6 million referrals.[32] ICBs will support them as they continue to develop in their role connecting people to activities, groups and community-based services that can help meet practical, social and emotional needs and improve health outcomes and wellbeing. For example, around one in six practices have a link to their local Parkrun, which helps people to improve their own health.[33]

C. Expanding community pharmacy services

Ambition

Community pharmacy is an essential part of primary care and offers people easy access to health services in the heart of their communities. 80% of people in England live within a 20-minute walk of a pharmacy and there are twice as many pharmacies in areas of deprivation. They give expert clinical advice and 90% of people feel comfortable consulting a community pharmacist for a minor illness. Over 90% who have done so say they received good advice.[34]

Pharmacy's role has been increasing in recent years. In 2019 we set out how we would work to embed and integrate community pharmacy into the NHS, delivering more clinical

[30] 2023/24 priorities and operational planning guidance
[31] Note: These services must include an assessment to exclude aggressive pathology as a rare cause of musculoskeletal pain.
[32] Network Contract DES (MI) – 2021/22 (GPES 2022/23).
[33] The parkrun practice initiative
[34] Public perceptions of community pharmacy (Ipsos Mori, December 2022).

services and making them the first port of call for many minor illnesses. We have made good progress:

- General practice and NHS 111 can refer patients to community pharmacies for advice and treatment,[35] and 111 can also refer for urgent medicines supply. Over 2 million referrals have been made through these routes.[36]
- Community pharmacies support over 200,000 people a month when they start new medicines and 8,000 patients a month who have had their medicines changed following a visit to hospital, which reduces readmissions.
- ~6,000 pharmacies have delivered over 930,000 blood pressure checks in just over a year, allowing those with high blood pressure to be identified and referred for onward management.
- Pharmacy is increasing its contribution to our vaccine programmes, including delivering almost 5 million flu vaccinations in 2021/22, and a third of the COVID-19 vaccines in the Omicron surge.[37,38]

We want to build on this success and expand the services offered, increasing convenience for the public by introducing a Pharmacy First service for patients and expanding two existing services if agreed through consultation. We recognise this requires new funding, which would mark the next step in the journey we started in 2019 to make better use of the clinical skills in community pharmacy teams and better integrate community pharmacies into the NHS by making them the first port of call for minor common conditions.

How we will deliver

Pharmacy First

Pharmacy First will launch before the end of 2023, learning from areas that have implemented similar models, subject to a DHSC-led consultation with the Pharmaceutical Services Negotiating Committee.[39] This service will enable pharmacists to supply

[35] Through the Community Pharmacy Consultation Service: includes helping patients with common conditions such as coughs, aches and pains and red eyes.
[36] NHS Business Services Authority (Dispensing contractors' data).
[37] NHS England statistics October 21 to January 22 (Covid vaccines).
[38] NHS Business Services Authority (flu vaccines).
[39] Soon to be called Community Pharmacy England.

prescription-only medicines,[40] including antibiotics and antivirals where clinically appropriate, to treat seven common health conditions (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women) without the need to visit a GP. NHS England will also support research to ensure a consistent approach to antibiotic and antiviral use between general practice and community pharmacy.[41]

Blood pressure check service and oral contraceptives

NHS England introduced a blood pressure check advanced service in October 2021, and over 6,000 community pharmacies are supporting the identification and prevention of cardiovascular disease. This service currently delivers up to 120,000 checks per month, which we will expand with new funding to a further 2.5 million blood pressure checks in community pharmacy to support ongoing monitoring in partnership with GP practices (subject to consultation). Good blood pressure control helps to reduce heart attacks and strokes. We estimate that the increase in capacity in community pharmacy in year 1 could prevent over 1,350 cardiovascular events such as heart attacks and strokes. Savings of around £13 million would be seen from the reductions in these events across primary, secondary and social care.

From April 2023, community pharmacy started to manage ongoing oral contraception for women. We will expand this service from late 2023, dependent on findings from initial pilots currently underway and consultation. We estimate a quarter of women taking oral contraceptives could be using this service by 2024.

The new funding will allow for the expansion of these services, so more patients can be supported outside a general practice setting, subject to consultation.

IT system connectivity

As part of the new funding and to ensure the highest standard of care for patients, we will invest to significantly improve the digital infrastructure between general practice and community pharmacy. NHS England will work with community pharmacy suppliers and general practice IT suppliers to develop and deliver interoperable digital solutions. These will streamline referrals, provide additional access to relevant clinical information from the

[40] Pharmacists would supply these prescription-only medicines under Patient Group Directions (PGDs), which allow medicines to be supplied to patients who meet certain criteria after having a consultation with their pharmacist.
[41] National Institute for Health and Care Research funding confirmed – to be commissioned after consultation.

GP record, and share structured updates quickly and efficiently following a pharmacy consultation back into the GP patient record.

These IT improvements will improve existing and future services; for example, by allowing GP patient records to be updated following supply of oral contraception or a blood pressure consultation in community pharmacy.

Greater flexibility

We also want to give community pharmacy contractors more choice about how they deploy staff and release pharmacists' time for more patient-facing services. Pharmacists and pharmacy technicians are experts in medicines, and from 2026 updated training standards will ensure all newly qualified pharmacists are independent prescribers.[42] We want to better use these clinical skills to benefit patients. To support this:

- The Government is introducing VAT (value added tax) reliefs to support pharmacists and pharmacies in two ways. Medical services provided by pharmacists are already exempt from VAT. The Government has changed the law to extend this exemption to medical services carried out by staff supervised by registered pharmacists from 1 May 2023. Prescription medicines currently have a zero rate of VAT. This zero-rating will be extended to medicines supplied through PGDs by pharmacists, from autumn 2023.
- DHSC will clarify the roles of pharmacy professionals and enable a better use of skill mix, after consulting on the law on pharmacist supervision in the summer alongside the work the General Pharmaceutical Council is doing to revise the standards on responsible and superintendent pharmacists.
- DHSC will also enable pharmacy technicians to administer and supply medicines under PGDs subject to consultation.
- Government will give pharmacists the flexibility to dispense medicines in their original packs and to widen pharmacy hub-and-spoke arrangements, both of which aim to facilitate greater use of automation to increase efficiency, by progressing legislation following the consultations.
- The Medicines and Healthcare products Regulatory Agency, DHSC and NHS England will work together with suppliers to identify medicines which could be reclassified from 'available only on prescription (POM)' to 'available in a pharmacy (P)', based on international practice and real-world evidence of safety.[43] This might

[42] Initial education and training of pharmacists - reform programme (HEE)
[43] Medicines: reclassify your product

include different strength medicines to those available today, combination formulations, or medicines manufacturers already offer without prescriptions in other countries.

Implementing Modern General Practice Access

Our central ambitions are to tackle the 8am rush by making it easier for the public to contact their practice by phone and online, and to know the same day how their request will be handled. It is time to consign to history patients being asked to call back on another day for an appointment. While this is the right thing to do for patients, we recognise it will be a major change for some practices.

Hundreds of innovative practices have shown the way forward.[44] They use better digital online contact tools and telephony and have changed their workflow to assess requests better and navigate them to the right local service or member of the practice team. The approach, which we are calling Modern General Practice Access, has three components:

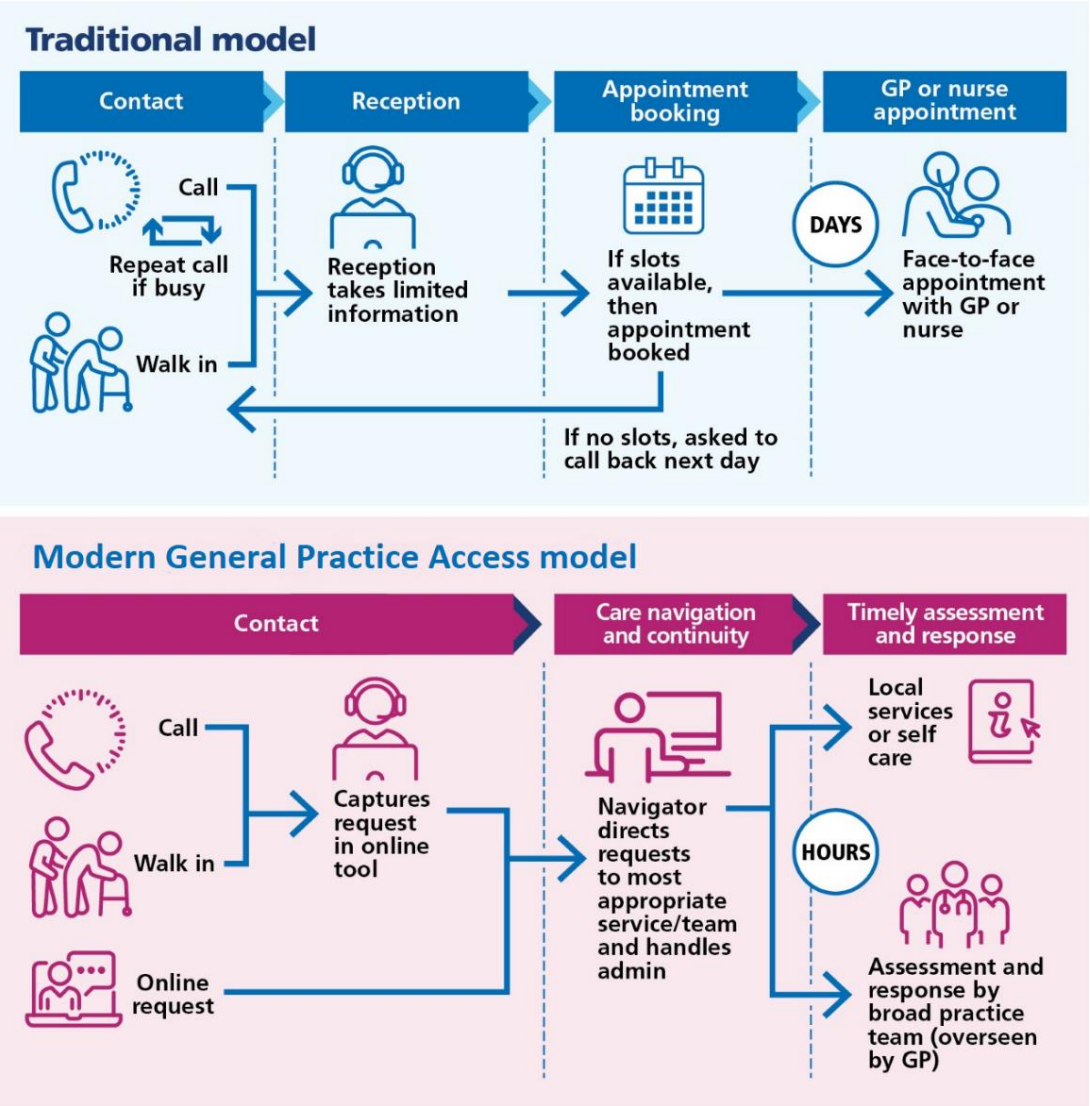
A. better digital telephony
B. simpler online requests
C. faster navigation, assessment and response.

Practices that have fully implemented this approach have overall patient experience scores on average 6 percentage points higher than the national average.[45] As the Priory case study shows, in some cases these gains can be much larger (>50 percentage points). These practices also find most patients choose to contact them online, and those who phone find it much easier due to shorter queues and better digital telephony.

We estimate around 40% of practices use clinicians to triage requests and 10% receive most requests online. But while many practices have adopted all or parts of this approach, for practices still largely working in a traditional model, this is a major change and to many may not feel achievable. However, practices that have implemented it

[44] Estimates: ~10% of practices have >65% of contacts coming in online, ~40% use clinicians to sort/triage at least some patients, and ~20% use software which can enable Modern General Practice Access. Sources: NHS England survey via Institute of General Practice Management (February 2023) and management information.
[45] Practices using high-quality online contact and workflow tool to deliver Modern General Practice Access had better patient experience. Forthcoming IAU report – Use of an OC system and patient experience of primary care.

provide evidence that demand is predictable and finite:[46] many older people prefer online; modern digital tools make it easier to manage patient requests and involve the wider practice team; and patient satisfaction rates are higher than with the traditional model.



[46] Practice interviews and public data on patient contacts.

Case study – Assessment and same-day response for all requests: StowHealth (rural Suffolk)

StowHealth was a rural practice struggling with high demand, stressed staff, three-week waits for routine appointments, challenges with patient continuity, and rising levels of complaints.

First, they moved to care navigation via telephone but noticed many cases could be answered more easily via email. So, in January 2020 they introduced an online tool (askmyGP), where patients fill in a simple online form describing their issue and capturing their preferences. Online requests go into a single workflow along with those requests that come in by phone, and care navigators sort and assign these requests across the full practice team, based on patient preference and clinical priority. The form can also be adapted quickly to direct messages to patients on emerging issues, such as Strep A infection, and automatically gathers GP Survey and Friends and Family Test feedback, saving practice staff time.

Implementation was preceded by an analysis of existing demand, which suggested a revised model for staffing across the week. Training was offered to staff in advance as part of the rollout, and the practice sent a letter to patients about the new system so they would understand the changes.

Although the phone line will always remain an option, the practice now has 80% of requests coming in online, including from patients in their 90s. If a patient does not want to use the online system, the reception team simply asks the patient the questions on the online form and fills it in for them, so the service is identical whether contact is online-only or on the phone. Since the phone lines are less busy, care navigators are able to spend longer on the phone to those who need more help.

Now, twice as many patients are seen face-to-face than request it, based on need following clinical assessment. And 45% of requests ask for email responses. This allows clinicians to respond to and resolve many requests very quickly.

The median closure time of patient requests over the last eight weeks was 120 minutes, and all patient contacts are concluded on the same day unless they choose to be seen on a later date. 80% of patients rate their experience as better than before. Instead of 21 days for routine requests, almost all patient contacts are now concluded on the same day, unless they choose to be seen on a later date.

A. Better digital telephony

Ambition

We want to see an end to people getting engaged tones when they call their practice, in part because the frustration of long waits on the phone without information can affect the caller's interaction with reception staff when they do get through. This occurs when practices have analogue phone systems with a fixed number of lines and no call management system. During the 8am rush an average-sized practice can receive over 100 calls in the first hour of opening on a Monday.[47] To manage this we want all practices still on analogue lines[48] to move to digital telephony that handles multiple calls and includes call-back functions so patients get a better experience, particularly for those calling on pay-as-you-go phone plans.

All analogue phone systems across the country are due to be switched off by December 2025,[49] so this move is also a prerequisite ahead of this date.

How we will deliver

NHS England will support the transition to digital telephony for practices that commit by 1 July 2023 to the move, including procurement, contract negotiation and financial support for new equipment, transition costs and training. Our ambition is to transition at least 1,000 practices before the end of 2023, so around 65% of all practices will be using this technology, and we expect to transition all other practices who sign up by the end of March 2024.

In trials, moving to high-quality digital telephony raised 'ease of getting through' scores by 30 percentage points,[50] driven by these features:

- **queuing:** enables practices to manage multiple calls, patients are notified of queue position and wait time, and never get an engaged tone
- **call-back:** patients have the option to be called back when they are higher in the queue
- **call-routing:** supports directing patients to the right person or team (eg a medicines team serving the whole PCN)

[47] Based on NHS England analysis of an example practice.
[48] NHS England survey of practices (November 2022, n=~2000) in addition to previous baselining and other intelligence (<3,000 confirmed on digital telephony, and therefore up to 3,500 practices on analogue).
[49] UK transition from analogue to digital landlines
[50] Phase 1 pilot of NHS England rolling out (digital) cloud-based telephony, survey of 767 patients over 113 practices.

- **integration with clinical systems:** allows practice staff to quickly identify patients and find relevant information with less searching.

The 2023/24 GP Contract[51] requires practices to use the nationally set Cloud (digital) Telephony Framework[52] for procuring digital telephony. This lists suppliers who can provide the functionality required to support high-quality patient access.

Digital telephony offers detailed management information to support further quality improvement, such as the call volume and length for each member of the practice staff. This is helpful in planning capacity quality improvement. It is also important for practices, PCNs, places and systems to have in mind the strategic direction described in the Fuller Stocktake, especially Shared Action #1 to develop a single system-wide approach to managing integrated urgent care. Some of the benefits are being able to direct calls easily to teams working on different sites. NHS England recommends PCNs use the same provider, and ICBs may want places or whole systems to do so (see Leeds case study).

Case study – Leeds Digital Telephony

54 practices across Leeds have moved to a single digital (cloud-based) telephony system to overcome access issues and complaints related to fixed analogue phone lines and patients getting engaged tones when lines were busy.

The 8am rush is now consigned to history, by rostering more staff onto answering the phone first thing and introducing automatic prompts to route callers to the most appropriate team member. The data provided means the team can learn from and respond to the real-time feedback about call length and waiting times. Both practices and the ICB can now better understand demand and match resources to improve response times to patient calls.

Other benefits include working remotely, and practices across Leeds can support each other if under pressure or short-notice changes mean a practice may not be able to meet its daily requests from patients.

The team plans to adopt queueing and call-back features, so patients can opt to hang up and be called back when they reach the front of the queue, freeing up patients'

[51] Changes to the GP Contract in 2023/24 (NHS England).
[52] Advanced telephony better purchasing framework, replaced with DCS Cloud Telephony Framework later this year.

time. A further feature will be integration of the clinical patient record so that a clinician can open the patient's record when they call, or even click 'call' from within a patient's record, which will release practice team time.

B. Simpler online requests

Ambition

While people will always be able to ring their practice, we want to make online requests easy and dependable. Many practices that encourage patients to make online requests find it becomes the preferred route and overwhelmingly so for working age adults when using high quality tools. These requests are easier for practices to sort to different members of the practice team and respond to, especially where practices combine all patient requests (online, in person and by phone) into a single online tool. An additional benefit is improved management data.

How we will deliver

Practices are required contractually to provide online access. However, this was introduced during the pandemic, and we recognise that due to the inevitable pace the pandemic demanded, many practices neither had the time to fully assess the range of products on offer nor to fully implement systems and workflows supporting online access.

NHS England will make high-quality online consultation, messaging and booking tools available to general practice,[53] alongside guidance on the relative strengths of the tools in different areas by July 2023.[54] ICBs will work with PCNs and practices to decide which tools will best enable them to shift to the Modern General Practice Access model.[55]

Practices need to offer accessible and easily usable websites, and NHS England will encourage the implementation of the 'what good looks like' guidance,[56] by giving ICBs a simple tool to help them review sites, identify best practice examples in their systems, and target areas for improvements.

[53] To do so, we will change the tools available on the Digital Care Services (DCS) catalogue by introducing a new group of fully funded products (Digital Pathways Lot) from July 2023.
[54] NHS England will publish research highlighting which of the main products are most accessible for patients and useful for practices for different uses in July 2023.
[55] Which they will procure through the ICB.
[56] Creating a highly usable and accessible GP website for patients

Case study – Modern General Practice Access: the Priory Medical Group (York)

The Priory Medical Group (60,000 patients) implemented a same-day response model in November 2020, after nine months of planning and seeing demand rise by a third compared to pre-pandemic.

The team uses an online consultation system (Klinik) where patients fill in a simple form and the practice responds the same day. From the outset patient uptake was high, and soon 80% of requests were logged online, with traditional phone and walk-in channels maintained to ensure no one was excluded.

The software collects high-quality information and allows phone and online contacts to be viewed on a single dashboard. The practice did extensive data analysis in the planning period to understand true clinical need, and reviewed and streamlined hundreds of common patient requests, so staff knew which practice team member should handle which. This process is helped by artificial intelligence, which proposes the initial patient navigation and flags potentially urgent requests, releasing time for clinicians and reception staff.

The system has meant that the practice can use nursing and pharmacist staff to deal with 7.3% and 10% more requests respectively, allowing the group to contact 8,000 more patients per quarter with no extra clinical resource since launch.

Patient satisfaction with access has increased from 27% to 83%, and 92% of staff think the new system is better than the old.

C. Faster navigation, assessment and response

Ambition

We want to make it easier for people to contact their practice and to make getting a response the same day the norm, so patients know how their request will be dealt with.

Care navigation becomes a critical role as ~15% of current GP appointments could be navigated to self-care, community pharmacy, admin teams or other more appropriate local services.[57] With the right protocols it can also mean directing patients to secondary

[57] Malby B, Downham N, Hufflett T (2018) Organisational development is essential to support systems change in primary care. London Southbank University.

care (see Maidstone Care Navigation case study below), while others are directed to the most appropriate staff member in the wider practice team. It requires good understanding of local services and the expanded range of practice roles,[58] as well as the customer service skills to effectively direct patients. Therefore, we will invest in a new National Care Navigation Training programme for up to 6,500 staff, rolling this out from May 2023. This will use the care navigation competency framework developed by Health Education England and every practice will benefit. A key element of navigation is identifying those patients who would like or benefit from continuity, and this will be part of this training.

Evidence shows that relational continuity yields significant benefits for patients, systems and staff, and is especially important for patients with multiple or complex conditions.[59] The care navigator role improves continuity; this may be as simple as asking if the patient would like to wait for a preferred staff member or using flags in a patient's notes to direct them to a certain staff member. We encourage practices to use the Royal College of General Practitioners (RCGP) Continuity Toolkit as part of the QOF quality improvement module for 2023/24 on avoidable appointments.

Case study – Maidstone Care Navigation

In Maidstone a new system allows patients who contact their GP practice to be referred directly to specialist cancer services without the need for an appointment. If the patient has certain cancer symptoms, eg coughing up blood, then care navigators use a clinical algorithm at the first point of contact and automatically refer them to the right cancer service.

Previously, patients would need to see a GP before being referred, so navigating them directly to a specialist service gives patients faster access to cancer pathways. This approach also releases GP appointments and improves patient experience and access.

For those contacts directed to the wider practice team, our ambition is that clinically urgent requests should be assessed on the same day, and when the request is not urgent, an appointment, if needed, should be scheduled within two weeks. For some routine follow-up requests (eg a B12 injection or a cervical smear), a longer timeframe

[58] See Annex B of the Network Contract DES Specification for the minimum role requirements for each of the reimbursable roles.
[59] Improving continuity: THE clinical challenge (InnovAiT 2016).

may be clinically appropriate or preferred by the patient. Importantly, by putting the assessment of the urgent clinical risk front and centre, patient safety is improved.

How we will deliver

NHS England will fund higher-quality digital tools that enable the shift to online and support the combined workflow for all requests, for the whole practice team to contribute to rapid assessment and response.

Practices also tell us that ahead of moving to Modern General Practice Access, the existing appointment book should be reduced ahead of time to provide good capacity at the launch of the new approach. NHS England will also support practices that commit to significant transformation with extra capacity over the next two years, ~£13,500 per practice.

We have streamlined the IIF to provide unconditional funding to PCNs (~£11,500/month for an average PCN) to support the transition. We have also strengthened the 2023/24 GP Contract to include the expectation that patients will be offered an assessment of need, an appointment, or signposted to an appropriate service when they contact their practice and should not be advised to 'call back another day'.

Building capacity

Our broader plans on workforce, including primary care, will be described in the NHS Long Term Workforce Plan that will be published shortly.

Shorter term, as practices improve access, they will have to manage more patient requests and optimise the use of the full practice team, but it also means we need to continue to build total general practice capacity. The immediate growth will be in the broader practice team, strengthening the foundation for more multidisciplinary working in the future.

GP numbers are not where we would like them to be, and it will take time for higher training numbers to work their way through. We will do more to bring new doctors into general practice, retain those working today and encourage recent leavers to return.

We know there is pressure on estates, particularly in areas of housing growth. Ahead of ICBs doing longer-term planning, government will consult on planning guidance to raise the priority of primary care. In addition, we will support the development of a new

standardised design for primary care buildings, providing modern facilities that create a positive working environment for staff and patients and use modern construction methods.

We will build capacity through:

A. larger multidisciplinary teams
B. more new doctors
C. retention and return of experienced GPs
D. higher priority for primary care in housing developments.

A. Larger multidisciplinary teams

Ambition

We want to continue to grow the practice team, especially roles with responsibility for direct patient care which can be part of larger multidisciplinary teams. We will deliver our commitment of 26,000 more direct patient care professionals in general practice and 50 million more appointments by 31 March 2024.

How we will deliver

Since its introduction in 2019, the Additional Roles Reimbursement Scheme (ARRS) has supported salary costs for ARRS staff, including pharmacists, care co-ordinators and social prescribing link workers.[60] This has helped grow the total number of clinical and direct patient care staff in general practice by over 25,000 FTE staff against our commitment of 26,000.[61] Although the five-year framework contract ends this year, ARRS staff are a critical part of general practice and staff will continue to be funded after 2023/24.[62] We want PCNs to make full use of their entitlement in the full knowledge that support for these staff will continue.

For 2023/34 we will make up to a further £385 million available in ARRS funding to continue to grow capacity. We have also expanded the roles in ARRS and, so PCNs have more choice over who they recruit and, by streamlining the IIF, how they deploy them. New roles include the recently announced digital and transformation lead, which

[60] Expanding our workforce
[61] March 2019 to December 2022 (NHS Digital general practice and primary care workforce).
[62] Update to the GP Contract Agreement 2020/21-2023/24, para 1.20.

will help practices move to the new digital tools and support the Modern General Practice Access approach.[63]

Practice nurses pre-date ARRS, but for 2023/24 we have added advanced clinical practitioner nurses, and in the October 2022 update we added reimbursement of training time for nursing associates to become registered nurses. We will continue to provide systems with £4 million of System Development Funding (SDF) which they can use to recruit and retain general practice nurses.

We will continue to ensure that all primary care staff have access to the 'Looking After You' suite of accessible health and wellbeing offers, and we have recently extended the Practitioner Health service, a free, confidential mental health and addiction service, to all primary care staff to self-refer.

NHS England will publish further resources, developed with frontline staff, to make best use of these roles, as we know there is variation in how they are deployed. NHS England is also asking and incentivising practices to refine their General Practice Appointments Data (GPAD), to help us more accurately track appointments and who is delivering them. This will also enable practices to better track the commitment to action urgent clinical need on the same day and non-urgent needs within two weeks.

We are launching care navigator and digital and transformation staff training to help upskill these newer roles in general practice.

Case study – embedding ARRS staff

Kingswood Health Centre is a practice with 13,000 patients and a practice team with a wide range of ARRS roles. The lead GP partner developed a protocol for care navigators to match requests to who in the team could provide the most appropriate care. For example, a patient with knee pain would be booked directly with the practice first-contact physiotherapist, instead of seeing a GP first. The protocol means the reception team knows how to direct and book with the right clinician, and effective communication between the GPs and the reception team means that questions can be dealt with quickly if they are unsure where to book in. This model has freed up enough GP time to move from 10 to 15-minute GP appointments, giving patients more time where it is needed, and recruitment to and retention of the practice team have significantly improved. The reception team feels better able to help patients and patient

[63] Changes to the GP Contract in 2023/24

feedback has been positive. Patients now phone to request to see the paramedic or the physiotherapist, as they know more about the breadth of the practice team.

B. More new doctors

Ambition

We want to continue to have more new doctors in general practice by training more GPs and supporting other doctors to transition to general practice.

How we will deliver

The NHS Long Term Workforce Plan, which will be published shortly, will set out our ambitious plans to significantly expand GP specialty training and ensure the NHS can recruit and retain the GP workforce it needs in the future, alongside an expanded and empowered wider primary care team. NHS England will continue to support newly qualified GPs into general practice. All doctors completing GP specialty training can access our two-year fellowship, including international medical graduates and nurses. Up to £35 million of SDF funding will be available for general practice fellowships in 2023/24.

Over half of doctors in GP training are international medical graduates, who are critical to general practice. Given the length of GP training, these doctors are typically not eligible for indefinite leave to remain when they qualify and must be employed by a practice with a visa sponsorship licence to continue working in the UK. Working with the Home Office, from autumn 2023 government will introduce an additional four months at the end of a visa for newly trained GPs to remain in the UK and NHS England will continue to increase the number of GP surgeries holding visa sponsorship licences.

In 2023/24, NHS England will work with partners to facilitate ways in which doctors other than GPs, such as SAS doctors,[64] can work in general practice as part of a multidisciplinary team to help increase practice capacity while providing a new and rewarding career option. DHSC will consult on reforms to the Medical Performers List to retain the flexibilities introduced during the pandemic so these doctors work in a safe and supported way.

[64] SAS doctors: specialty doctors and specialist grade doctors with at least four years of postgraduate training.

C. Retention and return of experienced GPs

Ambition

We want experienced GPs to stay in general practice and encourage those who have recently left, or taken a short break or time overseas, to return.

How we will deliver

We want to address the pension challenges that contribute to the loss of experienced GPs. Following consultation DHSC has decided to make it easier for staff to retire and return and to protect NHS staff from unintentionally higher tax charges driven by inflation. Implementation is planned for later in 2023.

Government also recognised that the annual and lifetime allowances incentivised GPs to work fewer hours or to retire. As announced in the 2023 spring Budget, the government is increasing the annual allowance from £40,000 to £60,000 to encourage GPs to continue to work their existing, or more, hours, and abolishing the lifetime allowance entirely so pension tax charges do not act as a driver for early retirements.

NHS England already welcomes over 100 qualified GPs every year through the GP Return to Practice and International Induction programmes. From May 2023, we are making it easier for doctors to return by replacing the fixed set of multiple assessments with an individual pathway based on a personal review. For those GPs who would benefit from a placement in general practice, we have from April increased the monthly bursary from £3,500 to £4,000.

NHS England will run a campaign to encourage GPs to return to general practice or to support NHS 111 in flexible roles where, for example, working from home is possible, as described in the delivery plan for recovering urgent and emergency care services. We will continue to invest in GP retention schemes with funding for this part of the SDF allocated to each ICB. We have already engaged with over 750 general practice staff to better understand the value of these various schemes and will use this and broader stakeholder feedback to shape a simplified set of offers that support GPs throughout their careers.

D. Higher priority for primary care in housing developments

Ambition

As practice teams grow, we need to invest in the general practice estate. ICBs should take this into account when considering their wider strategy and investment requirements.

As pressure on the primary care estate is particularly intense in areas of rapid housing growth, it is important that new development is accompanied by primary care infrastructure, and that this is supported by the planning system.

How we will deliver

ICBs have delegated responsibility to ensure that the population has adequate primary medical services. As part of normal planning processes, ICBs should work with local stakeholders and take account of areas where housing developments are putting pressure on existing services.

As part of the government's wider review of the National Planning Policy Framework and planning guidance, we will consider how primary care infrastructure can better be supported. Before this, government will update planning obligations guidance to ensure that primary care infrastructure is addressed by local planning authorities as they do for other infrastructure demands, such as education. Government will also update guidance to encourage local planning authorities to engage with ICBs on large sites which may create need for extra primary care capacity.

The Levelling Up and Regeneration Bill introduces a new Infrastructure Levy[65] to support local infrastructure such as roads, schools and GP surgeries, and a requirement for local authorities to prepare an infrastructure delivery strategy to consider how this levy will be spent. Government is consulting on how ICBs, along with other infrastructure bodies, should be part of this improved planning process. The Infrastructure Levy is designed to increase certainty about what forms of infrastructure will be delivered alongside new development, reducing the scope for negotiation and delay experienced in the current system.

[65] A new levy to make sure developers pay their fair share for affordable housing and local infrastructure.

Cutting bureaucracy

A major part of the access challenge is the rise in workload, particularly for experienced GPs, which risks them being overloaded and having less time available for patients.[66] Pressure stems from the rising number of patient contacts, which practices report have grown by 20% to 40% since pre-pandemic.[67]

We have heard from the profession that recording of targets can detract from time for clinical care and reduce flexibility. In the 2023/24 contract we significantly streamlined the IIF from 36 to five indicators to support practices to focus on improving patient experience and to create the capacity to deliver the changes in this plan. This higher-trust, lower bureaucracy approach is also in line with the recommendations of the recent Health and Social Care Select Committee report into the future of general practice. [68]

We will also consult on the future of the Quality Outcomes Framework (QOF) and IIF this summer. But another part of the workload challenge is administrative burden. We know over 30% of GP time is spent on indirect patient care (including paperwork such as referral letters, fit notes and medical certification, and analysing and responding to test results).[69] There are opportunities to reduce this workload by:

A. improving the primary-secondary care interface

B. building on the Bureaucracy Busting Concordat.

A. Improving the primary-secondary care interface

Ambition

We want to reduce time spent by practice teams on lower-value administrative work and work generated by issues at the primary-secondary care interface. Practices estimate they spend 10% to 20% of their time on this.[70]

How we will deliver

In September 2022, NHS England asked the AoMRC to review how to reduce unnecessary work on the interface between general practice and NHS trusts. Its report is

[66] Eleventh GPWLS 2021.pdf (prucomm.ac.uk)
[67] NHS England survey via Institute of General Practice Management (February 2023) (n=68).
[68] The future of general practice - Health and Social Care Committee (parliament.uk)
[69] NHS England clinician experience and clinician roundtables.
[70] NHS England survey of 67 practices issued by the Institute of General Practice Management.

published alongside this plan and includes many case studies of improvements which have already been made across the country.[71]

NHS England is asking ICB chief medical officers to establish the local mechanism, which will allow both general practice and consultant-led teams to raise local issues, to jointly prioritise working with LMCs, and to tackle the high-priority issues including those in the AoMRC report. In addition, ICBs must address these four areas:

1. **Onward referrals:** if a patient has been referred into secondary care and they need another referral, for an immediate or a related need, the secondary care provider should make this for them, rather than sending them back to general practice which causes a further delay before being referred again.[72] This improves patient care, saves time and was the most common request we heard from general practices about bureaucracy.
2. **Complete care (fit notes and discharge letters):** trusts should ensure that on discharge or after an outpatient appointment, patients receive everything they need, rather than – as too often happens now – leaving patients to return prematurely to their practice, which often does not know what they need. Therefore, where patients need them, fit notes should be issued which include any appropriate information on adjustments that could support and enable returns to employment following this period, avoiding unnecessary return appointments to general practice. Discharge letters should highlight clear actions for general practice (including prescribing medications required). Also, by 30 November 2023, providers of NHS-funded secondary care services should have implemented the capability to issue a fit note electronically. From December this means hospital staff will more easily be able to issue patients with a fit note by text or email alongside other discharge papers, further preventing unnecessary return appointments.
3. **Call and recall:** for patients under their care, NHS trusts should establish their own call/recall systems for patients for follow-up tests or appointments. This means that patients will have a clear route to contact secondary care and will no

[71] You can contact psci@aomrc.org.uk for further details about the report and the initiatives included.
[72] NHS Standard Contract and The interface between primary and secondary care (2017). The contract requires that any subsequent onward referrals for either immediate needs, or for matters directly related to the condition for which the original referral was made, are to be done by secondary care, and does not explicitly require this approach for an onward referral, for non-immediate but related needs, to another provider, but NHS England recommends that this should also be done.

longer have to ask their practice to follow up on their behalf, which can often be frustrating when practices also do not know how to get the information.

4. **Clear points of contact:** ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly: eg single outpatient department email for GP practices or primary care liaison officers in secondary care. Currently practices cannot always get prompt answers to issues with requests, such as advice and guidance or referrals, which results in patients receiving delayed care.

NHS England will expect ICBs to provide an update to their public board in October or November 2023 on the four areas above. Their priorities, implementation plans and timelines are part of the annual assessment of performance that has been a requirement of the NHS Standard Contract since 2021/22.[73]

B. Building on the Bureaucracy Busting Concordat

Ambition

We want to reduce the demands on practice time from unnecessary or low-value asks and improve processes for only the most important requests for medical evidence that remain.

How we will deliver

Since 2020, we have been reducing the burden on GPs of verifying health information and providing medical evidence, including by developing the COVID-19 isolation note, streamlining appraisals, digitising fit notes and expanding the range of health professionals who can sign fit notes or answer DVLA medical information requests.

DHSC also developed the Bureaucracy Busting Concordat, setting out seven principles to reduce unnecessary bureaucracy in general practice in consultation with RCGP and the British Medical Association. We will continue to reduce medical evidence requests and increase self-certification; examples include:

- Working with the aviation industry to encourage clear, proportionate and pragmatic processes, so passengers with medical conditions who need to fly with medication or medical equipment can do so easily.

[73] NHS Standard Contract, Service condition 3.16.

- Working with His Majesty's Courts and Tribunals Service to amend guidance to staff and correspondence with jurors, so people summoned for jury service do not seek a note from a GP as evidence of illness unless they are asked to by the court service. These changes will be made by September 2023.
- Exploring opportunities to improve efficiencies for both GPs and local authorities regarding the medical needs of people wishing to access social housing, such as updating guidance to local authorities and housing associations on when it is appropriate to seek medical advice.

If practices have examples of any burdensome bureaucracy in general practice they would like to reduce, please contact us using this online form.

Delivering this plan

Accountability

ICBs are accountable to NHS England for the commissioning of general practice services and delivery against the contract. From April 2023 all ICBs have accountability for commissioning community pharmacy, dental and optometry services. NHS England will ask ICBs to develop their own system-level access improvement plan, which includes a summation of the actions their PCNs and practices have committed to, including confirmation of the funding and offers each want to take up, and the outcomes expected. ICBs should take these plans to their public boards in October or November 2023 with a further update in February or March 2024.

ICBs will want to ensure the actions in their plans align with the vision described in the Fuller Stocktake. An immediate critical enabler is to ensure digital telephony systems can support the future direction of PCNs and places in offering a single system-wide approach to integrated urgent care and integrated neighbourhood teams.[74]

To reinforce the ICB role as commissioner and in driving improvement, each element of the plan is supported by one or a combination of: (i) a new 2023/24 contract requirement; (ii) a new 2023/24 contractual incentive; (iii) reprioritised national funding; (iv) greater transparency of outcomes at system, PCN and practice level; or (v) the ability to leverage the existing standard trust contract.

[74] Fuller Stocktake: framework for shared action, #1, #3 and #4.

A major change in 2023/24 is for 30% of the retargeted IIF incentive to be awarded by ICBs conditional on PCNs achieving agreed improvement in access and experience. This will require systems to understand the GP Patient Survey for their PCNs and practices and triangulate the data with local feedback and insights. NHS England regional teams will play a key role in supporting systems and providing assurance on the delivery of these plans. Local system-level access improvement plans should prioritise supporting those with the lowest patient satisfaction scores. Taking local plans and updates through the ICB public boards this autumn will raise transparency. The core data in these plans will be used in regional assurance and national-level public reporting.

Transformation support

From May 2023, NHS England will introduce a National General Practice Improvement Programme with three tiers of support to help general practice deliver change. These offers will be underpinned by a set of principles to ensure change is clinically led, data-driven, evidence-based and measurable.

The first tier will be open to everyone. NHS England will build communities of practice and run a series of webinars on each of the key areas of this plan, including learning from peers. We will look at how those who have implemented change can share their experiences, including planning around demand and capacity, and for companies providing digital telephony and tools to showcase their offers.

To address variation in patient experience, NHS England will adapt its existing 'Accelerate' programme into the second and third tiers to help practices in the most challenging circumstances or those that simply feel they do not have the capacity or bandwidth to plan a path towards a Modern General Practice Access approach. In 2022, the Accelerate programme reached 550 practices and 97% reported productivity gains which helped patients and staff.[75]

Of these two offers over the next two years, up to six months of support will be provided for up to 1,500 practices, which will be selected based on need and ICB nomination. An intermediate option will provide up to three months of support to 800 practices and 160 PCNs. Both options will involve hands-on support, a data diagnostic and a tailored analysis of demand and capacity. NHS England will facilitate courses for systems to help build transformation capability so that they can support a further 850 practices. For practices looking to implement a Modern General Practice Access model over the next

[75] NHS England evaluation of the Accelerate programme (phase 1 2022) (internal and unpublished).

two years, and which need appointment books to be cleared in advance, we will also fund up to three weeks of transition cover (~£13,500/practice) – this could include sessions from current practice staff, by sessional GPs or support from experienced peers.

Choice and equity of access

Our ambition is to make it easier for **everyone** to contact their practice in the way they prefer. To reduce variation, ICBs will need to focus the most intense support on PCNs and practices in the most challenging circumstances.

That is why this plan largely does not call out specific cohorts of patients – we want to improve access, experience and outcomes for all – but we will ensure that primary care services reflect the needs of diverse groups of people, including all age groups, people with mental health issues or dementia, people with learning disabilities and autistic people. And patients will always have the option of visiting their practice in person. The move away from a 'first come, first served' approach towards a more equitable approach will benefit all patients, regardless of their chosen route of access.

Patients are entitled to choose which GP practice they register with, and to ask to see a particular member of the GP practice team. To make it easier to join a new practice, NHS England has simplified the forms and created an easy-to-use online registration service that is also available on the NHS App. This service is already in use across 750 practices and is available to all practices. We aim to have it rolled out to up to 2,000 practices by December 2023.

Patients also have the legal right to choose which hospital or secondary care service they go to – whether this is an NHS organisation or an independent sector provider. We want to make it easier for people to exercise this right, by giving patients more information to compare services and make the most of modern technology to make choices in a seamless way. GP practices play a critical role in supporting patients to make their choice and should therefore discuss patients' options with them and offer a full range of providers to choose from which are appropriate to clinical need. [76]

We are making more options available to the public by expanding services in community pharmacies, subject to consultation, and continuing to support rural locations through the Pharmacy Access Scheme. We will also work with distance selling pharmacies (DSPs) to

[76] The NHS Choice Framework: what choices are available to me in the NHS?

help remove barriers to the provision of remote services where appropriate and make it easier for patients to choose these services if they wish.

Communicating with the public

We know navigating healthcare is not always easy and many of us have at some point wondered whether it is best to call our practice, go to a pharmacy, ring NHS 111 or go online, or whether we should attend an urgent treatment centre or accident and emergency department (A&E). We want to make navigation clearer for patients.

This plan commits to a national campaign with three components to increase public understanding of the changes to primary care services, the benefits they bring, and how and what services they can access.

1. **Digital access:** to build knowledge and confidence in use of the NHS App and the digital access routes to general practice.
2. **Wider practice team:** to explain to the public that there is now a much broader range of staff in the practice team (eg pharmacists). Greater knowledge will help practices increase use of these roles, protecting GP time for what only they can do.
3. **Wider care available:** to help the public better access the right care by explaining when, why and how to access self-care advice, community pharmacy, general practice, NHS 111, 111 online and A&E.

The campaign will also create a set of communications toolkits for ICBs to develop their own local messages.

Case study – Quality communications

During 2021, Humber and North Yorkshire Integrated Care System piloted a well targeted, consistent communications approach to assess its effectiveness in improving patients' awareness and understanding of the changes in access to general practice and building confidence in these changes.

In total 69 practices took part, with a toolkit of materials communicating that, "there are three ways patients can request care from their practice, by phone, in person or using a secure online form on their practice's website. Whichever route used, patients would receive the care they need with either a face to face, phone, text or online message or a referral to another service".

53% of patients interviewed were open to trying online requests, with only 14% aware this was an option offered by their practice. After the communications were shared, 64% felt more confident their practice would respond if they used the online form.[77]

Engaging on the future of primary care

General practice

This plan is the first step to address the access challenge ahead of longer-term reforms. The other two elements of the Fuller Stocktake vision of more proactive, anticipatory and preventative care, delivered by multidisciplinary teams and integrated neighbourhood teams, remain important and can help mitigate demand. Some PCNs and practices that have already implemented Modern General Practice Access are successfully working on these, helping to build the learning on what it takes to implement.

Case study – Optimising workforce and continuity of care

Foundry PCN has a key goal to implement the Fuller Stocktake vision. Its first step was to better manage reactive care by putting all patient requests across three surgery sites into a single risk-stratified workflow. This approach has allowed more efficient use of staff across the PCN of four practices and reduced avoidable appointments to 6%. A PCN dashboard of waiting times for types of need indicates whether they are 'running hot', which helps manage capacity dynamically.

For anticipatory care, multidisciplinary teams were set up to include specialised staff to proactively deliver healthcare for a group of patients with specific needs, such as those with dementia. This approach has delivered team-based continuity of care and markedly reduced unscheduled demand in both primary and secondary care from patients under each multidisciplinary team, saving an estimated £2.3 million over three years. By integrating its PCN team into their neighbourhood team – eg designating a dedicated nursing home team (GP, nurse and paramedic) – Foundry PCN has been able to offer seven-day cover with a weekly 'ward round' for scheduled reviews, and urgent on-the-day requests supported by a weekend check-in.

[77] NHS England Summary evaluation of a pilot in Humber and North Yorkshire

Integrating primary care requires general practice to operate at a larger scale either as part of PCNs or at place level, and other system partners, such as community, acute and mental health services, will need to organise care more locally to integrate with primary care. This may require changes to today's arrangements, and indeed the Fuller Stocktake called on DHSC and NHS England to "rapidly undertake further work on the legislative, contractual, commissioning and funding framework to enable and support new models of integrated primary care", to improve equity in resource distribution and improve health outcomes.

We will engage on a broad set of themes ahead of the 2024/25 contract discussions. The 2024/25 contract provides an opportunity, after the 2019 five-year framework ends and the PCN DES was introduced, to reflect on successes and lessons learned.

We will explore alternative approaches that can work alongside the partnership model and explore additional opportunities to better align clinical and financial responsibilities in primary care, enabling primary care teams to shape NHS services in their area and reinvest savings in frontline services. NHS England will review and evaluate the Additional Roles Reimbursement Scheme as part of this work and to inform future options that could apply from 2024/25 onwards. We want to work with the profession and consult on the future of QOF this summer. We will also explore how to link QOF to key strategies such as the upcoming Major Conditions Strategy.

Community pharmacy

Community pharmacy is core to delivering on the Fuller Stocktake vision of integrating primary care, and the proposed changes in this plan, the enabling IT infrastructure and the legislation changes move us a step closer.

We will continue to support the transformation of services offered by community pharmacy by removing barriers to innovation and improving the IT connectivity with other parts of the NHS, supporting both community pharmacies and DSPs to receive referrals more promptly, manage appointments remotely where appropriate, and more rapidly update patient records.

But we know there is more to do, and alongside the service expansions outlined in this plan we are supporting a series of further pathfinder sites across England over the coming year to test independent prescribing models. We will continue to engage with the

sector as these progress, including on the outcomes of the work The King's Fund and the Nuffield Trust are doing over the summer on the future of community pharmacy.

Acknowledgements

This plan has been informed by and developed with a wide range of stakeholders, including:

Academy of Medical Royal Colleges

The Association of Pharmacy Technicians

British Medical Association General Practice Committee

Care Quality Commission

The Health Foundation

Healthwatch

Integrated care boards – chief executives and some primary care leads

Institute of General Practice Management

The King's Fund

National Association of Primary Care

National Association of Sessional GPs

National Voices

NHS Confederation

Nuffield Trust

Patients' Association

The Pharmaceutical Services Negotiating Committee

Practice Managers Association

Richmond Group of Charities

Royal College of General Practitioners

The Royal Pharmaceutical Society

Staff insights and ideas, and contributions from practice managers, clinicians, and primary care providers, have been invaluable.

We remain committed to working with partners as we deliver this plan, including through national engagement forums, communities of best practice and existing primary care advisory groups.

Thank you to everyone for sharing their time, energy, expertise and experience.

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This publication can be made available in a number of alternative formats on request.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐				
	NHS HWE ICB Primary Care Board meeting held in Public				**Meeting Date:**	**25/05/2023**		
Report Title:	**Primary Care Transformation update – Draft Strategic Delivery Plan**				**Agenda Item:**	**11A**		
Report Author(s):	James Gleed, Associate Director Primary Care Strategy and Transformation Emily Perry, Primary Care Manager – Strategy and Transformation							
Report Presented by:	James Gleed, Associate Director Primary Care Strategy and Transformation							
Report Signed off by:	Avni Shah, Director of Primary Care Transformation							
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☒	**Information**	☒
Which Strategic Objectives are relevant to this report **[Please list]**	▪ *Improving outcomes in population health and healthcare* ▪ *Tackling inequalities in outcomes, experience and access* ▪ *Enhancing productivity and value for money*							
Key questions for the ICB Board / Committee:	< Please list two / three key questions for the ICB Board / Committee > ▪ Are the key objectives outlined in the plan appropriate? ▪ Will the stated enabling workstreams support delivery of the objectives? ▪ Does the board support the next steps, further work and planned delivery at place footprints							
Report History:	A summary of the proposed areas of focus to be included within the HWEICB Primary Care Strategic Delivery Plan came to the Primary Care Board on 23 March 2023 for information. Since this meeting an initial draft version of the document has been created and is in the process of being taken to a number of place-based meetings as part of the engagement plan, the work to engage key stakeholders will continue until the document comes to HWEICB Board at the end of July where we will be requesting sign off of the document.							
Executive Summary:	The Hertfordshire and West Essex ICB Primary Care Team continue to develop the Primary Care Strategic Delivery Plan, which will encompass the key recommendations from the Fuller Stocktake Report and recently							

<table>
<tr><td></td><td colspan="4">published plan for recovering access. The scope of our plan is wider primary care including dental, community pharmacy and optometry (not just primary medical services); in this document we have set out three chief transformation objectives;

➢ The establishment of Integrated Neighbourhood Teams (INTs)
➢ Simplifying and enhancing access for acute primary health needs
➢ Continued focus on prevention and helping people to stay well for longer.

It is believed that focusing time and resource in these areas will have the greatest impact on the sustainability and resilience of primary care services and wellbeing of the workforce. These objectives will be supported by a number of key enabling workstreams as outlined below:

➢ Patient empowerment and education
➢ Workforce
➢ Premises
➢ Data, information, and digital technology
➢ Support from the ICB primary care team
➢ Investment

The final document will feature key projects that are planned for the next three years associated with each of the enabling workstreams.

The plan will be delivered through collaborative working between the ICB, primary care and the wider system.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">▪ For the board to note the draft Primary Care Strategic Delivery Plan document - noting that the document will continue to be edited over the coming 6 weeks before it goes to ICB Board at the end of July 2023.
▪ To discuss / highlight any additional areas of focus that the Board would like to see within the delivery plan</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">To be evaluated individually as part of specific projects to transform access and service provision</td></tr>
</table>

Risk: *Link to Risk Register*	*To be evaluated individually as part of specific projects to transform access and service provision*	
Financial Implications:	*To be evaluated individually as part of specific projects to transform access and service provision*	
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	To be undertaken as part of the individual transformation projects
	Quality Impact Assessment:	To be undertaken as part of the individual transformation projects
	Data Protection Impact Assessment:	To be undertaken as part of the individual transformation projects

Hertfordshire and West Essex Integrated Care System

DRAFT

Primary Care Outline Strategic Delivery Plan

2023-2026

Working together
for a healthier future

Primary Care Services – HWE

A snapshot of organisations in our Integrated Care System area – Who Are We?

1.5million people

1 Integrated Care Board
1 Integrated Care Partnership
3 Health and Care Partnerships
1 Mental Health, Learning Disability and Autism Collaborative

1 Voluntary, Community, Faith & Social Enterprise Alliance, representing thousands of local organisations

2 county councils and 13 district/borough councils

4 mental health and community providers

3 acute providers

8 GP federations (3 in S&W (one is Uber Fed across all of SWH), 2 in WE and 4 in ENH) covering a population of over 1 million people

130 GP practices ; 35 Primary Care Networks

276 community pharmacies

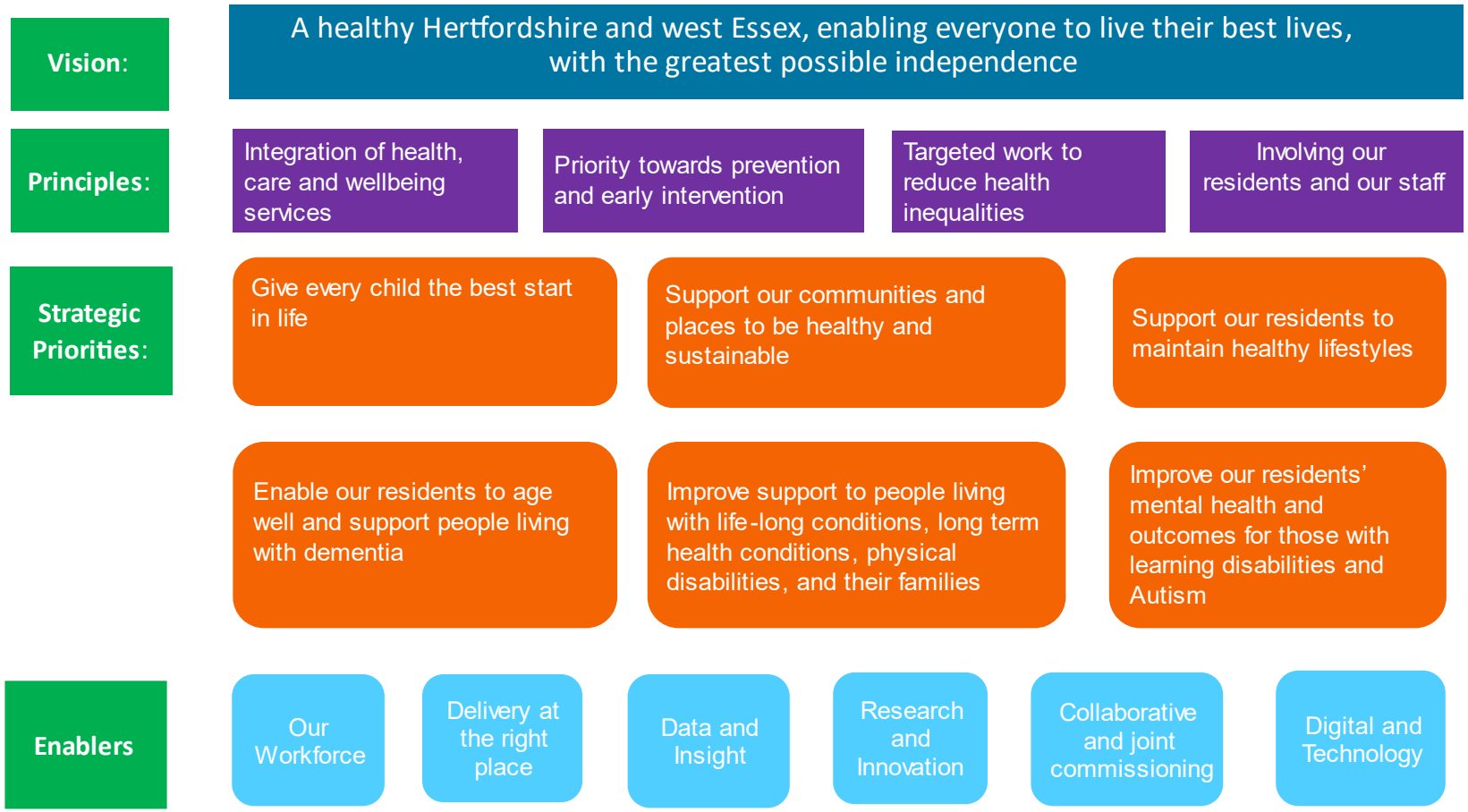
225 opticians

243 dental practices

Hertfordshire and West Essex Integrated Care System

10 year Integrated Care Strategy

To support the delivery of the aims of the Integrated Care System and meet the needs of our population a 10-year Integrated Care Strategy was developed by the Integrated Care Partnerships (ICP) and approved in December 2022. An overview of the strategy is outlined below:



Hertfordshire & West Essex Strategic Framework- 2022-2027

To support the delivery of the NHS elements of the Integrated Care Strategy (ICP) and the ICB core purposes, the ICB has agreed a strategic framework that outlines its missions and aims for the next five years. An overview of this is below:

Our mission

- **Better, healthier and longer lives for all**

We will achieve this by

- **Improving physical and mental health across our population**
- **Tackling unequal access, experience and outcomes**
- **Enhancing productivity and value for money**
- **Ensuring the NHS supports broader social and economic development.**

In the first 3-5 years we will

- Increase healthy life expectancy, and reduce inequality
- Give every child the best start in life
- Improve access to health and care services
- Increase the numbers of citizens taking steps to improve their wellbeing
- Achieve a balanced financial position annually

The ICB will deliver this by:

- Setting direction for the NHS in Hertfordshire and West Essex
- Allocating NHS resources fairly and effectively
- Supporting, equipping, and empowering our people
- Working with and pooling resources with our partners
- Enabling improvement and driving change, with a focus on quality
- Using data and evidence to generate insight and assess impact

Hertfordshire and West Essex Integrated Care System

Alignment with other local strategies / key priorities

The Primary Care Strategic Delivery Plan aligns with local strategies including:

- The UEC strategy (supporting the key stated objectives such as reducing demand for UEC, reducing ED attendances, reducing emergency admissions and supporting safe and effective discharge through taking a Population Health Management approach in INTs and improving same day access in primary care, and developing the role of social prescribing link workers)

- The HWEICB Primary Care Digital strategy (noting the importance that digital and technology plays in supporting the key objectives outlined in the primary care strategic plan, such as the establishment of a single fully joined up, interoperable landscape of local platforms, remote monitoring of patients where appropriate, use of the NHS App, supporting digitally excluded patients by utilising VCSFE and advance telephony)

- Supporting the key mental health priorities such as new model development, access, integration with primary care, and early intervention with children and young people.

National view - Fuller Stocktake Report

Aim of the Fuller Report was to provide a stocktake on integrated primary care, looking at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry) across systems.

The remit excluded the partnership model, the GP contract and the funding formula. Key areas of priorities included:

A person-centred, team-based approach to Chronic Disease Management and Complex Care - Integrated Neighbourhood Teams

- Development to enable PCNs to drive the creation of **integrated neighbourhood teams** through place in partnership with all system and local partners and stakeholders – providing more proactive, personalised care (medical/social/psychological) with support from a multidisciplinary team of professionals across health and care and wider community assets.
- **Secondary prevention**, driven by proactive management of chronic disease, to prevent deterioration in health and prolong healthy life expectancy, Enabling and supporting people to manage their own long-term conditions

A scaled and streamlined model to deliver Urgent and Episodic Care – Access

- Streamlining Urgent Primary Care Access using PHM approach at PCN/Locality level which may include streamlining/integrating Enhanced Access; integrated urgent primary care e.g NHS111 and same day access to all urgent care services including mental health, dental, community etc and more importantly an improved front of door in general practice with a combination of use of digital tools fully operationalised and embedded within the practice/network.
- Flexibility to offer **virtual or face to face options in line with patient preference and need**. Delivered at a **scale** that makes sense for local systems, as part of a wider integrated urgent and emergency care system, enabled by risk stratification of patients and shared care records.

A step-change in our ambitions on Preventative Care

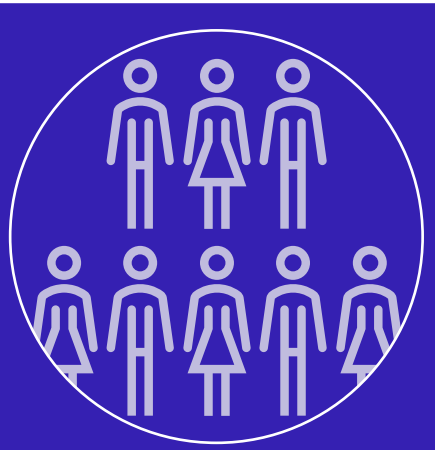
- Continued focus on prevention and helping people to stay well for longer
- **Supporting lifestyle change** via a combination of national and local programmes providing advice and support to improve diet, fitness and wellbeing, e.g health coaches and capitalising on evidence-based health apps, and the NHS app. This should involve the extended primary care team, harnessing the growing role of community pharmacy and dentistry in prevention, VCS, and working at scale on prevention with Local Authority Public Health colleagues.
- A scaled approach **to delivering population-level interventions**, including screening and health checks, and adult vaccinations, building on the community engagement that characterised the Covid-19 vaccination programme.

NHS England delivery plan for recovering access to primary care – key messages

The NHSE Delivery Plan for Recovering Access to Primary Care was released on 9 May 2023 and has a focus on four key areas:

Empower patients to manage their own health including using the NHS App, self referral pathways and through more services offered from community pharmacy (investing up to £645 million over two years to expand services offered by community pharmacy) – including expanding pharmacy oral contraception and blood pressure services this year, to increase access and convenience for millions of patients, (subject to consultation) and launching Pharmacy First so that by end of 2023 community pharmacies can supply prescription only medicines for seven common conditions. This, together with oral contraception and blood pressure expansion, could save 10 million appointments in general practice a year once scaled, (subject to consultation). This will relieve pressure on general practice.

Implement 'Modern General Practice Access' to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment, so patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message. Re-targeting £240 million – for a practice still on analogue phones - this could mean ~£60,000 of support over 2 years. This includes supporting all practices on analogue lines to move to digital telephony, including call back functionality, if they sign up by July 2023, providing all practices with the digital tools and care navigation training for Modern General Practice Access and funding transition cover for those that commit to adopt this approach before March 2025. It also covers delivering training and transformation support to all practices from May 2023 through a new National General Practice Improvement Programme.



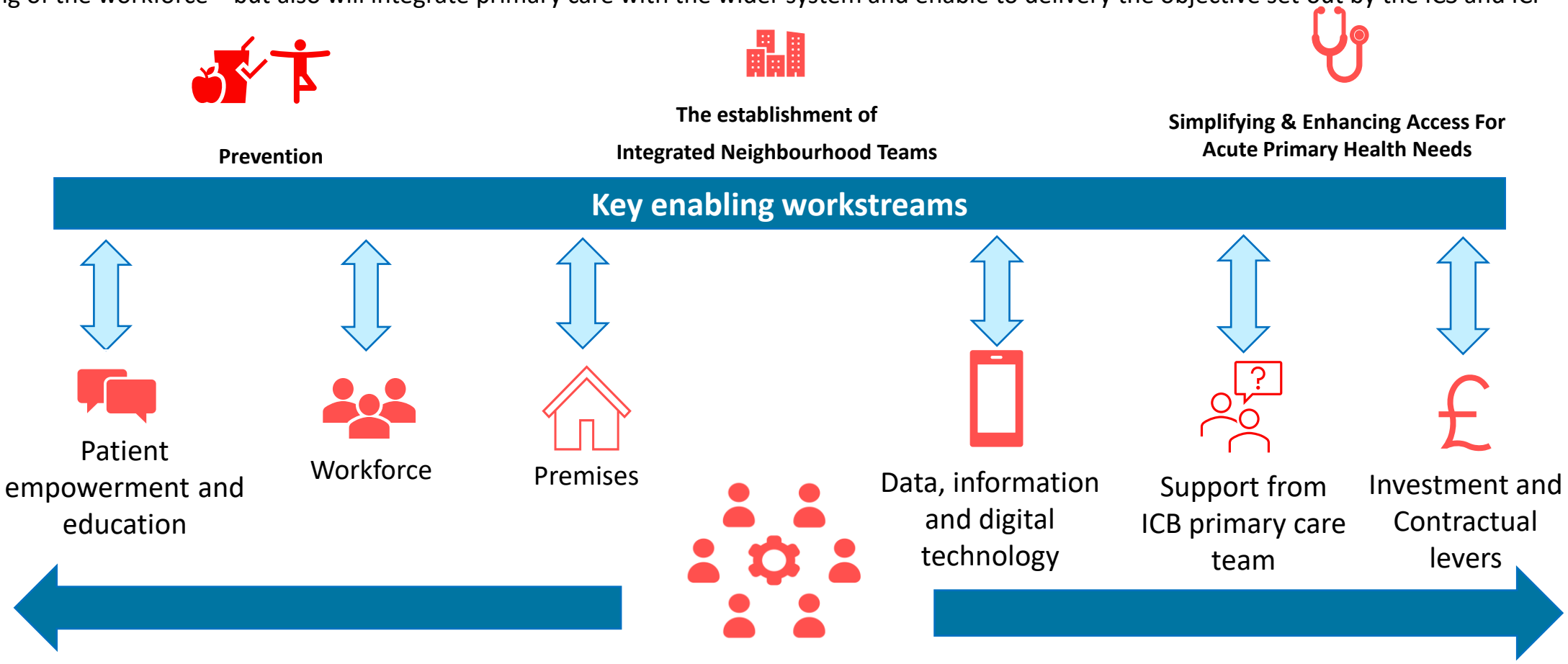
Build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed. Making available an extra £385 million in 2023/24 to employ 26,000 more direct patient care staff and deliver 50 million more appointments by March 2024 (compared to 2019), as well as further expand GP specialty training – and making it easier for newly trained GPs who require a visa to remain in England. Another aspect is to encourage experienced GPs to stay in practice through the pension reforms announced in the Budget and create simpler routes back to practice for the recently retired, and changing local authority planning guidance this year to raise the priority of primary care facilities when considering how funds from new housing developments are allocated

Cut bureaucracy Reducing the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients, including reducing time spent liaising with hospitals – by requiring ICBs to report progress on improving the interface with primary care, reducing requests to GPs to verify medical evidence, including by increasing self-certification, by continuing to advance the Bureaucracy Busting Concordat and streamlining the Investment and Impact Fund (IIF) from 36 to five indicators – retarget £246 million – and protect 25% of Quality and Outcomes Framework (QOF) clinical indicators

HWEICB Primary Care Transformation objectives

As outlined at the Board there 3 key transformation objectives; **the establishment of Integrated Neighbourhood Teams (INTs) , simplifying and enhancing access for acute primary health needs** and **continued focus on prevention and helping people to stay well for longer**.

It is believed that focusing time and resource in these areas will have the greatest impact on the sustainability and resilience of not just primary care services and wellbeing of the workforce – but also will integrate primary care with the wider system and enable to delivery the objective set out by the ICS and ICP



DRAFT DIAGRAM

Priority one:
Preventing ill health

Priority two:
Integrated Neighbourhood Teams

Primary Care Network (PCN)

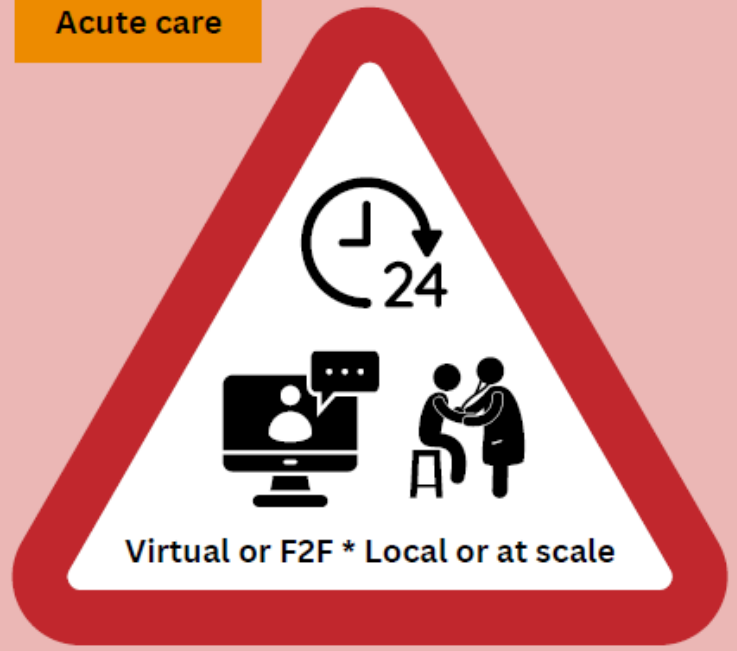
- Social Prescriber
- Healthy Hubs
- Social care
- Vol orgs
- Providers of care
- Community nursing & therapy
- Mental health
- Hospice

Patient supported by multi-disciplinary team delivering proactive case management

Working together as an Integrated Neighbourhood Team to improve people's outcomes and experience by meeting the health and social care needs of the local population

Priority three:
Same day / urgent access to care

- NHS 111
- GP out of hours
- SDEC
- Mental health crisis
- Community care
- Acute care



Virtual or F2F * Local or at scale

Timely access to:

Dental
Pharmacy
Optometry

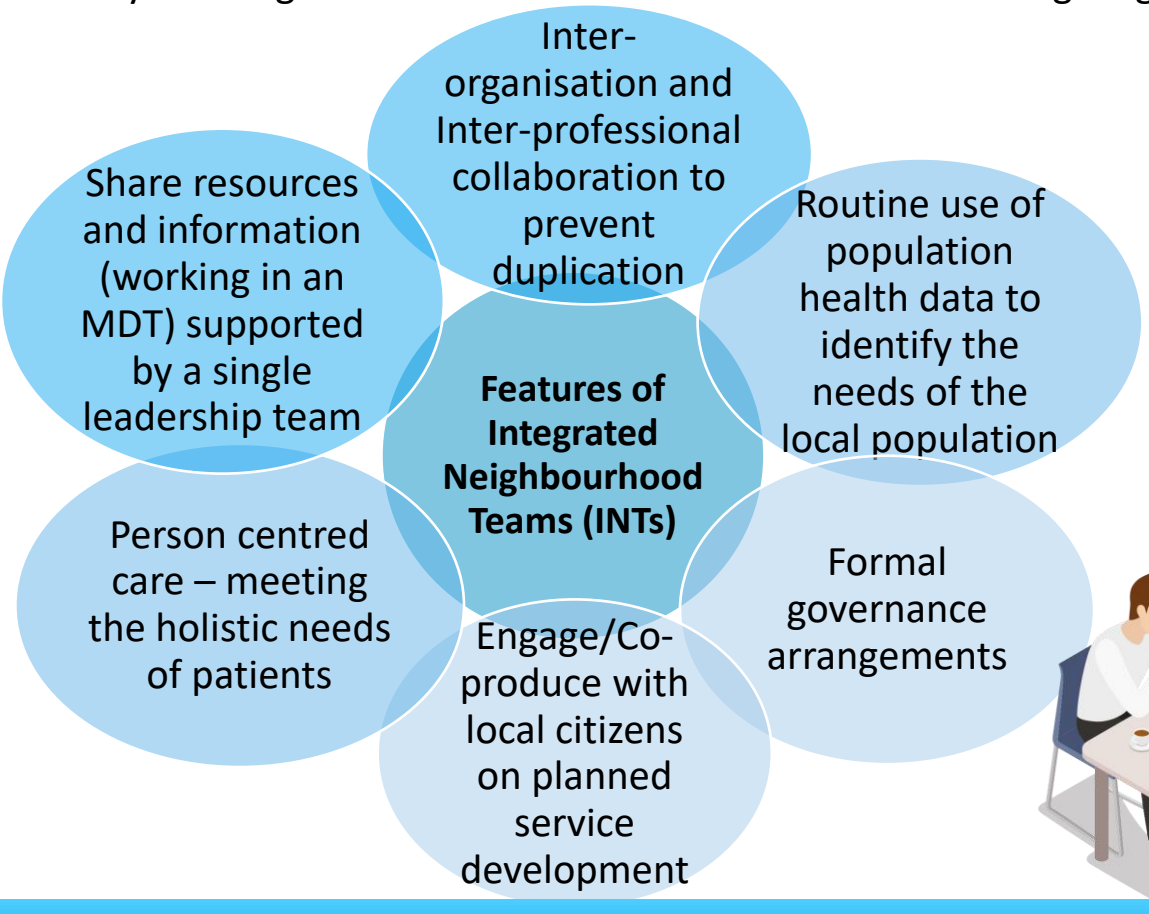
Work to reduce health inequalities and unfairness in health outcomes in all we do

The Establishment of Integrated Neighbourhood Teams (INTs)

The establishment of Integrated Neighbourhood Teams (INTs) - a person-centred, team-based approach to Chronic Disease Management and Complex Care

What is an Integrated Neighbourhood Team (INT) – Defining features

The key objective of establishing INTs is to deliver person centered seamless care- this will be achieved by forging partnerships between the NHS, social care, primary care, voluntary sector and the community, for the benefit of the local population, as well as to benefit staff. Some of the key defining features of INTs are outlined in the following diagram:



The Fuller Stocktake report (May 2022) states that

'Integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks (PCNs), and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.

This requires two significant cultural shifts: towards a more psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community; and realignment of the wider health and care system to a population-based approach – for example, aligning community, mental health, social care and secondary care specialists to neighbourhood teams.'

Integrated Neighbourhood Teams Vision Statement:

"Working together as an Integrated Neighbourhood Team to improve people's outcomes and experience by meeting the health and social care needs of the local population"

DRAFT outline of the functions provided by INTs, along with the expected outcomes – example from West Essex

Function	Description	Outcomes
1. Prevention and self-care	• Promote uptake of screening programmes • Ensure that awareness campaigns are publicised • Sharing intelligence across all partners (health and social) • Engage with the community • Expanding lifestyle medicine to support patients • Supporting Children and Young People (CYP) via family approach in the early years, e.g through support from care coordinators	• Increased life-span • Improvement in physical health / activity levels • Protecting mental health and reduction in stress and anxiety • Boost to self-esteem
2. Identification	• Utilising population health management data • Use of appropriate systems, registers and assessment tools • Training for all system partners • In-reach model of care	• Earlier detection of disease may lead to better outcomes • Reduction in escalation of care and support • Early diagnosis of a condition can give the opportunity to address uncertainties & allow time for education
3. Pro-active care planning , care delivery and management of complex patients	• Well attended, holistic approach to MDTs • Delivery of integrated care – including domiciliary and reablement care providers • Working together to develop / share pathways Sharing of info surrounding service development / services available • Making communication easier with a named accountable lead professional for every complex patient • Facilitating early hospital discharges, in line with national policy, through in-reach • Ensuring appropriate documentation is in place, up to date and accessible (PEACE etc.) • Receive proactive info from the CCC to feed into the MDTs	• Promotes a holistic, person-centred approach • Enables most effective utilisation of available services • Supports safe, early discharge • Reduced failed discharges • Promotes flexible, place based / at home care and support • Improved utilisation of system capacity • Improved pathways for seamless care • Reduced delays in care provision
4. Preventing escalation of need	• Access specialist / additional support from the CCC and from within the INT Working together to identify rising risk and putting care plans in place anticipate need • Focus on hospital avoidance • Continued monitoring / oversight of caseloads • Receive proactive info from the CCC to action urgent response • Working across organisational boundaries	• Further integration across all health and social care providers to deliver shared outcomes with system capacity • Reduced duplication and hand-offs for patients • Early intervention prevention / decision making
5. Urgent Care delivered at local level	• Timely urgent response based on patient need • 24-hour crisis support to deliver care in an individual's home	• Most appropriate level of care / resource available for the patient • In and out of hours seamless care provision
6. Supporting care homes	• Ensuring dedicated resources are available to support care homes • Build on relationships with care homes • Enhanced health in care homes (EHCH) PCN DES care home delivery spec • Access specialist / additional support from the care home hub & provide info to the care home hub • Training and support to the care homes	• Supports the patient to stay in their care home • Staff upskilled and confidence built to support residents • Holistic approach • Supported care at the right time, by the right staff • Reduction of ED attendances and NEL

Integrated Neighbourhood Teams (INT) case study

To implementing across HWE need to have commitment from all system partners to support the development of integrated neighbourhood teams for a shared common purpose at PCN/locality

Senior Leadership commitment from all system partners

Agree the key features of the an INT at PCN. Senior leadership oversight at locality/place level to provide continued support

Leadership to create conditions within respective organisation to enable managers and professionals to be released to develop the INT at PCN

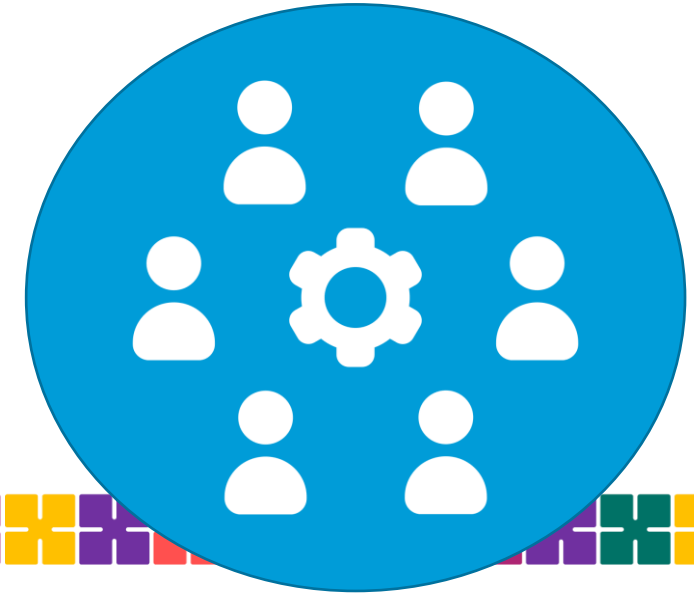
Each INT brings together a skilled workforce of professionals across health and care sector supported by a **single leadership team** to promote multi-disciplinary problem solving and utilisation of all available community assets to improve the outcomes and experience of the local population.

PCN INT to use PHM segmentation information to create a shared vision for the identified cohort

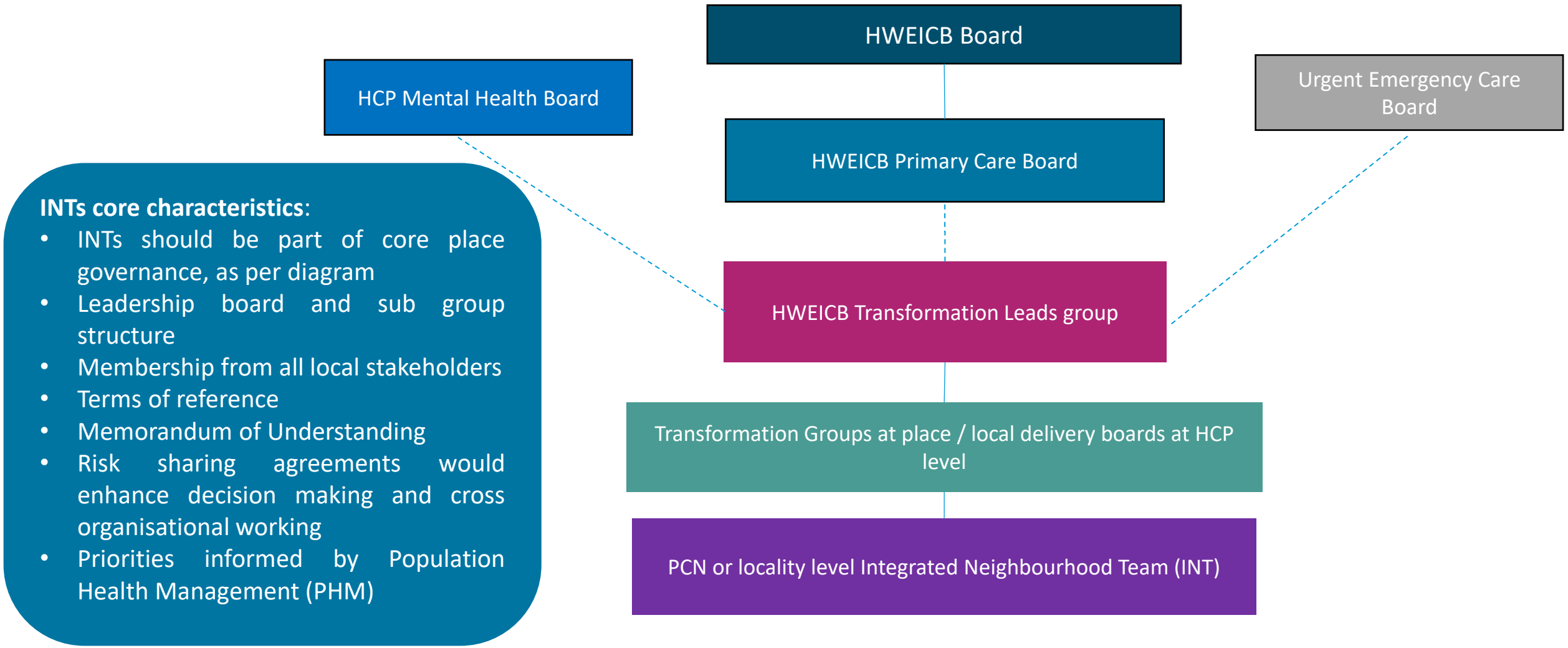
The teams enable collaborative, flexible working with simple care pathways that prevent duplication.

INT/MDT to have a lead care – coordinator (example using ARRS role flexibly) and deliver proactive care through MDT approach with a named lead professional.

Record and monitor outcomes with oversight via the senior leadership



Core characteristics of Integrated Neighbourhood Teams (INTs)



INTs core characteristics:

- INTs should be part of core place governance, as per diagram
- Leadership board and sub group structure
- Membership from all local stakeholders
- Terms of reference
- Memorandum of Understanding
- Risk sharing agreements would enhance decision making and cross organisational working
- Priorities informed by Population Health Management (PHM)

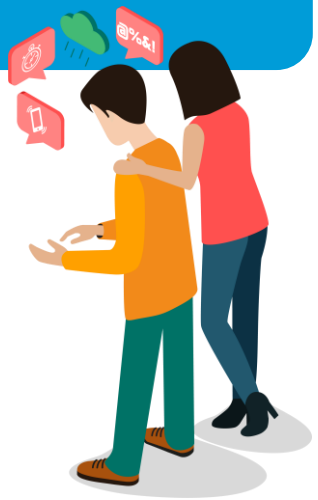
Simplifying & Enhancing Access For Acute Primary Health Needs

Simplifying & Enhancing Access For Acute Primary Health Needs

The establishment of same day access models which is led by a multidisciplinary team of colleagues will be key to ensuring the national direction of travel can be delivered across Hertfordshire and West Essex.

We know that access varies across practices and PCNs and we will seek to address variation through building on our existing practice and PCN based service models evolving across HWE including delivery of Extended Access, scoping on PCN triage model, PCN e-consultation model, PCN integration with NHS 111/Community Care Co-ordination Centre model for single front door etc

Working across the whole system → Patients are seen in the right place at the right time → Better outcomes for patients



General practice, community, acute, 111, dental, pharmacy, optometry, mental health, social care, Vol sector etc

Increasing Access for Acute Primary Health Needs: Defining Features

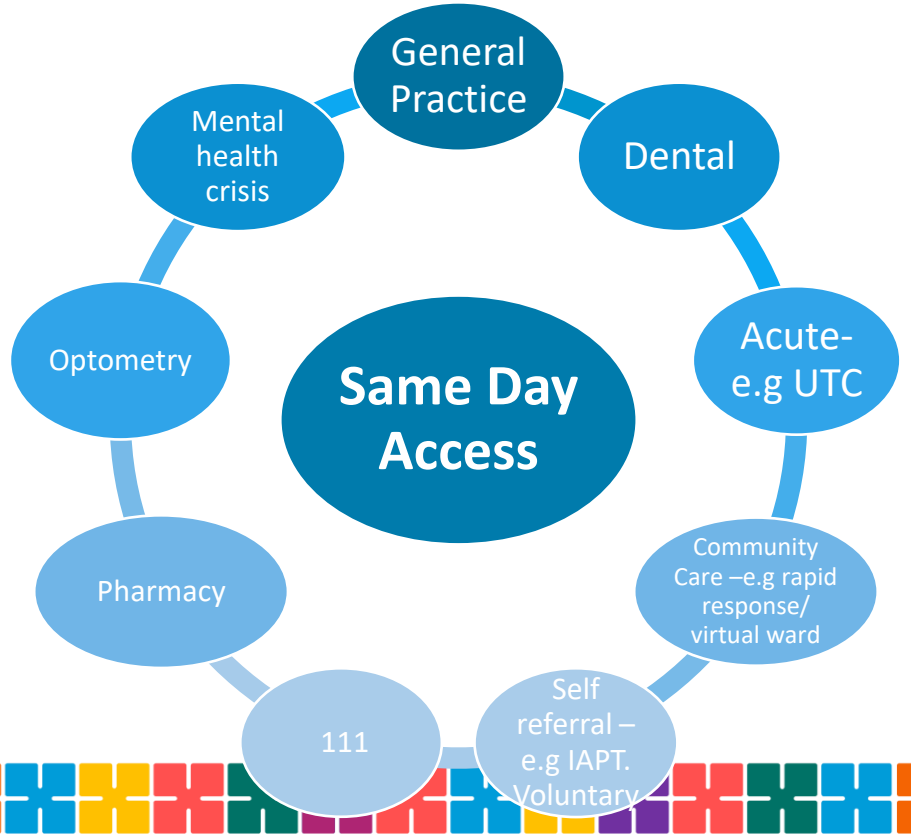
Features of Simplifying Enhancing Access For Acute Primary Health Needs

- Increased use of non-medical healthcare professionals, non-registered workers and voluntary sector
- System is easy to navigate for patients; *consolidate points of access; enhance use of digital and automation (AI)*
- Patient empowerment / education and coproduction (Self care/self referrals)
- Access is non-discriminatory and takes into account the needs of all service users
- Access is needs-led and the assessment of need is holistic

Case study: The following video showcases the urgent on the day service that Stort Valley and Villages PCN have implemented and how this is supporting both patients and staff: Stort Valley and Villages Urgent on the Day Service

What does this mean for the health and care system?

- The establishment of same day access which is led by a multidisciplinary team of colleagues to meet the increasing demand and growing need of patients/citizens.
- We will seek to address variation across practices and PCNs through hands on work with individual practices and PCN and transformative work with all partners seeking opportunity as it arises such as redesigning on UTC, NHS 111, Extended access, acute adult and children same day access to LTC such as respiratory pathways, minor ailments and injury etc
- **Enhancing same day access applies to all providers – not just general practice / primary care, and also incorporates self referral options (e.g IAPT):**



One of the key aspirations for the future of community pharmacy in HWE is that **Community pharmacy is integrated into primary and community care, often being the first point of contact for patients, supporting better access** and improved outcomes for patients and the population.

Dental Out of Hours service – interlinked with NHS 111 to see patients with urgent dental needs week day evenings and weekends.
Dental in hours – analysis of demands vs provision will take place to ensure dental health needs are met, including promotion of preventative measures.

The ICB will be reviewing urgent and emergency eye services over the coming 12 months, taking into account the pilot results from the MECS service to form new commissioning plans


Preventing ill health

Preventing ill health

"Primary care has an essential role to play in preventing ill health and tackling health inequalities, working in partnership with other system players to prevent ill health and manage long-term conditions" – Fuller Stocktake report (May 2022)

A number of projects are in place across HWEICB to support patients to prevent ill health and to tackle health inequalities – This includes examples of primary/secondary and tertiary prevention:

Population Health Management – using data to address healthcare needs at PCN level across a number of conditions and to better tackle health inequalities in specific groups, such as veterans (increasing veteran friendly practices); obesity; case finding LTC

Community pharmacy - supporting self-care; role in primary prevention including smoking cessation; case finding hypertension;

Secondary prevention – Cholesterol and BP monitoring

Enhanced Commissioning Framework (ECF) for GP Case finding; Secondary prevention in CHD; Disease staging and enhanced proactive management to prevent tertiary conditions

VCSE –

Strengthen the role of the Voluntary Care and Social Enterprise in prevention and community resilience

Continue to grow the personalised care approach - Through social prescriber/health wellbeing coach, and care-coordinators. Ensuring focus on prevention from an early age in Children and Young People.

Timeline for key transformation projects DRAFT

	Year 1 - 2023/24	Year 2 - 2024/25	Year 3 - 2025/26
Integrated Neighbourhood Teams*	**September 2023 -** HWE will have INT coverage		
	December 2023 - All INTs will have identified a population cohort that would benefit from a joined-up approach		
		March / April 2024 – all INTs will be delivering a collaborative service or health intervention	
			By March 2025 – we will see improved health and wellbeing outcomes in those clinical domain(s) identified
Simplifying & Enhancing Access for Acute Primary Health Needs	**June 2023** - ICB working with PCNs with their core practices and non-core members will have mapped all access points and reviewed relevant data to determine where access is most challenged.		
	September 2023 - Plans developed for one or more initiatives that are expected to improve access in a key area where there is the greatest potential to have a positive impact on access		
	September 2023-March 2024 - Explore opportunities for integrated service models between General Practice providers, Integrated Urgent Care and other community-based services		
		From April 2024 - Pilot new integrated, multi-provider service models - following successful pilots explore opportunities to make new modes BAU	
			Continue to embed new models as BAU
	Review of dental needs, including ongoing pilots and specialist pathways to support identification of dental transformation		
Preventing ill health	Enhanced Commissioning Framework in place - the aim of the ECF is to support local and national priorities and more importantly in line with the development of the HWE Primary Care Strategic Delivery plan aligned to ICB strategies and the national Fuller implementation of next steps towards integrating primary care.		
	2023/24 and 2025/26 – Diabetes Prevention Programme to continue to be available for eligible patients across HWEICB		
	Ongoing training and development of the 3 personalised care roles (social prescribing link worker, health and wellbeing coach and care coordinators) – including comprehensive training, as well as support to embed into PCNs and INTs.		
	Development of personalised care and social prescribing for children and young people.		
		Development of a digital solution to capture outcomes and impact of personalised care on population health outcomes.	

**Unless alternative timelines have been agreed – e.g INTs already established in West Essex and proactive care cohort model is already being rolled out*

Key Enabling Workstreams

Areas of focus on enablers

Patient empowerment and education

Continue enhancing the work on development of PPGs at practice and PCN/Locality with partners.

Building on existing forums including identified target groups such as schools, MH, LD co-production boards in place

Workforce

Continue on recruitment, retention for all primary care workforce staff through PCN Education team;

Scope opportunity around locums and how we can retain them in the system

Develop and implement integrated/rotational roles

Premises and sustainability

Development of the ICS infrastructure strategy to support enhanced discussions with partners

Closer planning with districts with housing/population growth

Testing innovative approaches to leases such as federation/incorporated PCN etc

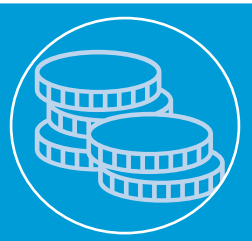
Data, information and digital technology

Embedding PHM and segmentation model across all PCN/locality and partners. Embedding digital tools to support operational/workforce planning within the practice/PCN to increase throughput/productivity as appropriate

Reduce digital inequality – work with VCSE

Support from ICB primary care team

The ICB primary care team will support primary care in the establishment of Integrated Neighbourhood Teams, enhancing access and supporting the prevention agenda – this will include project support, as well as operational guidance and relevant materials.



Investment

Opportunities through existing funds to be repurposed – for example growth monies across place systems, pooling of resources

Protect the autonomy as independent practitioners but provide the framework to deliver the care through PHM lens which inevitably improves patient experience; happy workforce

One size does not fit but we need to share good practice through range of fora/platform


Will it feel any different?

What else will feel different once this plan is delivered?

- ✓ Improved patient experience and satisfaction
- ✓ There will be increased understanding of each others roles across teams and organisations
- ✓ Improved staff morale
- ✓ Improved recruitment and retention of staff
- ✓ More efficient and better value for money care provision
- ✓ Reallocation of resource where appropriate, to follow work / need
- ✓ Greater ability to make impactful decisions across organisations to improve patient care

How will we know things have changed?

- As outlined at the beginning of this document, our plan supports the delivery of the HWEICS 10 year Integrated Care Strategy and the HWEICB Strategic Framework 2022-2027, therefore we would expect to see the benefit of our key objectives reflected in the progress being made under these wider objectives, and in the relevant health and wellbeing outcomes data that is being collected.

- In addition to this, as part of delivering local projects at place as part of the plan, local monitoring should be considered to further evidence the impact that the key objectives are having – e.g local staff surveys. This will be part of the support that the ICB Primary Care Directorate will be providing.

Next steps

- The ICB primary care team will continue to engage with both primary care and the wider system about the strategic delivery plan – seeking feedback to ensure the plan is deliverable and that we have buy in from across the board

- The place teams at the ICB will work with localities and PCNs to support the establishment of Integrated Neighbourhood Teams, same day access and projects to support prevention of ill health

- The ICB primary care team will work to establish template documentation and other resources that will help in the establishment of the key objectives, such as risk sharing agreements, data sharing agreements for INTs etc

- We will work with primary care place teams to ensure appropriate KPIs are set at local level, to ensure it is possible to measure impact of the changes being made to care provision.

- The document will be taken to the ICB Board at the end of July for sign off.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	NHS HWE ICB Primary Care Board meeting held in Public				**Meeting Date:**	**25/05/2023**	
Report Title:	**Primary Care Digital Roadmap – Strategy**				**Agenda Item:**	**11B**	
Report Author(s):	Tito Clark – Project Manager, Primary Care Digital Gopesh Farmah – GP & Digital Lead Dr Parul Karia – GP & Digital Lead						
Report Presented by:	Gopesh Farmah – GP & Digital Lead						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval / Decision**	☒	**Assurance**	☐	**Discussion**	☐	**Information** ☐
Which Strategic Objectives are relevant to this report **[Please list]**	▪ *Improving outcomes in population health and healthcare* ▪ *Tackling inequalities in outcomes, experience and access* ▪ *Enhancing productivity and value for money*						
Key questions for the ICB Board / Committee:	▪ The Board is asked to review this strategy and provide feedback.						
Report History:	▪ This strategy was presented to the ICS Digital Transformation meeting on 18/05/2023 for discussion and to note.						
Executive Summary:	This strategy provides a review of the status of Primary Care as it moves into an exciting period of transformation and identifies the issues to health and healthcare within the ICB from those that experience these challenges. It is intended as a blueprint that will both guide the strategic and operational development of primary care within Hertfordshire and West Essex and emphasise its importance and contribution to the entire health and care system.						
Recommendations:	▪ The Board is asked to approve this strategy.						

Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A			
Implications / Impact:				
Patient Safety:	*No impact.*			
Risk: *Link to Risk Register*	*No risks directly linked to this strategy.*			
Financial Implications:	*No financial implications associated with approval of this strategy.*			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***		N/A	
	Quality Impact Assessment:		N/A	
	Data Protection Impact Assessment:		N/A	

Hertfordshire and West Essex Integrated Care System

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Herts and West Essex ICB – Primary Care Digital Strategy

May 2023

Working together
for a healthier future

Hertfordshire and West Essex Integrated Care System

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Introduction

Working together
for a healthier future

Herts and west Essex – an introduction

This roadmap provides a review of the status of Primary Care as it moves into an exciting period of transformation and identifies the issues to health and healthcare within the ICB from those that experience these challenges. It is intended as a blueprint that will both guide the strategic and operational development of primary care within Hertfordshire and West Essex and emphasise its importance and contribution to the entire health and care system.

Herts & West Essex ICB (HWE ICB) service a diverse population across Hertfordshire and West Essex. HWE ICB commissions local hospital services, primary care, mental health services and community services. Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry services.

We engaged with a varied level of groups and organisations within the Primary Care landscape on the content and delivery of this strategy. Engagement took place between Jan 2023 and March 2023 to ensure it appropriately reflects and is aligned with our key stakeholders' direction of travel at that time. It is noted that further engagement will be required in the future because opinions and perspectives are changeable, this level of engagement was appropriate given the timing and scope of this piece of work.

Organisations / Groups Involved
Essex LMC
Bed and Herts LMC
Primary Care Digital Forums
Digital First Primary Care
Digital Clinical Leads meeting
Essex Local Dentistry Committee
Essex Optometry Committee
HealthWatch - Herts
HealthWatch - Essex
Herts LPC - Community Pharmacy
Essex LPC - Community Pharmacy
Pharmacy & Medicines Optimisation Team
Practice Nurse Committee
Hertfordshire Partnership Foundation Trust
HWE ICB - Community
HBL IT

The Herts and West Essex ICB Digital Strategy

Herts and West Essex ICB developed a Digital Strategy in 2022. This set out the desired approach to take as an ICS for the future with a near-term focus on the coming three years. The Digital Strategy was developed collaboratively with system leadership from partners. The strategy and the associated three-year roadmap plan are built around the key areas of focus that came from those discussions, and which are building on work already in progress across the ICS from the ICS Digital strategy.

The key enablers in achieving success in digital maturity as an ICS are far broader than just technology and our ICS digital strategy therefore focuses on not only technology but applying a digital culture with commitment from all in supporting its delivery.

The Digital Vision for the ICS has been developed by the system's digital leadership team to support the overall ICS vision of:

- Care will be high quality, proactive and joined up,
- To deliver a healthier future for our population and our services,
- Our team comes together to deliver an effortless, integrated digital experience without boundaries to improve health and care outcomes for all people.

The Herts and West Essex ICB Digital Strategy

Herts and west Essex Digital Strategy Themes

Digital Collaboration
System Wide Digital Collaboration

To achieve this, we will adopt a coordinated health and care needs led approach to digital that focuses on local demands, but coordinated through place-based digital and care professional networks, closer to the resident such as GPs, social workers, pharmacists, optometrists, dentists, third sector orgs in the community.

Digital Platforms
Essential Strategic Digital Platforms

To achieve this, we will build and then enhance and optimise the key strategic digital platforms we need once for the ICS, or we will develop a fully joined up, interoperable, landscape of local platforms. We will optimise existing digital platforms wherever possible rather than building new replacements.

Digital Direct Care
Proven Digital Care Enablers

To achieve this, we will use digital technology at scale to bring care closer to our residents in their homes or the places they call home. We will focus on engagement with our users internally and residents in the co creation of new ways of digital working and make solutions easy to use and with a consistent look and feel.

Digital Innovation
Local Digital Care Innovation

To achieve this, we will pilot digital health and care innovation at smaller scale where there is a potential to grow and deploy this more widely, and we will learn from others using innovative technologies such as Artificial Intelligence, Precision Medicines and Robotics.

Digital Skills
Digital Inclusion and Workforce Capability

To achieve this, we will develop a coordinated approach with third sector partners and others to address barriers to accessing health and care services digitally, providing access to technology, information and navigation to those least able to access digital services.

Primary Care In Herts and West Essex ICB

Herts and West Essex is a complex landscape in terms of the provision of health and care, involving the organisations illustrated opposite alongside care homes, pharmacists, optometrists, dentists, third sector organisations and others in the community. Care pathways cross boundaries between places within the new Integrated Care System (ICS) and colleagues in London and Cambridge amongst others.

Services are provided by organisations that deliver similar services to other ICSs, notably EPUT, Essex County Council and Central London Community Healthcare NHS Trust.

The ICS is starting from a low technological base, resulting from a historical lack of resources and investment. This is reflected in the current baseline position against the new “What Good Looks Like” (WGLL) digital maturity framework which averages three out of five overall. However, there are several significant digital investment programmes underway.

Good progress has also been made on some large system-wide projects – notably the HWE Shared Care Record which has been described by senior clinicians as “transformational” in the delivery of care.

Landscape of HWE Primary Care

Overall

Practices: 131
Pharmacies: 300
Optometry Practices: 220
Dental Practices: 249
PCNs: 31
Patients: 1,628,794

East & North Herts

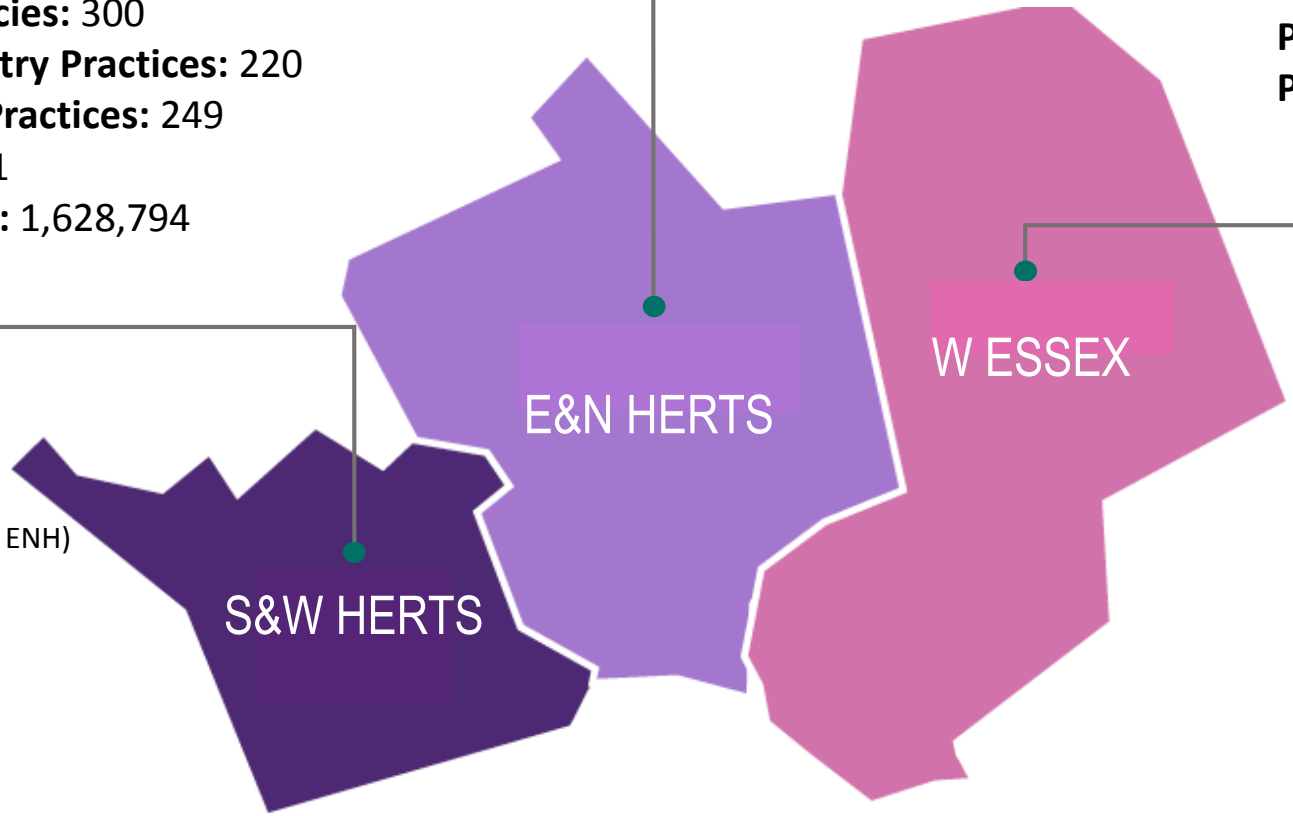
Practices: 51
Pharmacies: 240 (Inc SWH)
Optometry Practices: 186 (Inc SWH)
Dental Practices: 208 (Inc SWH)
PCNs: 12
Patients: 622,283

West Essex

Practices: 30
Pharmacies: 50
Optometry Practices: 34
Dental Practices: 41
PCNs: 6
Patients: 328,731

South & West Herts

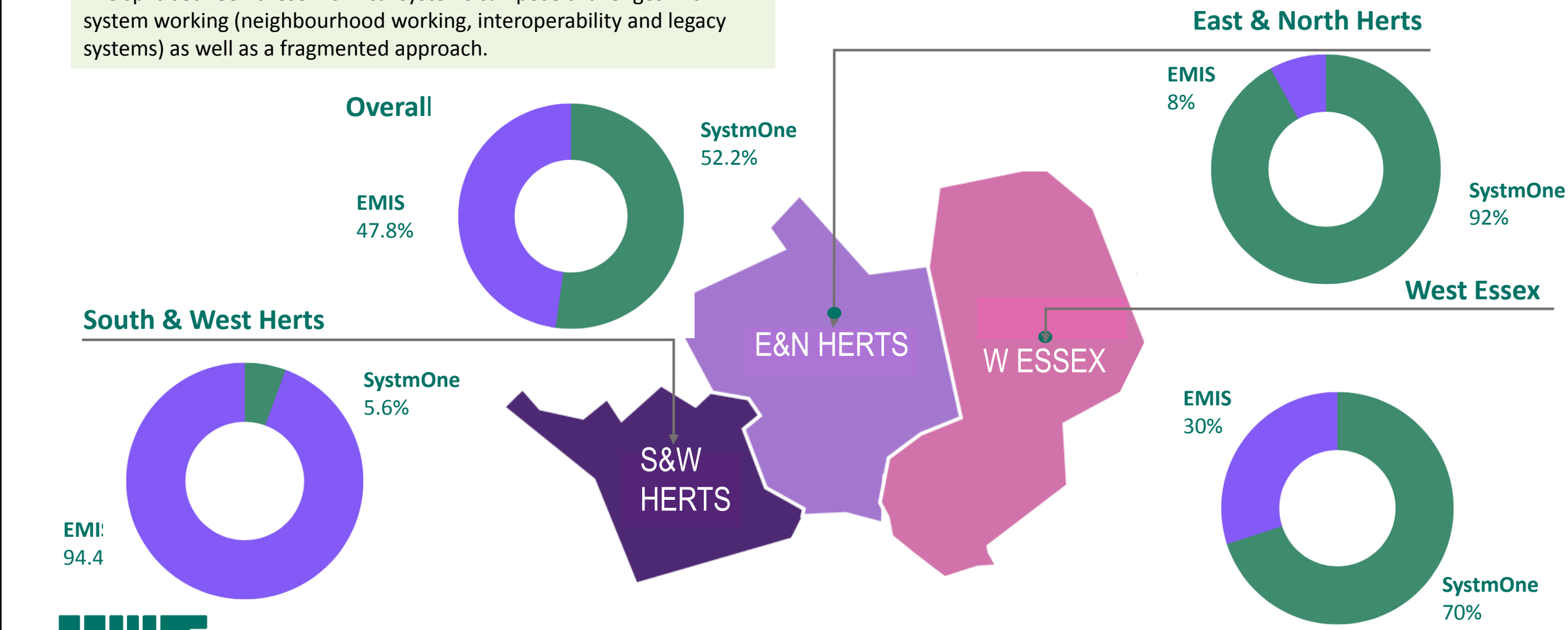
Practices: 50
Pharmacies: 240 (Inc ENH)
Optometry Practices: 186 (Inc ENH)
Dental Practices: 208 (Inc ENH)
PCNs: 13
Patients: 677,780



Hertfordshire and West Essex Integrated Care System

Variation of Patient Record Systems in General Practice

The split between these 2 clinical systems can pose challenges with system working (neighbourhood working, interoperability and legacy systems) as well as a fragmented approach.



Hertfordshire and West Essex Integrated Care System

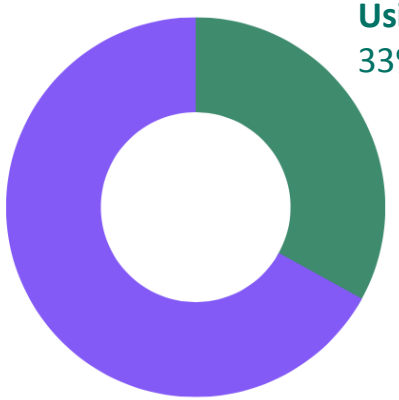
Breakdown of HWE Shared Care Record Usage

The ICB has made significant strides in the procurement and promotion of the Shared Care Record to better support the patient's health journey through the system.

Overall

	SWH	ENH	WE
Total Views	2905	668	2423
Unique Views	279	62	152
# of practices	38	16	17
% of practices using	72%	33%	52%

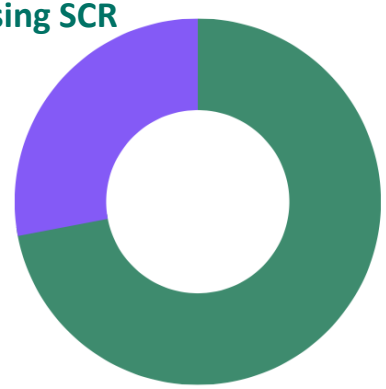
East & North Herts



Using SCR
33%

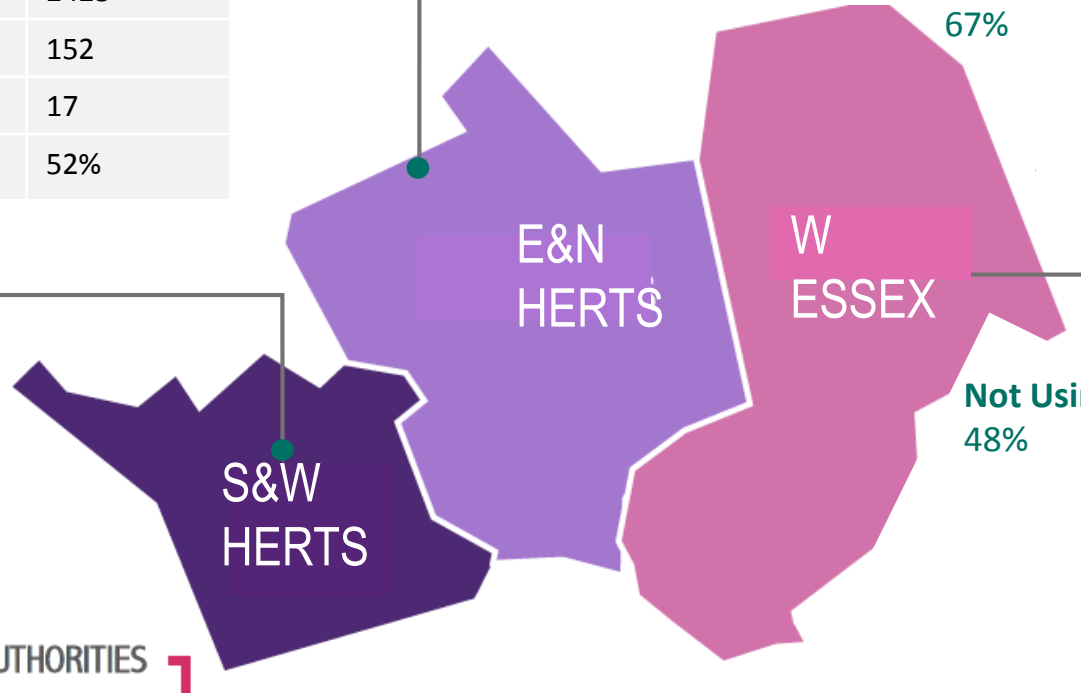
Not Using SCR
67%

South & West Herts

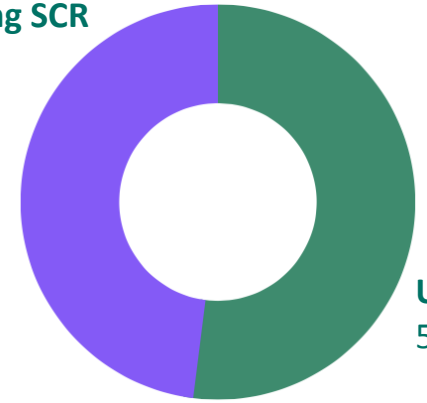


Not Using SCR
28%

Using SCR
72%



West Essex



Not Using SCR
48%

Using SCR
52%

Hertfordshire and West Essex Integrated Care System

Breakdown of HWE Online Prescription Usage (GP Only)

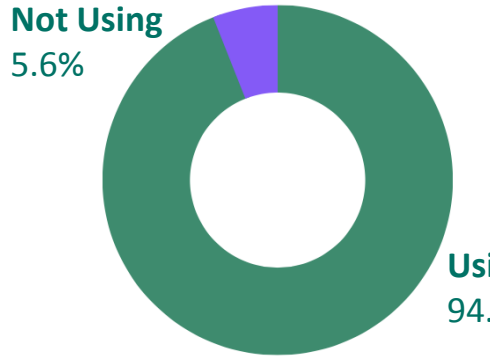
The widespread use of electronic prescriptions was directed by NHSE and the vast majority of GP surgeries use this. This is only used by GPs at present as the technology interfaces are yet to be developed in other areas of the ICB.

Overall

East & North Hertfordshire	South West Herts	West Essex	ICB	National
94.33%	93.44%	79.94%	90.86%	89.25%

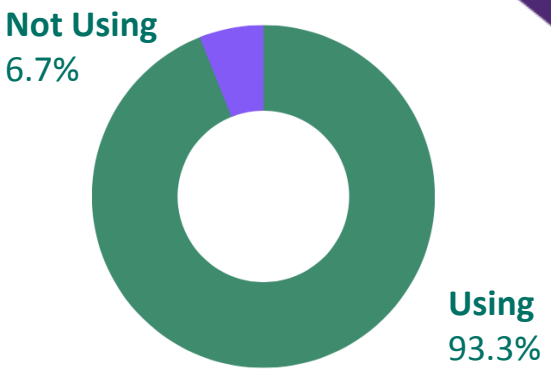
East & North Herts

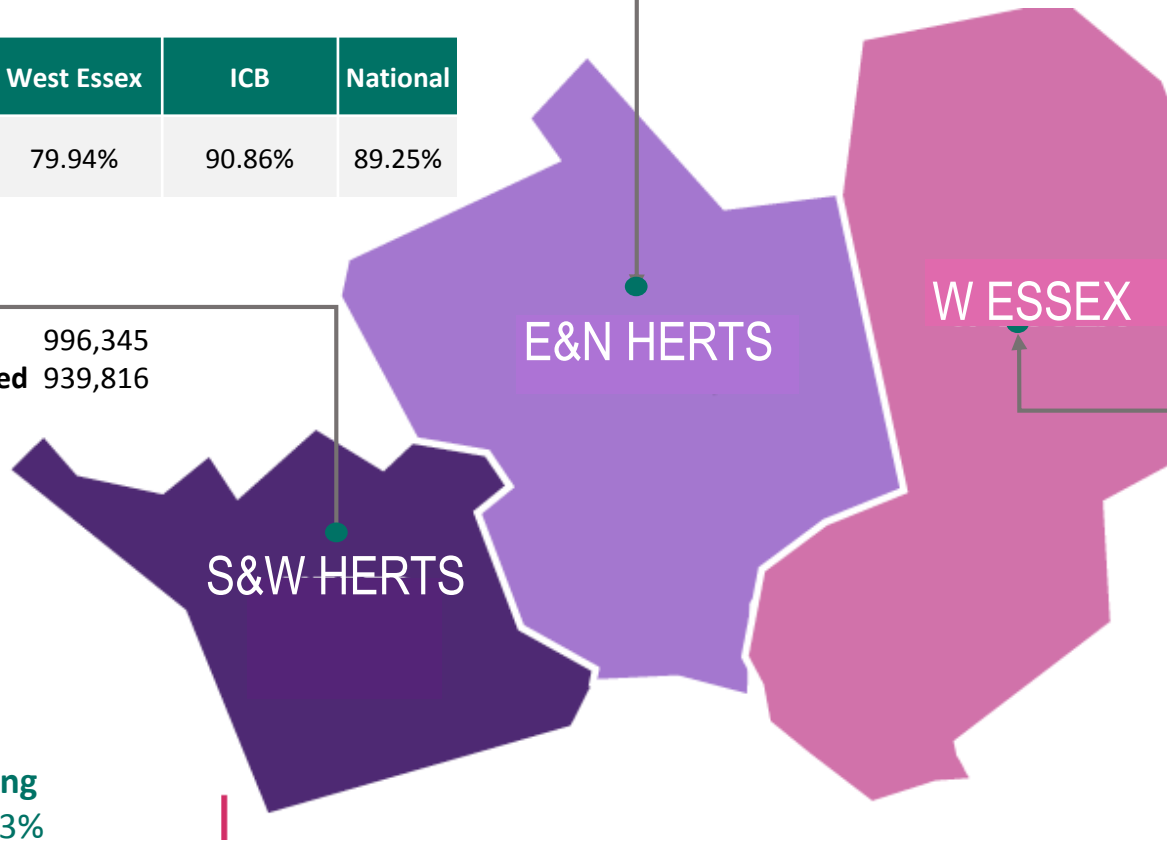
Number of Prescriptions Requested 861,672
Number of Online Prescriptions dispensed 805,125
**Dec 2022*



South & West Herts

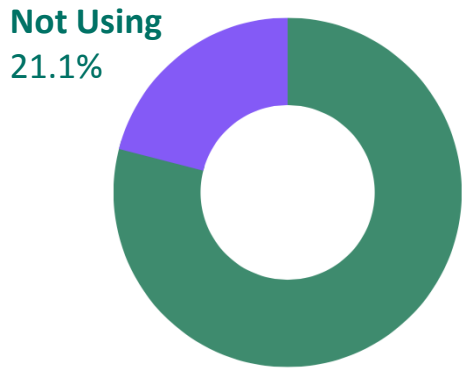
Number of Prescriptions Requested 996,345
Number of Online Prescriptions dispensed 939,816
**Dec 2022*





West Essex

Number of Prescriptions Requested 520,682
Number of Online Prescriptions dispensed 416,259
**Dec 2022*



Hertfordshire and West Essex Integrated Care System

Why do we need a Primary Care Digital Strategy Roadmap?

The Hertfordshire and West Essex (HWE) Digital Primary Care Roadmap is designed to provide a practical means of describing how and when digital initiatives, programmes and projects will be delivered to support Primary Care across Hertfordshire and West Essex. A clearly articulated and consistent vision for Primary Care strategy will be important to enable and improve collaboration with partners as we develop our Integrated Care Partnerships(ICP's) and our Integrated Care System(ICS).

The roadmap takes into account national directives as well as local needs and priorities and will remain flexible to change, providing a truly tailored digital journey for our system. The roadmap has been developed collaboratively with stakeholder engagement in all areas.

Key drivers for the Roadmap:

- Lack of clarity regarding strategic direction, projects and delivery
- Increasing deliverables regarding digitisation of Primary care services
- Increasing patient expectations regarding Digital Service offer
- Desire for a consistent baseline for Digital Primary Care throughout
- Undergoing a period of significant change in the design of Primary Care services, introducing Primary Care Networks, Integrated Care Teams etc. with technology as a key enabler

What the Roadmap is not:

- To replace organisations' or place digital strategies; rather it informs, provides a reference point and context for those.
- To Address Business as Usual digital and information technology plans
- Funded out of local budget allocations to maintain day-to-day services.
- Covering initiatives that don't meet the strategic transformation, investment or delivery principles.
- Address digital solutions specific to one organisation's specialist needs.

The inclusion of Pharmacy, Dentistry and Ophthalmology in Primary Care

On 1 April 2023, responsibility for commissioning pharmaceutical, general ophthalmic services and dentistry (POD) was delegated to integrated care boards (ICBs) with the aim of moving towards primary care services that are more joined up, locally led and locally responsive.

It is hoped that bringing together the management of these primary care functions at a system level will enable a stronger voice for primary care providers, patients, the public and other key stakeholders in service design and delivery at a local level. Devolving commissioning to a system level also helps ICBs to achieve the aspirations of the Fuller Stocktake, to improve same day access to care and advice, deliver proactive care and help people to stay well for longer.

General Practice is funded via NHSE (GP IT). We require further clarity and research around the digital systems used by Pharmacy, Dentistry and Optometry to understand how systems might work collaboratively.

Hertfordshire and West Essex Integrated Care System

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National Themes and Policies

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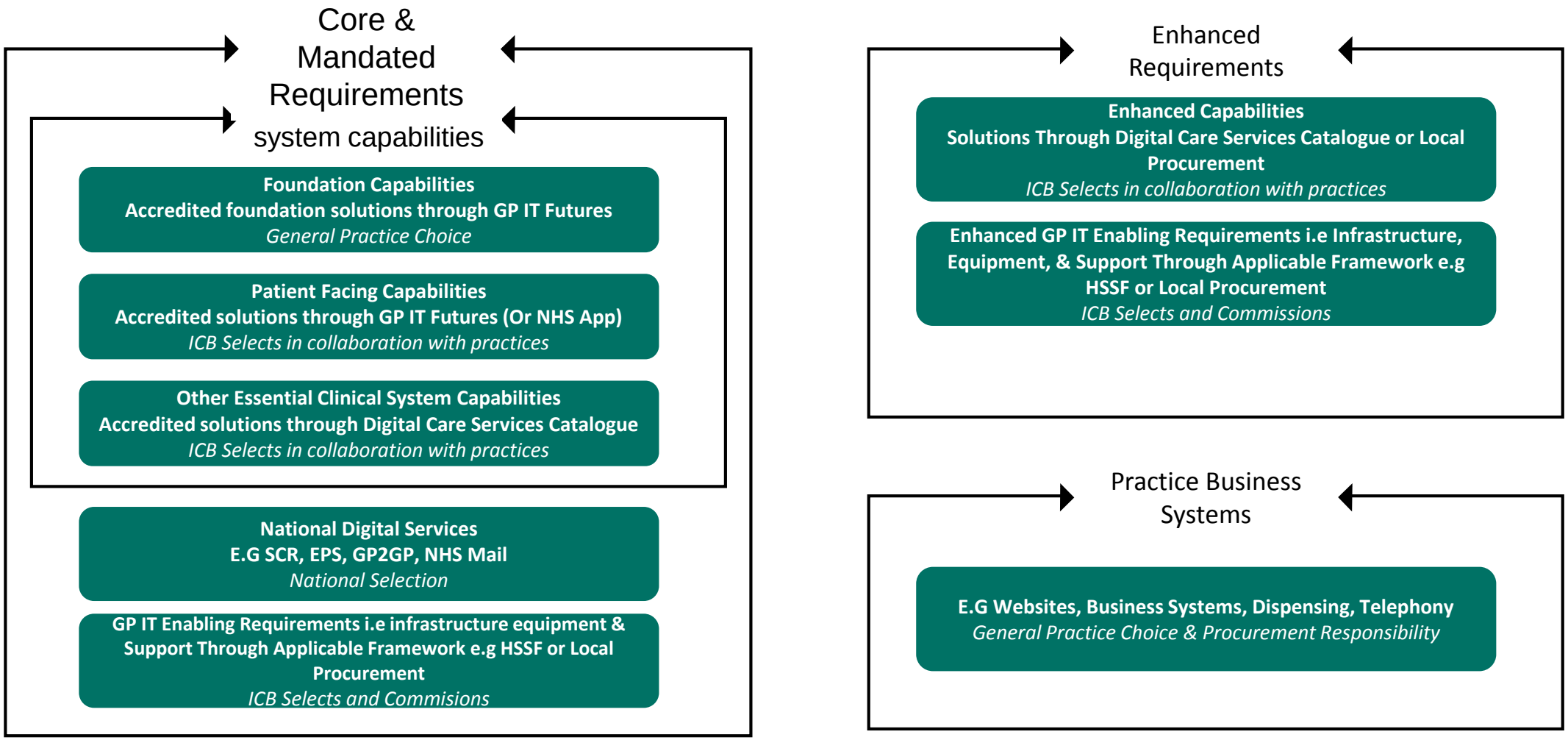
National Themes and Policy

- National GP IT Operating Framework – sets out NHSE funding and framework for GP IT systems and solutions, due to be updated in July 2023.
- Fuller Stocktake
- Delivery plan for recovering access

GP IT Operating Framework (2019 – 2023)



Hertfordshire and West Essex Integrated Care System

Fuller Stocktake (published 26th May 2022)

Stocktake undertaken by Dr Claire Fuller, Chief Executive-designate Surrey Heartlands Integrated Care System and GP on integrated primary care, looking at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry) across systems.

Key strategic themes:

- Prevention of illness
- Neighbourhood teams and management of Long Term Conditions using a Multi Disciplinary Team approach
- Managing Urgent and Same Day access

Delivery Plan For Recovering Access

[Delivery plan for recovering access to primary care (england.nhs.uk)]

In May 2023, NHSE published its delivery plan for recovering access to Primary Care. It focussed on the following 4 areas which provide key elements of the HWE Primary Care Digital Strategy :

Empowering Patients

Empower patients to manage their own health including using the NHS App, self- referral pathways and through more services offered from community pharmacy. This may relieve pressure on general practice.

Implementing Modern General Practice

Implement Modern General Practice Access to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment.

Building Capacity

Build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.

Cutting Bureaucracy

Cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

Delivery Plan For Recovering Access: Digital Themes

Utilisation of technology can empower us with information to make decisions, make processes more efficient, give staff more flexibility and reduce costs.

To help the public do more for themselves, NHSE want to make information and easy-to-use tools available by:

- **Improving access to information, appointments and NHS App functionality**

Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024.
Support all practices on analogue lines to move to digital telephony, including call back.
Provide all practices with the digital tools and care navigation training for Modern General Practice Access and fund transition cover for those that commit to adopt this approach before March 2025.

- **Supporting self-directed care**

In the 2023/24 operational planning guidance NHS England asks systems to expand this for certain carefully considered community-based services. These include selected community musculoskeletal services, audiology for older people including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services.

- **Expanding community pharmacy services**

Pharmacy First will launch before the end of 2023, subject to a DHSC-led consultation with the Pharmaceutical Services Negotiating Committee. This service will enable pharmacists to supply prescription-only medicines for seven common conditions .

It is essential that the Roadmap aligns with direction of travel of National Digital priorities in order to secure funding.

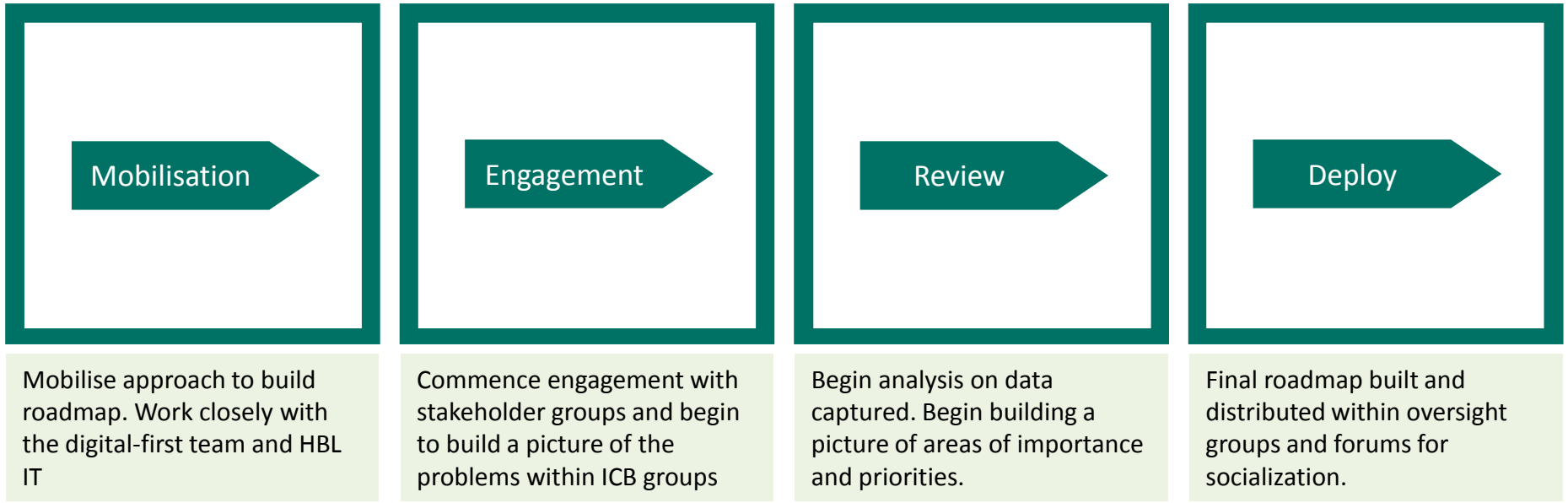
8 Expected Themes of Future Digital Funding for Primary Care:

- Make it easier for patients to contact practices by optimising telephony and online communication
- Raise the quality of navigation and triage by utilising demand and capacity tools
- Ensure appointment demand aligns with practice capacity
- Increase the range of appointments and improve the accuracy of coding appointments
- Support the retention of GP staff
- Support the reduction of overall GP workload
- Patient self-service and self-referral channels via Community Pharmacy and NHS App
- Strategic communication campaign around the evolving model for primary care access

The work we have done

In order to capture insight and perspectives to inform the roadmap, quantitative data capture forms were created and distributed to patients, practice managers and GPs. As well as this, we built lists of the organisations and groups that we were looking to interview to capture their insights and perspectives in a qualitative approach to build the roadmap.

Once we had the list of stakeholders, we began the process of finding named representatives that would be able to answer on behalf of their organisation. Once representation was agreed upon, emails and engagement commenced in order to reach out and schedule an interview or if they were unable to meet in the desired time window we would distribute them the online form to complete. Alongside this, we attended groups within primary care to ensure adequate buy-in and engagement from stakeholder groups from varied groups of stakeholders and interests.



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Engagement

Working together
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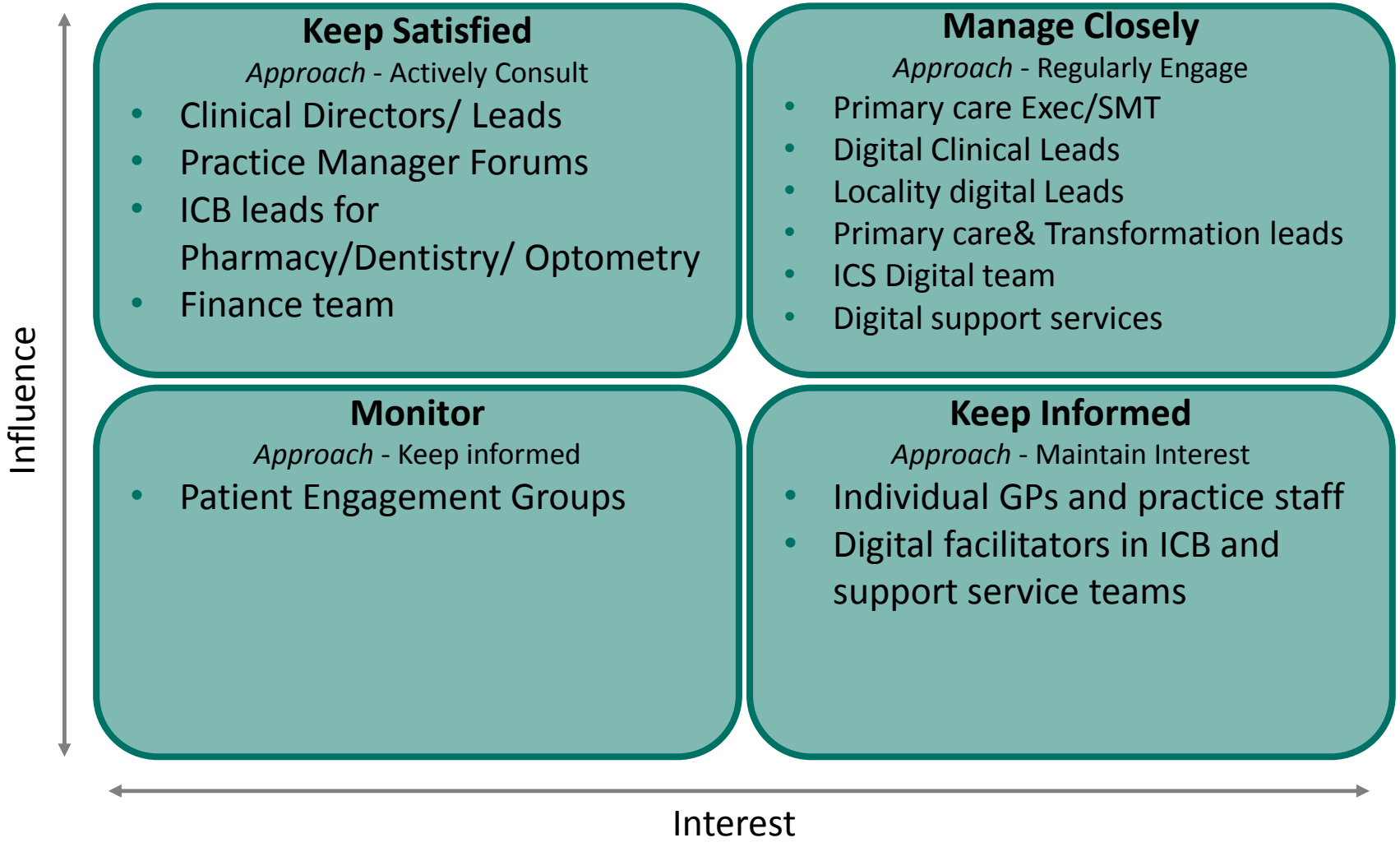
Stakeholder Mapping – Herts and West Essex Primary Care



Stakeholder Group Engagement Findings – Patients

Insights captured through quantitative surveys and interviews

- **The digital readiness of patients** – Of those that responded, 77% use online services to access their practice services. Those that responded that they don't use digital services, gave responses such as: "There are never any online appointments", "I'd prefer to speak to somebody", and "IT is very difficult and difficult to manage".

- **Patient's expectation from primary care** – 40% of those that responded indicated that they most wanted "Choice of the type of appointment offered", i.e via phone, in-person etc with 27% responding indicating that they wanted the continuity of seeing the same clinicians. Only 6% responded indicating that they wanted flexibility around appointment times.

- **Interest in accessing medical record via NHS App** – Only 8% of patients that responded indicated that they were not interested in having their medical record accessible via the NHS App.

- **Thoughts on how practices could improve their services over the next three years** – 67% of respondents indicated that they wanted easier access to clinician appointments as well as more time with the clinician.

- **Patients' attitudes towards digital** - 93% of respondents indicated that they wanted the same level or more digital options for care

Projects underway that effect Patients

Online Consultation, online consultation tools are being implemented within all practices in the ICB to support patient management.

Telephony, Advanced telephony is being offered around the practices within the ICB to support practice operations on a day-to-day basis.

NHS App, Practices are introducing the NHS app within certain areas.

Digital Inclusion, there are projects underway in order to ensure all of the tools in use are not digitally exclusive.

Stakeholder Group Engagement findings - Practices

Insights captured through quantitative surveys and interviews

- **Do Online Consultation tools aid in consultations** – From those that responded 76% indicated that they believe that Online consultation tools aid in their consultations.

- **Why do Online tools not aid in consultations** – Of the 14% that responded "No", there were responses as follows; "They reduce clinician availability to vulnerable patients that need us most, who are generally not IT literate", "not convinced that e-consult helps to reduce workload and efficiency" and "Helps with access but needs to be more smarter. in terms of questioning and integration with systmone"

- **Do patient interactions improve following usage of digital tools** – of the practices that responded only 8% said no, they don't think patient engagement has improved interactions. "Patient interactions have improved Patients benefit from not having to phone reception and "compete" at certain times of day for the available appointments", yes- as it increases access. No - as it tends to be used for asking unimportant questions(tends to be sent at 10pm from their ipad) and increases our workload without increasing the quality of care.

- **What do practices want to see from primary care in the next three years** – The top response was "Improving digital communications between primary and secondary care", and joint second were "more laptops and support for remote working" and "Help to automate back-office processes and improve workflow"

Projects underway that affect Practices

Online Consultation, online consultation tools are being implemented within all practices in the ICB.

Virtual Desktop Interface, VDI is being introduced to a group of pilot practices.

Telephony, Advanced telephony is being offered around the practices within the ICB to support operations.

NHS App, Practices are introducing the NHS app within certain areas.

Digital Inclusion, there are projects underway in order to ensure all of the tools in use are not digitally exclusive.

Stakeholder Group Engagement findings - Pharmacy

Insights captured through qualitative interviews

- **Additional digital support is required** – From our discussions it was made clear that within pharmacy there was never the level of digital support and training offered, as such there is a very varied level of digital maturity across pharmacy within the region.
- **Access to record sharing** – Another key area mentioned was the access to the Spine/Shared Care Record for record sharing for patients, with alerts indicating when medications have or haven't been dispensed.
- **ICB Reporting models** – Work has to go into aligning reporting and governance procedures for Pharmacy because there is a discrepancy between how the ICB works with General Practices and how LPC interact with Pharmacies. As it stands pharmacies act on their own accord with no wider standardization/collaboration within the region.
- **Pharmacies have autonomy on the tools they use** – there is no pre defined list of Online tools for pharmacies to use, with most it comes down to cost/benefit analysis to determine the tools suitability. Although support in awareness of digital tools would be useful.
- **Lack of digital strategy for community pharmacy** – There isn't a digital strategy for Community pharmacy.

Projects underway that affect Pharmacy

At this stage, further unification work is required to align Pharmacy within primary care.

From discussions, it was clear that there is scope for shared learning of Online systems and ways of working as well as digital maturity.

The aim for pharmacy to take on additional primary care workload as highlighted in the delivery plan for recovering access is still being negotiated at the national level. This might also include pharmacists supplying prescription-only medications. Having access to the patient record will be imperative to support this.

Stakeholder Group Engagement findings - Dentistry

Insights captured

- **Telephone triage is still key** – Dentistry offices are still utilizing telephone triage following on from the pandemic, although methods vary within each practice with some using Teams, Zoom and WhatsApp.
- **Self-reliance on tools** – Practices are also having to self-fund tools within the practice, with some practices utilizing tools such as WhatsApp to communicate with patients and share comments. Even on websites, practices are left to manage and moderate, there is no governance on this.
- **No digital strategy** – There is no strategy for dentistry, more effort is being spent to ensure workforce challenges are being managed and mitigate to ensure continuity of service.
- **Priority for the next three years is maintaining services** – the emphasis is on ensuring services being utilised are to be maintained. Monitoring to be managed to ensure uptake.
- **Access to patient records and sharing of medical history** – In the discussions this was emphasized as the key area that the ICB could support with for dentistry over the next three years.

Projects underway

At this stage, further unification work is required to align Dentistry within primary care.

Once alignment has progressed, there will be a better picture of the projects being run by Primary Care and how they can benefit Dentistry.

From discussions, it was clear that there is scope for supporting a clear standardised digital plan that seeks to stabilize and build for the future of Dentistry.

Stakeholder Group Engagement findings – Optometry

Insights captured

- **There are no practice standard tools for Digital Services -** some practices within HWE use online consultation tools but this is very varied and usage is sporadic in some areas.
- **Access to patient records and sharing of medical history** – In the discussions, this was emphasized as the key area that the ICB could support Optometry over the next three years.
- **Lack of suitable Online tools** - Due to poor commissioning nationally, as well as restrictions to access (Locally and nationally) and also the willingness of the workforce to use complex digital tools. Digital solutions do not take in requirements for optometry.
- **Optometry has no digital strategy** – Some practices may, but there is a lack of governance of practices because they are individual businesses that operate in a different manner to the GP practices in ICB.
- **No NHS Funding for digital innovation** – For practices that do minimal NHS work, these benefit from higher financial capital, whereas lack of NHS funding causes difficulty in digital innovation.
- **Top priorities for next three years** – 1 – Electronic referral system, 2 – Access to spine, 3 – Support for the uniform provision of community services and digital processes.

Projects underway

At this stage, further unification work is required to align Optometry within primary care.

Once alignment has progressed, there will be a better picture of the projects being run by Primary Care and how they can benefit Optometry.

From discussions, it was clear that there is scope for shared learning of Online systems and ways of working as well as digital maturity.

Digital Inclusion in Herts and West Essex ICB

Late 2021 a report was commissioned from We Are Digital to gain insight into digital inclusion and explore why certain patient groups struggle to engage with the digitization of healthcare. The full report that was published in May 2022 is available upon request.

Projects are currently underway to support and promote digital inclusion within HWE. This work is under the remit of the Herts and West Essex Voluntary, Community, Faith and Social Enterprise (VCFSE) Alliance. This group seeks to ensure that all developments and services look at the "Community end of the pathway" to ensure digital inclusion is at the forefront of projects.

Eleven million people (20% of the population of the UK) lack basic digital skills, or do not use digital technology at all. These are likely to be older, less educated and in poorer health than the rest of the population. It is imperative local health and care services take into account the needs of people who may be digitally excluded.

Digital Inclusion in Herts and West Essex ICB

According to the 2020 ONS internet user survey, there are an estimated 70,000 internet non-users in HWE. Based on our research, we estimate that of the 1.61m patients registered with a GP practice in HWE, **approximately 87,000 lack the skills or confidence to access digital services** and that over 64,000 have internet safety concerns that prevent them using digital channels to access personal healthcare services.

Digital exclusion is affecting a significant proportion of primary care patients in HWE;

- Over a quarter of surveyed patients (26%) strongly disagreed that they always prefer to use websites to access services than speak to somebody
- **15% strongly disagreed** that they are confident to use digital services
- **8% strongly agreed** that the internet is not secure enough to share information about their health online.

Digital Inclusion in Herts and West Essex ICB

There is a significant difference between patients' general communications preferences and their preferences for contacting personal healthcare services;

- 33% of patients (the largest group) preferred website-only communications with service providers, followed by a mixture of phone and website channels,
- **Most (56%) patients preferred to contact healthcare providers by phone only**
- 30% of people surveyed preferred digital channels only, with the most common reason for not using digital channels being negative experiences of using online services and being more easily able to access services via non-digital channels.

Male, older and disabled patients and those registered with GP practices in deprived areas are more likely to be digitally excluded and, older patients particularly, are more likely to have a strong preference for contacting their GP practice via non-digital channels. Digitally excluded patients are also more likely to have a higher level of contact with their GP practice, with **those in the most digitally excluded group being twice as likely to have had contact with their GP practice twelve or more times in the previous year** than any other group.

Our intention is to embed the support of the digitally excluded within the primary care digital roadmap, to ensure the needs of the most vulnerable are part and parcel of any process that is being developed.

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Alignment of ICB & Primary Care Digital Strategy

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The Herts and West Essex ICB Digital Strategy & Digital Primary Care Alignment

What digital capability will we deliver?	Due
Invest in a sustainable multi-disciplinary digital care professional "office of the CCIO" at ICS level.	Q1/23
Invest in Digital Board education as part of the Programme of developing digital awareness and capability.	Q1/23
Invest for the long term in digital clinical fellows at ICS levels and care professional digital leads for all ICS organisations.	Q4/23
Introduce a quality improvement method at ICS level in support of the identification of digital initiatives.	Q1/24

What does this include?

• We will focus on communication, collaboration and leadership of digital change involving care professionals at all levels and across all settings, and engagement of and co-creation of solutions with our residents.
• The Governance model will be adjusted to support the new landscape ensuring alignment with the strategy and driving benefits for residents, care professionals and partner organisations.
• By 2025 we will deliver a well-led, well-governed, accessible digital ecosystem in terms of collaboration for Residents and care professionals meeting relevant technical and safety standards.
• We will aim to deliver digital solutions once for the common good converging existing solutions in line with our investment principles and national ambition for the convergence of health and care digital technologies.
• We will develop a coordinated, professionally led approach to digitally enabled safe care, collectively making recommendations for investment and focus on support of our ICS priorities.
• We will aim to "level up" our capability on data quality, removal of paper processes, and digital maturity.
• We will promote the use of shared funding, resources and acquisition of digital solutions across the ICS where this is in line with our investment and delivery principles.
• We will ensure ICS to ICS collaboration to make sure that our residents are cared for across ICS borders or between places within our ICS, and that we build our digital solutions in a seamless way that supports this.

Themes we captured from our engagement

Shared learning is crucial within primary care to develop better ways of working and cross-area benefits. From a Dentistry, Pharmacy and Optometry perspective there was not the digital learning support provided to practices in previous years, so there is huge scope for shared learning within primary care and lessons from General Practice to bring those areas up to speed.

Hertfordshire and West Essex Integrated Care System

The Herts and West Essex ICB Digital Strategy & Digital Primary Care Alignment

Build & Optimise
Essential strategic digital platforms

What digital capability will we deliver?	Due
Shared Care Record	25 – for all care pathways
Electronic Care Record	22 –27
Shared Data Platform and Population Health Management (PHM) technologies	24
Resident Access platforms	24
Care Coordination Centre(s)	24
Shared infrastructure	23

What does this include?

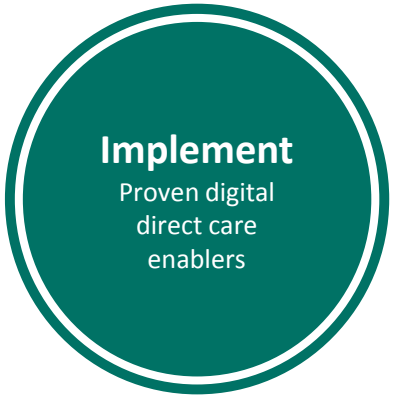
- The digital MUST DOs for strategic platforms in the NHS Long Term Plan.
- Further developed Shared Care Records including ICS to ICS connectivity to bring together the full picture of our resident's health and care needs.
- Create a focus on high-quality data to high-quality care and meaningful analytics.
- Shared Data Platform and Population Health Management (PHM) technologies to help us better understand the needs of the population we serve using modern approaches such as predictive analytics.
- Resident Access platforms to enable our residents to access their information and engage with and manage their own health and care whilst respecting their preferences.
- Care Coordination Centre(s) to coordinate health and care provision.
- Electronic Care Record convergence to bring together the clinical platforms used by health and care professionals both within our ICS and beyond it.
- Shared infrastructure where appropriate to provide a standardised and lower cost service to our teams, more effective collaboration and MDT working, resident access and to support the HWE green.

Themes we captured from our engagement

Within Pharmacy, Dentistry and Optometry there are gaps in the patient journey due to a lack of access to the patient care record or NHS Spine-related infrastructure. Access to this technology will enable greater collaboration and safer care for patients. Access to this technology needs to be integrated, instead of just "made available" to ensure adoption and utilisation.

Hertfordshire and West Essex Integrated Care System

The Herts and West Essex ICB Digital Strategy & Digital Primary Care Alignment



What digital capability will we deliver?	Due
ASC DTF Falls Prevention to be used to protect 20% of care home residents by 2024.	Q3/24/25
Early Memory Diagnosis and Support Remote Monitoring of SMI patients	Progressive once agreed to 24/25
Wound Care Digital App for Community Nurses	Progressive once agreed to 24/25
Virtual Ward and Hospital programmes	Progressive once agreed to 26/27
Online/Virtual Consultation Expansion	Progressive once agreed to 26/27
Secondary Care physician support and advice to Primary Care clinicians	Progressive once agreed to 26/27

What does this include?

NHS Long Term Plan MUST DO objectives that focus on out of hospital care settings co-created with our residents focusing on “connected lives”.

- Supporting Elective Recovery ensuring direct care initiatives are aligned with improved pathways where possible
- Digitally enabled objectives set out in the Primary Care Strategy 2022.
- Virtual Wards and Hospital@Home in line with the national priorities to provide top class care remotely in peoples’ homes.
- Remote monitoring to enable us to monitor the health and care needs of our residents and provide direct care when needed.
- Increased use of online/virtual consultations, supporting the HWE green plan and reduced travel and inconvenience for service users.
- Assistive Technology to support residents who need help with their daily living needs.
- Secondary Care to Primary Care specialist advice and support leading to the removal of consultations, where appropriate, and supporting interventions through more proactive care introducing specialists at the right time.
- Cross-care setting bed management, demand and capacity/scheduling/case management systems

Themes we captured from our engagement

It is important to understand the role that digital maturity and digital inclusion play in the adoption of technology and tech-enabled processes. Whilst all areas in primary care may have access to the same technologies, there is vast difference across the landscape in terms of readiness to integrate. Shared learning and support on integration is crucial to embed change and begin to realise benefits.

Hertfordshire and West Essex Integrated Care System

The Herts and West Essex ICB Digital Strategy & Digital Primary Care Alignment

Target
Local digital care innovation

What digital capability will we deliver?	Due
Established links with the wider NHS, universities, AHSNs, and others aligned to explore and testing new tech for care in line with the NHS Long Term Plan.	23
Remote monitoring and resident owned devices	24
Robotic Process Automation	Progressive once agreed to 26/27
AI Diagnostics including expansion of pilot for MRI & prostate, and support for cancer diagnosis	Progressive once agreed to 26/27
Genomic treatments to support cancer patients	Progressive once agreed to 26/27

What does this include?
Innovation where there is capacity to invest in this at ICS level and where it makes sense from the overall perspective of digital maturity of the system.

- New medical devices and approaches.
- We will explore the use of robotic process automation to reduce costs and save time in our back office.
- We may explore “Artificial Intelligence” applications where appropriate including machine learning and data science for Population Health Management.
- We will seek to adopt precision medicine technologies as they become proven.
- We will horizon scan to understand the full potential of digital health and care technologies for our population.
- We will leverage Virtual/Augmented Reality (e.g. remote assistance for community working).
- We will consider providing a safe space for innovation including working with external innovators and research companies.
- We will build on health and care innovation being developed by near neighbours such as Cambridge University Hospitals and in London.

Themes we captured from our engagement

There is appetite for new technologies to enable processes within primary care but these are reliant on ensuring digital maturity across organisations within the ICB. Access to forums and opportunities to ensure all organisations are digitally mature enough to utilise new technologies. It is also key that new technologies are aligned to the digital inclusion of patients in the region by offering the core functionality and accessibility that is required to core adoption.

Hertfordshire and West Essex Integrated Care System

The Herts and West Essex ICB Digital Strategy & Digital Primary Care Alignment

What digital capability will we deliver?	Due
Supporting people without access to technology to gain access and the skills to interact with their health and care providers digitally when they wish to.	25
Support services for digital access to health and care commissioned across all of the communities we serve.	23-27
By March 2025, constituent organisations of an ICS have: established digital, data and technology talent pipelines, and improved digital literacy among leaders and the workforce	24-26

What does this include?

• We will build the digital capacity, capability and confidence of our staff at all levels from front line to Board.
• We will always ensure that the digital solutions we build are easy to use, and work towards a unified digital interface across our ICS both for care professionals and residents whilst recognising our resident preferences for accessing services.
• We will understand, monitor and tackle digital exclusion in our communities where we can, but always ensure that
no-one is excluded from safe, excellent care, leveraging the excellent work Social Care and the third sector are already delivering.
• We will work to create a culture that is comfortable with the use of digital solutions for staff to deliver care across all care settings.
• We will engage with national initiatives to close the digital divide for health and care including empowering residents via the adoption of the NHS App, NHS Apps library, GP online services and free NHS Wi-Fi
• We will build trust in digital solutions for our residents through co-creation with them and through the skills and confidence of our teams in using them to provide safe care.
• We will encourage the safe and appropriate use of digital technologies that operate to recognised standards and ensure that we safeguard the wellbeing of our staff and residents online.

Themes we captured from our engagement

The facilitation of shared learning and guidance forums is a useful commodity to practices and PCNs within primary care. There is a need for access to similar forums for Dentistry, Pharmacy and Optometry in order to filter through the shared learnings. As it stands, these areas do not have a digital strategy, these types of forums can help raise awareness around benefits and efficiencies from the utilisation of digital capabilities.

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Primary Care Digital Roadmap

May 2023

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HWE Primary Care Digital Roadmap

The following slide describes the Primary Care digital roadmap from 2023-2025. We have drawn on the National priorities and themes for Primary Care to map key milestones. The themes from the overarching HWE ICB digital strategy have been colour coded (see key on this slide) to show where they align with the existing primary care digital projects already in place for 2023 and those that are planned for the next two years.

The results of our engagement with stakeholders highlighted the relative digital immaturity of the Pharmacy, Ophthalmology and Dentistry. The need for shared learning and collaboration on digital projects, together with the adoption of the shared care record and streamlining the patient journey still needs to be developed.

The Roadmap includes forward-thinking projects, such as developing electronic prescribing functionality across systems, resourcing the training and development of the Primary Care workforce to optimise the use of existing digital tools, using data analytics to map demand and capacity, supporting practices with transforming their delivery of care and supporting process change once AI tools and Robotic processes are fully functional. In addition, the empowerment of patients to self-care and navigate primary care through the use of a fully functioning NHS App is highlighted.

Supporting the needs of digitally excluded citizens is assumed to be integral to all projects and processes.

Roadmap Item Categorisation

Digital Collaboration
System-Wide Digital Collaboration

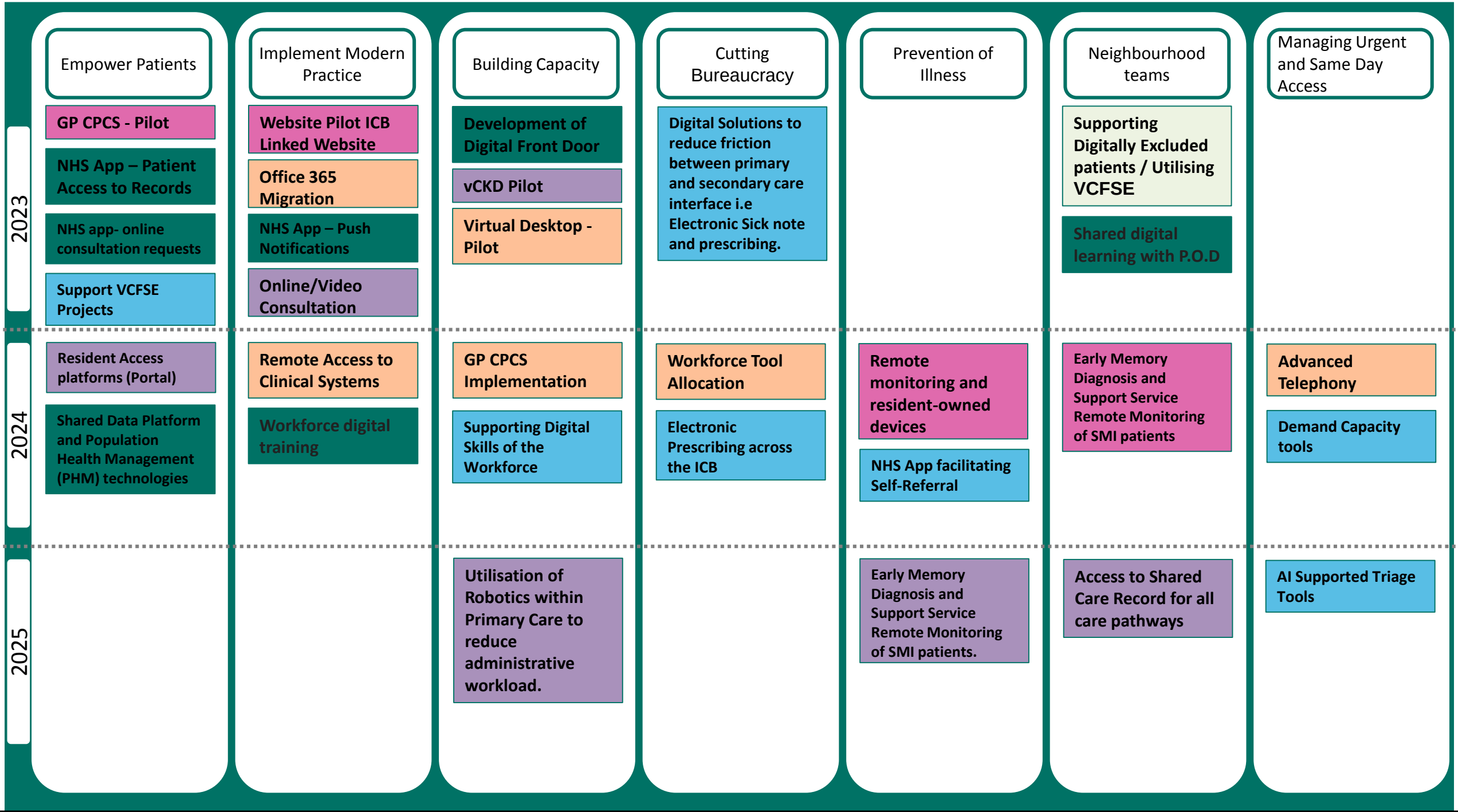
Digital Platforms
Essential Strategic Digital Platforms

Digital Direct Care
Proven Digital Care Enablers

Digital Innovation
Local Digital Care Innovation

Digital Skills
Digital Inclusion and Workforce Capability

Prospective Projects
Projects identified

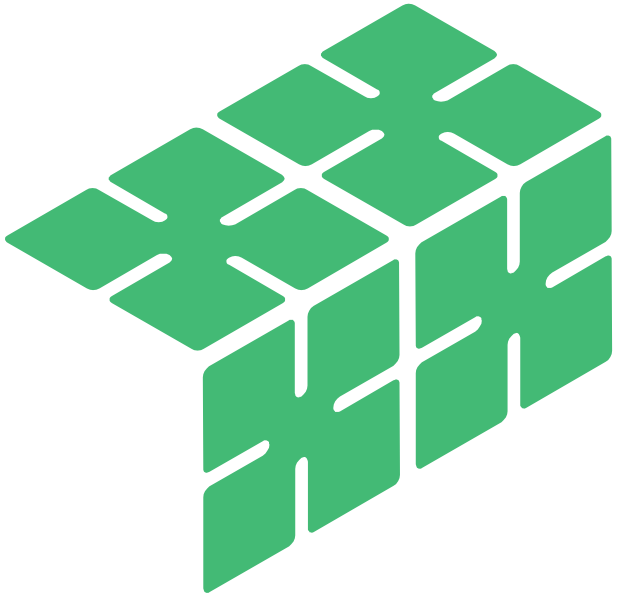

Empower Patients
Implement Modern Practice
Building Capacity
Cutting Bureaucracy
Prevention of Illness
Neighbourhood teams
Managing Urgent and Same Day Access
2023
2024
2025
GP CPCS - Pilot
NHS App – Patient Access to Records
NHS app- online consultation requests
Support VCFSE Projects
Website Pilot ICB Linked Website
Office 365 Migration
NHS App – Push Notifications
Online/Video Consultation
Development of Digital Front Door
vCKD Pilot
Virtual Desktop - Pilot
Digital Solutions to reduce friction between primary and secondary care interface i.e Electronic Sick note and prescribing.
Supporting Digitally Excluded patients / Utilising VCFSE
Shared digital learning with P.O.D
Resident Access platforms (Portal)
Shared Data Platform and Population Health Management (PHM) technologies
Remote Access to Clinical Systems
Workforce digital training
GP CPCS Implementation
Supporting Digital Skills of the Workforce
Workforce Tool Allocation
Electronic Prescribing across the ICB
Remote monitoring and resident-owned devices
NHS App facilitating Self-Referral
Early Memory Diagnosis and Support Service Remote Monitoring of SMI patients
Advanced Telephony
Demand Capacity tools
Utilisation of Robotics within Primary Care to reduce administrative workload.
Early Memory Diagnosis and Support Service Remote Monitoring of SMI patients.
Access to Shared Care Record for all care pathways
AI Supported Triage Tools

Roadmap

The high-level roadmap for the next 3 years and our 3-year investment plan build around the described themes, and also recognises the need to maintain flexibility in a challenging funding environment to deliver on our ambition. It sets out the technology that we are already in a position to optimise, new capabilities that we need to build, and processes that will ultimately bring us to a point of digital maturity that enables digital infrastructure to underpin the continuous improvement of the quality of the care we deliver to our residents. We will also work with our residents and listen to their preferences for interacting digitally.

We will use the following investment and delivery principles to guide our decisions and ensure that we deliver successfully and responsibly:

- Prioritise the solutions that residents and staff need
- Optimise the potential of digital suppliers
- Set clear, realistic goals (S.M.A.R.T.)
- Invest in a dedicated, expert ICS Digital/Transformation team
- Think long term, deliver in the short term
- Use data and evidence to drive learning
- Adapt and change in response to challenges in order to maximise benefits
- Build trust in digital solutions and infrastructure



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Lessons learnt & Risks

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Lessons learned

There are varying levels of digital maturity across the ICB with the new areas being introduced. Forums such as the DIG (Digital Innovation Group) and support offered by the Digital Front Door team will be crucial in order to support and help all areas understand the systems available and how to correctly embed them.

There needs to be support for opportunities for shared learning. The utilisation of Shared learning is required across all areas of primary care, to enable collaborative development within primary care. Sharing knowledge not only helps to learn from others and exchange ideas, but is essential for enabling change. It allows new research and evidence to be more easily spread and to make its way into practice more quickly. Learning, particularly in health and social care, is a fundamentally social act.

Record sharing is a significant requirement, *The Shared Care Record is allowing shared medical record access by connecting hospital EPRs to primary care networks. This is inline with national aims to ensure all clinicians have access to the full medical record.* There is a need for all areas within primary care for the ICB to have access to the patient's medical record and history. This should be supported with the implementation of the NHS App having access to the surmised patient record and enablement of Spine access to organisations involved in patient care within the ICB.

Digital tools can support practice operations by saving time and telephone calls but they have to be appropriately embedded, and this is not a one size fits all situation. Time and effort has to be exerted within the practice and outside the practice to ensure the models align with operating procedures for benefits realisation.

Risks and challenges to Primary Care

Within primary care, the landscape is always moving and changing, but the ICB will never invest in digital technology that might compromise the safety or quality of care of our residents. We may take balanced risk decisions to invest where the technology is proven to be safe and valuable at small scale, but unproven to be fully effective at a larger scale. We will occasionally actively seek to invest in digital technology innovation and take delivery and financial risks to innovate digitally where there is potential for significant benefits for our residents.

Our strategic risks

- **Funding**, Funding may not match our ambition - Mitigation via application of our investment principles, robust business cases and assurance processes and readiness to respond to funding opportunities.
- **Resource**, Resources may not be available to deliver our ambition – Mitigation via application of our delivery principles.
- **Governance**, Changes to policy or legislation may impact our strategic approach - Mitigation via a re-appraisal of the emphasis of our strategy within the overall mission rather than a wholesale change of strategy.
- **Duplication of effort**, Competing approaches to the same problem – Mitigation via rigorous application of our approach to business cases and investment and a “fund once only” approach at ICB level to common problems.
- **External influence**, Events in the external environment that impact our strategy – This includes unforeseen disruption to supply chains and populations such as a pandemic, economic downturn or global catastrophe.

Avni / Adam closing comments

Hertfordshire and
West Essex Integrated
Care System

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	NHS HWE ICB Primary Care Board meeting held in Public				**Meeting Date:**	**25/05/2023**	
Report Title:	**Delegation of Pharmacy, Optometry and Dental Commissioning - Update**				**Agenda Item:**	**12A**	
Report Author(s):	Jan Coates, Head of POD Delegation Rachel Halksworth, Assistant Director for Primary Care Contracting						
Report Presented by:	Rachel Halksworth, Assistant Director for Primary Care Contracting						
Report Signed off by:	Rachel Halksworth, Assistant Director for Primary Care Contracting						
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☐	**Information** ☒
Which Strategic Objectives are relevant to this report **[Please list]**	▪ Improving outcomes in population health and healthcare ▪ Tackling inequalities in outcomes, experience and access ▪ Enhancing productivity and value for money ▪ Develop the ways of working and profile of the integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working.						
Key questions for the ICB Board / Committee:	The Committee is asked to note the content of the report						
Report History:	Previous updates to Committee provided 23/03/23						
Executive Summary:	As below						
Recommendations:	To note the contents of the report						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			
	N/A						

Implications / Impact:		
Patient Safety:	N/A	
Risk: *Link to Risk Register*	N/A	
Financial Implications:	N/A	
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A

1. Executive summary

As of 1st April 2023, ICB's have taken on responsibility for the pharmaceutical, general ophthalmic and dental services under the terms of the Delegation Agreement with NHSE. This is for both the Commissioning and Contracting functions.

Hertfordshire and West Essex ICB are hosting the pharmacy and optometry (P&O) team for the six ICB's in the East of England, under a Memorandum of Understanding (MOU) which has been fully executed.

The Delegation Agreement has been fully executed by all parties and NHSE prior to the delegation on 31st March 2023. The ICB should be aware the concerns around the TUPE transfer, financial risks and information shared relating to the delegation were raised at the PCCC on 21st February 2023. The DPIA and DPA have been fully executed and shared with the relevant parties.

The ICB Governance Handbook has been updated to reflect the delegation of these services to the HWE ICB. The SoRD has been drafted and will be presented to the next Board meeting in May.

2. Background

Initially in October 2022, the ICB submitted a Pre-Delegation Assessment Framework to the regional team, inclusive of RAG ratings, which were mainly rated as RED due to the lack of information.

Following on from this each ICB was asked to complete a Safe Delegation Checklist (SDC) which RAG rated the ICB position against the indicators outlined in the SDC: Transformation and Quality, Governance and Leadership, Finance, Workforce, Contracts, and IG, IT and Records. The ICB task and finish group met on a weekly basis to update the progress and any issues. Overall at the point of delegation, we were rating ourselves as Amber though noting this was due to Region wide risks and not a barrier to delegation.

We also met on a weekly basis with NHSE and the five other ICB's in the Region to share updates, concerns, and any issues relating to this delegation.

The below outlines the contracts for POD transferred to HWE ICB:

Community Pharmacies	-	276
Opticians	-	225
Dental Practices	-	243

3. Actions since last update

The main focus of activity since the update to Committee in February has been the safe transfer of staff under TUPE form NHSE to HWE ICS. This has meant close working with colleagues in HR and finance to ensure a smooth handover. Two

welcome sessions were held in the last week of March to meet the new team members, undertake employment checks and issue IT equipment. These were well attended and received.

In addition, the MOU for P&O Contracting function has been signed by all 6 ICBs. A data sharing agreement is in place between the ICB and NHSE and the Delegation Agreement between NHSE and ICB has been executed. HWE ICB Scheme of Reservation and Delegation (SoRD) has been updated to reflect the changes and will be submitted to the HWE ICB Board in May.

4. Ongoing actions

Staffing

There are several areas where there are ongoing teething issues, around practical issues such as access to the Electronic Staff Record (ESR) for staff. We are working these through on a case-by-case basis.

There was a member of staff that declined to TUPE and we are therefore carrying an additional vacancy, with the consequent impact on capacity. In addition, the team are confirming with NHSE that resourcing for the vacancies has transferred so that the ICB can recruit to these posts.

IT

The team are working with NHSE to ensure we have ongoing access to relevant files and documentation.

Workplan

As highlighted in previous updates, there is a significant workload in business as usual (BAU) and transformation for Dental in particular and the team are developing a workplan which will be presented to a future Committee. There is a linked piece of work on how we have oversight of quality across the 3 additional contractor groups which the contracting team will work closely with quality, business inteligence and clinical colleagues to develop.

5. New issue

The Committee is asked to note a new issue arising, the Pharmaceutical Services Regulation Committee which covers the East of England region, will be hosted by HWE ICB on behalf of all 6 ICBs. It is a mandatory committee which is described in the Pharmacy Manual.

The Terms of Reference for this meeting differ from last year, in that previously Fitness to Practice Applications were delegated by PSRC in East of England to the Performers List Decision Panel. This is no longer allowed under the Regulations and therefore this becomes the responsibility of PSRC.

The PSRC will be administrated by the Pharmacy and Optometry Team and the lay member will continue on the Committee. The Chair and Vice Chair will be ICB officers,

Director of Primary Care Transformation and Assistant Director for Primary Care Contracting. A Clinical Advisor from the Professional Standards Team will be present to provide continuity and experience on Fitness to Practice.

In addition, the ICB has contracted PCC CIC to provide expert advice to the Committee and training for Committee members on Fitness to practice.

In addition, the management of Fitness to Practice applications will in future come under the P&O team. This has been agreed to transfer when there has been recruitment to a new administrative role within the team, and a sufficient handover and training has been completed.

There is also a live discussion on when all Pharmacy fitness concerns are delegated. These currently sit within the Professional Standards team at NHSE. There is clinical expertise and experienced case workers managing historic and new cases where there are clinical or professional concerns. The current position is to hold to business as usual until a safe delegation process can be established and completed. This paper is formally noting the risks inherent in this proposal.

NHSE are providing programme support to this workstream and there will be an update to the Board at the next meeting.

6. Next Steps

The transition phase of the delegation is broadly complete.

It is proposed that the contracting team run a development session for Primary Care Commissioning Committee (PCCC) and Primary Care Board members, looking at how the contracts are constructed and managed to assist in future discussion and decision making.

A work plan for the year, with prioritisation, will be submitted to a future meeting for discussion and agreement, with the governance for Pharmacy, Optometry and Dental now embedded at PCCC.

An update on the proposal to move Pharmacy concerns to ICBs will be presented to a future meeting of this Board.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	NHS HWE ICB Primary Care Board meeting held in Public				**Meeting Date:**	**25/05/2023**	
Report Title:	**Update on dental services including areas of priority**				**Agenda Item:**	**12B**	
Report Author(s):	Michelle Campbell, Head of Primary Care Contracts						
Report Signed off by:	Avni Shah, Director of Primary Care						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	N/A						
Executive Summary:	The delegated responsibility for Dental Contracting and Commissioning functions were transferred to the ICB from 1 April 2023. This paper provides the Board with an overview of the current dental contracts across the ICB and highlights priority areas of the current dental workplan. There are several contracts that are due to end in March 2024 and therefore a prioritisation plan will need to be agreed so that any potential procurement for services is staggered to ensure continuity of care. A sub-group of the Primary Care Board is being developed to support the Dental Transformation programme and future papers will be submitted to the Board to agree the strategic direction and priorities for primary, community and secondary care dental services.						
Recommendations:	The Board is asked to note the content of the paper.						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☐

1. Executive summary

From 1 April 2023, ICBs became responsible for the contract and commissioning functions for the all primary care contractor groups; Pharmaceutical, General Ophthalmic and Dental services (POD) as well as GP.

Since the delegated responsibility for Dental contracting and commissioning functions transitioned over to the ICB from 1 April 2023; including the TUPE of the appropriate staffing resource, the primary care contracting team have been reviewing the current contracts and pathways to understanding where there are gaps in services or areas of priority that need to be addressed to meet the oral health needs of the HWE ICB population.

Prior to the transition of the delegated functions to the ICB, NHS England agreed to extend a number of contracts that were due to expire on 31 March 2023 to ensure continuity of care to patients until the longer-term commissioning approach has been identified and agreed; all these contracts have been extended for 12 months up to 31 March 2024 and will need to be reviewed during 2023-24 to understand the options for future provision of these services.

Regular meetings are held with both the Hertfordshire and Essex Local Dental Committees who have provided the ICB with a list of areas that they feel need to be addressed; this has been gratefully received and has been considered when developing the dental workplan.

In addition to the dental service provision and current pathways, the ICB will need to focus on the oral health needs of its population and have a longer-term plan on dental transformation to address improving oral health. A Dental Health review has recently been undertaken by East of England Dental Public Health team and we are liaising with the Consultant in Dental Public Health to understand and identify the key points identified as part of the review.

2. HWE Dental Contracts and Workplan

There are 2 types of national dental contracts:

General Dental Services (GDS) – provision of mandatory dental services under contracts in perpetuity.
Personal Dental Services (PDS) – provision of mandatory and/or additional services under contracts which are time-limited and to meet specific needs of the population.

Additional services include the provision of:

- Orthodontic Services (most common form of PDS Contract)
- Advanced Mandatory
- Sedation Services
- Domiciliary services
- Dental Public Health

Additional services can be commissioned under a GDS Contract and can be time-limited within that contractual framework.

In HWE there are 241 General Dental Services (GDS) or Personal Dental Services (PDS) Contracts. This is broken down as follows:

- 23 Orthodontic Contracts
- 215 General Dental Services
- 1 Community Dental Service
- 1 Prison Dental Service
- 1 Domiciliary Dental Service

In addition to the above there is also a contract in place for a Dental Referral Management Service (RMS) which does not provide a consistent offer across the ICB. There are 2 contracts currently in place; one that covers Hertfordshire and BLMK and a separate contract which covers Essex. All dental referrals in Hertfordshire are sent via the RMS; however only Oral Surgery referrals go through this service in Essex. Both contracts are with the same provider so there is some scope to work with

neighbouring ICBs and the provider to level-up the service so that it is equal across the HWE footprint.

The above numbers do not take account of the contracts that are in the process of being handed back by the Provider, which we are aware that there a small number currently in progress.

2.1 Dental Workplan

A workplan is being developed that will set-out the areas of work with timelines in and assurance on the delivery of the plan will be submitted to the Primary Care Commissioning Committee. The workplan will cover both the contracting and commissioning/transformation functions as outlined below.

Dental Contract Management

The **2022-23 year-end performance** of the GDS and PDS Contracts is due to be reported to the ICB in June. Once the reports have been published the team will carry out a year-end reconciliation to identify delivery against the contracted activity and a report will be submitted to the Primary Care Commissioning Committee in June.

Dental Access remains a national priority and is identified in the 2023-24 NHSE Operating plan. The ICB will be required to provide assurance to NHSE on how access to dental services will be improved to meet the pre-Covid level. It is recognised that the number of contracts being handed back by providers is increasing and the recruitment and retention of the dental workforce is a major factor in this. Effectively utilising the skillset of the whole dental workforce will be key in maintaining access to services and to support the delivery of the dental transformation agenda.

General Contract Requests – regular requests are received from dental providers to either renegotiate their contract or to temporarily reduce their contracted activity to avoid significant under-delivery. A full review of all GDS Contracts will be undertaken and a plan developed for delegation to an ICB contracting panel for low value/risk commissioning decisions This will ensure that decisions can be made in a timely, responsive way to reduce variance in the renumeration and to maintain dental access.

As mentioned previously, several contracts have been extended and further analysis and review of these services need to be undertaken to identify the commissioning options post 31 March 2024; these include:

a) Urgent Dental Care – both in-hours and out of hours provision linking in with the ICB Urgent and Emergency Care Programme
b) Community Dental Service
c) Domiciliary Dental Services
d) Level 2 Endodontic and Periodontic Pilots
e) Level 1 Sedation Services
f) Level 2 Minor Oral Surgery Services

g) Orthodontic Contracts
h) Referral Management Service

Dental Practice Quality Visits – reinstate a programme of quality visits aligned to the CQC inspection programme. Identification framework to be developed to identify criteria on how practices will be selected.

Dental Commissioning / Transformation

We are beginning to identify where there are gaps in service provision which will need a full review to understand the commissioning need and to address reducing health inequalities. There are currently 2 areas that have been identified where there is a population need but no provision of services within HWE ICB:

- Access to a Bariatric Chair – There is no access to a bariatric chair in Hertfordshire, and the nearest access in Essex is outside the west Essex geography. An interim arrangement with the Bedfordshire Community Dental Service is being put in place whilst we develop a longer-term plan to commission access to Bariatric Chair more locally.
- Access for anxious children – there is no specific service to refer anxious children for dental services; these children require additional support to work with them to a) improve their oral health and b) overcome their anxieties using a range of methods to transition them back into mainstream, high street dental practices.

A Dental Transformation Group is being formed, which will be a sub-group to the Primary Care Board and will provide recommendations to support the strategic direction for dental services and identify key priority areas for change. The group will be made up of both primary, community and secondary care dental providers and other stakeholders such as the Local Dental Committees, Dental Public Health, Local Dental Network and Managed Clinical Network representatives.

Oral Health in HWE

A Dental Health Review was undertaken by the regional Dental Public Health team and the report was published in March 2023. The review focussed on the dental health of 5-year olds and sets out the prevalence and severity of dental decay in East of England and the constituent lower local authority areas of HWE.

This report highlights areas where the ICB may wish to prioritise commissioning decisions to address health inequalities. Key findings for HWE are:

- Harlow had the highest prevalence of experience of dental decay in 5-year-olds in 2022 in Hertfordshire and West Essex ICS.
- Harlow also had the highest average number of missing (extracted due to decay) teeth among those with decay experience in 5-year-olds in 2022 and highest prevalence of 5-year-olds with dental decay affecting incisor teeth in Hertfordshire and West Essex ICS.

- Welwyn Hatfield had the highest prevalence of 5-year-olds with one or more teeth coded as having decay involving the pulp at 9.9% this was higher than the national and regional prevalence.
- Welwyn Hatfield had the highest prevalence of 5-year-olds with pufa[1] in 2022 in Hertfordshire and West Essex ICS at 8.1% this was higher than the national and regional prevalence
- North Hertfordshire had the largest extraction index in 2022 in Hertfordshire and West Essex ICS at 19.3%

Although the data used is only a sample of the population and may be affected by variations in the response rate but it does highlight areas of higher dental need which will support some of the commissioning priorities that the ICB may wish to address.

Further discussions are planned with both Public Health teams in Hertfordshire and Essex County Councils to understand the Oral Health Promotion initiatives currently underway and to identify future initiatives and funding requirements to support.

It should be noted that the ICB is only in month 2 of taking over the delegated functions for dental contracting and commissioning and therefore this report only addresses the key priorities identified at this point. Further areas of work will be identified as we continue to increase our knowledge of current and future dental health needs.

7. Next Steps

1. Agreement on the priorities identified within the dental workplan:
    - Commissioning options on dental contracts ending in March 2024
    - Review of urgent dental care services; in hours and out of hours
    - Gaps in access and service provision
2. Establishment of the Dental Transformation Group and identification of areas for transformation.

[1] Pufa is an index used to assess the presence of oral conditions resulting from untreated caries. The index is recorded separately from decayed, missing and filled teeth and indicates the presence of either a visible pulp, ulceration, fistula or abscess.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	NHS HWE ICB Primary Care Board meeting held in Public				**Meeting Date:**	**25/05/2023**	
Report Title:	**Delegation of Primary Care Complaints function**				**Agenda Item:**	**12C**	
Report Author(s):	Jan Coates, Head of POD Delegation Louise Manders, Deputy Head of Communications and Engagement						
Report Signed off by:	Rachel Halksworth, Assistant Director of Primary Care Contracts						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☐
Report History:	N/A						
Executive Summary:	From 1 April 2023 the East of England (EoE) ICBs have taken on delegated responsibility from NHS England for the primary care complaints function. From 1st April 2023, EoE complaints staff are aligned to one of the six ICBs and currently undergoing a consultation process with a view to transfer of employment to ICBs from 1st July 2023. The national team have shared a slidedeck of key messages for stakeholders which is appended here for information.						
Recommendations:	The Committee is asked to note the content of this paper and to agree to the proposal for changes in the communication for patients and service users once this has been completed.						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☐

1. Executive summary

The current primary care complaints function will be transferred from NHS England to ICBs by July 2023, this will include:

- The process of managing primary care complaints
- The transfer of complaints staff from NHS England to ICBs
- The transfer of ongoing complaints and investigations (received after 1 July 2022).

Primary Care services includes GP practices, dentistry, opticians and community pharmacies.

The transfer of the primary care complaints function means that from 1 July 2023 members of the public will direct complaints (to their commissioner) to their local ICB. The process of making complaints direct to the provider will remain unchanged. Staff from the existing NHS England regional complaints teams will be transferred (and employed by ICBs) to support the handling of the complaints. The legal transfer of the function was on the 1 April 2023. The operational transfer of the function is 1 July 2023.

2. Background

From 1 July 2023, the HWE ICB will be responsible for all primary care complaints for the Hertfordshire and West Essex population due to the change in commissioner from NHSE to the ICBs.

The way members of the public make a complaint about primary care services to the commissioner is changing. Rather than contacting NHS England, they will contact their local integrated care board (ICB).

There will be two ways a complaint can be made:

- Complain to the healthcare provider: this is the organisation where you received the NHS service, for example a GP surgery or dental surgery.
- Complain to the commissioner of the service: this is the organisation that paid for the service or care you received.

Information about how to do this, including ways of contacting the ICB by phone, e-mail or written correspondence will be available on ICB/primary care websites and shared widely by ICBs to relevant stakeholders, partners and patient groups.

In HWE, this function will be managed through the patient experience team in accordance with our local and existing national policies.

In advance of the transfer on 1 July the ICB communications and engagement team will develop a programme of communications to make sure that patients and all key stakeholders - including patient groups, partners, and elected representatives - are

aware of the forthcoming change. We will base information on nationally prepared materials and key messages. Updated information about primary care complaints including the new role of the ICB and how people can make a complaint will be provided on the ICB websites and we will work with all primary care providers to support them in updating their information to patients too. We will work with partners, including advocacy services such as POhWER, to make sure that they are similarly updating their advice to patients.

Members of the public with any ongoing complaints received before 1 July 2022 will receive a letter from NHS England informing them that their complaint is being retained by NHS England with confirmation of their case handler.

5. Resource implications

There is limited resource transferring to the ICB, 1.5 WTE from the current complaints team in NHSE. Work is ongoing to understand the nature and volume of complaints. The staff transferring will form part of the existing patient experience team and work to integrate new staff and process to our local and existing national policies is part of the transition programme.

6. Risks/Mitigation Measures

We are aware that there may be a large number of unresolved of complaints in NHSE which may be a risk to the ICB if these complaints are transferred on 1st July.

NHSE Medical Directorate will support with any clinical complaints received. However, the amount of resource available to the ICB is not clear. Therefore, there may be risk that timelines for complaints and investigations will be unmet.

7. Recommendations

The Committee is asked to note the content of this paper.

8. Next Steps

- NHSE complaint staff to be transitioned to HWE ICB via the HR process once
- Communications Team to arrange Comms for the public displaying new information on how the contact the Commissioners (ICB).

Appendix 1

Transfer of primary care complaints function - key messages (1)

Delegation of primary care complaints function to ICBs

Key messages

April 2023

Introduction

Overview

From 1 April 2023 ICBs have taken on delegated responsibility from NHS England for the primary care complaints function. This is aligned to the delegation of the commissioning of pharmaceutical, ophthalmic and dental (POD) functions from NHS England to ICBs in April 2023.

Alongside the delegation of the primary care complaints functions, it has been agreed that all complaints staff will be transferred to ICBs by July 2023.

Staff transfers are in 2 phases, April 2023 or July 2023.

The key messages in this pack have been created to communicate the change in arrangements to the primary care complaints process to the public, stakeholders and staff.

Stakeholder messages

- The current primary care complaints function will be transferred from NHS England to ICBs by July 2023, this includes:
  - The process of managing primary care complaints
  - The transfer of complaints staff from NHS England to ICBs
  - The transfer of ongoing complaints and investigations (received after 1 July 2022).

- Regional complaints teams are working with ICBs to arrange the transfer and supporting materials.
- The transfer of the primary care complaints function means that from 1 July 2023 members of the public will direct complaints (to the commissioner) to their local ICB. The process of making complaints direct to the provider will remain unchanged. Staff from the existing NHS England regional complaints teams will be transferred (and employed by ICBs) to support the handling of the complaints. The legal transfer of the function is on the 1 April 2023. The operational transfer of the function is 1 July 2023.

What has changed and when

- From 1 July 2023 the way members of the public make a complaint about primary care services to the commissioner is changing. Rather than contacting NHS England, they will contact their local integrated care board (ICB).

- By primary care services we mean GPs, dentists, opticians or pharmacy services.

- There are two ways you can make a complaint:
  - You can complain to the healthcare provider: this is the organisation where you received the NHS service, for example a GP surgery or dental surgery.
  - You can complain to the commissioner of the service: this is the organisation that paid for the service or care you received.

- After 1 July 2023 if you want to make a complaint about primary care services to the commissioner you will now contact your local integrated care board instead of NHS England.

What has changed and when

- Information about how to do this, including ways of contacting the ICB by phone, e-mail or written correspondence will be available on ICB/primary care websites and shared widely by ICBs to relevant stakeholders, partners and patient groups.

- Members of the public will still be able to make a complaint to the provider. This is **NOT** changing.

- Members of the public with ongoing complaints received on/after 1 July 2022 will receive a letter from NHS England informing them that the ICB is now handling their complaint with confirmation of their case handler.

- Members of the public with any ongoing complaints received before 1 July 2022 will receive a letter from NHS England informing them that their complaint is being retained by NHS England with confirmation of their case handler.

- The central NHS England complaints team will retain the handling of complaints relating to services it still commissions directly.

- By giving ICBs responsibility for a broader range of functions, they will be able to design services, including how to make complaints, that better meet local priorities.

Key dates

- **Jan 2023: Consultation starts for phase 1 staff transfer**
- **Feb 2023: Informal communication on transfer starts for phase 2 staff**
- **April 2023: Consultation starts for phase 2 staff. Phase 1 staff transfer to ICBs. Delegation of POD functions complete.**
- **July 2023: Phase 2 staff transfer**

Useful resources

The following resources are useful to supplement the messaging in this pack:

- Updates are published in the NHS England **Primary care bulletin** published every Thursday
- **How do I feedback or make a complaint about an NHS service?**

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DRAFT

Meeting:	**ICB Primary Care Digital**			
	Meeting in public	☐	*Meeting in private (confidential)*	☒
Date:	**Thursday 20 April 2023**			
Time:	**10:00am**			
Venue:	**VIA MS TEAMS**			

NOTES AND ACTIONS

Name	Title	Organisation
Members present:		
Ian Perry (IP)	Partner member Digital Estates Infrastructure Lead (Chair)	HWE ICB
Andrew Tarry (AT)	Head of Primary Care Contracting	HWE ICB
David Coupe (DC)	GP System architect	HBLICT
Gopesh Farmah (GF)	GP & Primary Care Clinical Digital Lead	East and North place lead
Tito Clark (TC)	Project Manager Primary Care Digital	HWE ICB
James Gleed (JG)	Associate Director PC Strategy & Transformation	HWE ICB
Phil Turnock (PT)	Managing Director	HBLICT
Parul Karia (PK)	GP & Primary Care Digital Lead SW	HWE ICB
Trudi Mount (TM)	Programme Director ICB Digital Team	HWE ICB
Sarah Ost (SO)	Programme Director Digital Transformation Strategy	HWE ICB
Shane Scott (SS)	Associate Director of Informatics	HBLICT
Joanne Richardson (JR)	Digital First Primary Care Programme Manager	HWE ICB
Cathy Galione (CG)	Head of PC Transformation Integration & Development ENH	HWE ICB
Kolade Daodu (KD)	Clinical Director, Stevenage South PCN	HWE ENH
Anup Shah (AnS)	GP / PCN Rep for SW	HWE ICB
Ewan Maddock (EM)	Senior Comms Officer	HWE ICB
Louise Manders (LM)	Deputy Head of Communications and Engagement	HWE ICB
David Ladenheim (DL)	Lead Pharmaceutical Advisor S&W	HWE ICB
Deepa Dhawan (DD)	GP Waltham Abbey, CD Epping Forest PCN	HWE ICB

Maggie Kain (MK) Notes	EA to Primary Care	HWE ICB

PCD/01/23	**Welcome and apologies & DoI, previous minutes**
	IP welcomed the group Apologies from: Avni Shah, Indy Sunner; Sara Lingard No DOI Minutes from 16/03/2023 were approved.
PCD/02/23	**Action Tracker**
	PCD/05/22 Operation issues/updates from each place/HBLICT: To produce a way of what the SMS data indicates and what is the messaging/comms to practices: 20/04/2023 Update on agenda. **Ongoing.** PCD/04/23: *Comm Pharmacy IT Integration pilot Scheme*: 20/04/2023 SL to update at May meeting. **Ongoing**. PCD/05/23: Feedback from CL & other key meetings – *update on digital roadmap*. Feedback shared. 20/04/2023 TC update on agenda**. Ongoing** PCD/05/23: Operation update HWE *Covid Laptop support and maintenance*: 20/04/2023: update on agenda. **Ongoing** PCD/05/23c: Operational update- *HWE Desktop allocations – questionnaire to practices*. SS updated survey to go out to practices. **Ongoing** PCD/05/23b: Operational update – *GP IT SLA Report* – SS advised this is a long process and will update monthly of progress. **Ongoing** PCD/05/23i: Operational Update – *Patient Access to Hospital Records*: SO updated MSE going live with patient portal, PCK, in May and Josh doing coms to practices. Asked group for feedback and will update in May. **Ongoing** PCD/08/23: AOB – *Interoperability between systems* – DC updating on agenda**. Ongoing** PCD/08/23: AOB – *Panic Buttons* – SS updated; paper been circulated for discussion on agenda. **Ongoin**g
PCD/03/23	**Community Pharmacy IT Integration Pilot Update – progress update (SL)**
	To update at May meeting
PCD/04/23	**Feedback from Clinical Leads and other key meetings:**
	a) ICB Wide Digital Clinical lead forum b) National / Regional (PK/GF) • *National meeting of CCIO, CL*, discussion around national plans around digital workforce. Interesting that digital is front and centre of developments moving forward. • *Clinical Reference Group* – Remit was to discuss the problems all facing and potential digital solutions, key themes across the system. Main themes were Interoperability of systems, prescribing, workforce and training and accuracy of coding and work load shifting between the various trusts and sectors. • *Locally* issues around adult safeguarding portal (HCC). PK has met with relevant colleagues and agreed this needs to be escalated from a system point of view for a way forward. GF added he has had meetings with HPFT regarding online portals about referring in and concerns. • *Digital Innovation Group (DIG)* – meetings now developing and taking place to include PMs, Admin staff, clinicians from primary care, including AccuRx, EMIS, eConsult updates and working on getting speakers to the group. Hope to have a shared space to within the DIG to bring up problems. • *Clinical Advisory Group (CAG) :* Regional Group - Discussed User Proxy's (specifically around NHS App). c) GP IT Review (SO) – attended a NHSE update meeting and covered briefly GP Engagement Process and working with colleagues for a review summary. d) Assistive Technology Meeting – (PK/GF) Will update at next meeting e) Update on PC Digital Roadmap – TC Updated - Good engagement sessions with colleagues in Pharmacy, Optometry, CD group, Denistry, built a good picture on what we believe the current landscape looks like in what we have and what we want in Digital

	maturity in certain areas. Final refinements being made to roadmap, and will circulate for final review with the group shortly. GF advised that the roadmap is about collating the priorities of our primary care team and contextulising with the wider ICS and National regimes and has discussed with AL to bring main priorities going forward have and tried to emcompass some of this with the recovery plan. **Action**: TC to send final draft of roadmap to MK to circulate to group for feedback by 28th May. TC circulated 24/04. f) GMS Contractural Changes for 23/24 – AS to update May meeting  PRN00257_Changes_ to_the_GP_Contract_ir PK noted that the GP Operating framework is going to be updated in July 2023, this is a Nationally produced framework, that guides us in the core services NHS will supply, their responsibility, enhanced services negotiated with ICB, and sets out what practices are responsible for themselves. SS added that he is involved nationally with looking at the new agreement from July and will keep updated.
PCD/05/23	**Primary Care Risk Register (AT)**
	• AT updated that the Risk Register gets taken to PCB and PCCC and looking to expand scope to include PC Digital. There are three risks added from Digital as DPC aligned risks. JR added that project risks and departmental risks will be in Datix system. PK clarified that this group to bring and discuss risks prior to being added to the register. CG confirmed that the Risk Management will sit with her as portfolio lead going forward. Next steps meeeting on 4th May, 12-2 at Charter House that IP will also attend. There was a discussion on what the groups responsibility is, governance process, ordering and sharing of results between different provisers etc **Action:** CG to take forward to be discussed further on 4th May.  Primary Care Risk Register Mar23 incl D
PCD/06/23	**Operational Update**
	a. **Update from each place** – monthly report – trends SS added this is where work being done to restructure to report on incidents and WIP and will present summary. b. **GP IT SLA report** - SS as above. c. **HWE desktop/laptop allocation 2023-24**– SS updated this is around the survey, initial comments SO has received relate to this piece of work. Survey been distributed to GPs in group and workshop taken place. Now working through email to go to practices. JG asked if this was shared with any PMs, suggested it could be sent and will help identify PMs to help with this. This is not part of the GP IT review. CG added that the messaging for this survey should be clear, with help of CDs in its messaging along with the aims of the survey and next steps as an ICB, also noting that it is a Herts wide survey. SS confirmed that WE is still with Argen. In Herts the asset information is accurate at any given time. SS will be circulating the desktop/laptop register as part of the survey to each practice/PCN will be issued show what HBL think the practices have. d. **NHS app – usage in H/WE** : **Mjog – FFT – automation options** – DC updated – localised contract ended 31st March. Have helped sites move over to use AccuRx. Prctices use MS Forms to carry

	out FFT. ICBs IG team have authorised this. HBLICT have designed a form for sites to fill in when requesting to use MS forms for any process. This is now live across ten sites. **Iplato – WE – end of contract** – DC advised contract expires end of May, this is used by eight sies in WE, all have been notified and is working with practices to use alternative solutions like AccuRx. **EMIS X –** This is a new EMIS replacement for EMIS web. There are six sites involved in this programme, two practices in each place and will be rolled out imminently**.** TM raised concern regarding outward links from EMIS, ie. Shared care, HAE, ICE and that we tie in with all the right people to manage this. DC will keep group updated. e. **Accumail :** DC updated that this now 100% live to all our sites. This is a shortcut to NHS Mail. The AccuRx toolbar has an icon to click on, to enable sites to email colleagues directly from AccuRx toolbar. Clinicians can include referrals, or part of the medical records to the email. DC has met with AccuRx, and will invite to the next DIG meeting to deep dive, as practices need to be aware of this. There is no additional license fee involved. Concerns were raised by DD and GF and would like discussed at the DIG. f. **AccuRx Update** - The link to Online consultaton's via AccuRx on the NHS app has now been enabled. DC shared link to slides that include EMIS X video and NHS App data information. https://nhs-my.sharepoint.com/:p:/g/personal/david_coupe_nhs_net/EdKOVY2ra7BBodZuMUW47EYBncCIfaFRdv6U31jW8L-Nzw g. **Patient access to records** (TM) – this is for patient access to prospective information via the NHS app. There are 16 live practices. An email will be going out to all EMIS practices offering them the opportunity to opt into the programme. TPP will be doing a similar piece of work with System1 practices. TM/SS Waiting for feedback from those that have gone live, no concerns at present. Region asking for this to be monitored. h. EMIS Enterprise access hub issues with EA – accessing pathology, in an out of hours setting. SS been looking into and has broken down into four area and looking into this and will update in May.
PCD/07/23	**Finance Report Update (PO)**
	• PO to present at May meeting.
PCD/08/23	**DFPC Update (JR)**
	• DFPC was a standalone programme that is coming to an end and moving into BAU. From the digital front door perspective, alongside the DIG, JR is looking to finalise some of that work and give practices some confidence, they are bringing together a short document of what some of the processes need look like when considering the Digital Front Door and mapping into some of the operating systems. • Adv telephony - the PC teams are looking to evaluate the practices who have had the advanced telephony system for some time. • Practice websites – Digital first have been working with the PC Teams and Comms team, currently have a live practice website, there are five practices participating in ENH. The first launch is at Whitwell today and is a 90 day pilot. This is being built to NHSE guidelines.
PCD/09/23	**Any Other Business**
	• S&W will be removing EMIS panic buttons from their desktop at end of June. SS advised they looked at two alternatives, Little Green Button and SAFE, both do as EMIS panic button does. SS circulated a paper prior to meeting. • **Action**: SS to be forwarded paper to clinicians in the group to look at functionality for comment back to SS by Friday 28 April.

	HWE EMIS Panic Button.pdf **Action:** JG will pick up with AS regarding decisions and governance of paper.
PCD/10/23	**Close of meeting**
	12:06hrs
PCB/11/23	**Date and Time of next meeting**
	Thursday 18th May 2023 – 10.00 am

HERTFORDSHIRE AND WEST ESSEX TRAINING HUB

HWE ICB PRIMARY CARE WORKFORCE IMPLEMENTATION GROUP

27th April 2023

1:00 – 2:30pm

Microsoft Teams Meeting

Attendees		
Dr Nicolas Small (NS)	Training Hub Clinical Lead **(Chair)**	Hertfordshire & West Essex ICB
Joyce Sweeney (JS)	Head of Primary Care Workforce	Hertfordshire & West Essex ICB
Lucy Eldon (LE)	ICS Primary Care Clinical Nurse Lead	Hertfordshire & West Essex ICB
Louise Casey (LC)	Training Hub Operations Manager	Hertfordshire & West Essex ICB
Jane Scotter (JnSc)	Training Hub Operations Manager	Hertfordshire & West Essex ICB
Dr Jayna Gadawala (JG)	Primary Care Workforce GP Clinical Lead	Hertfordshire & West Essex ICB
Dr Sarah Dixon (SD)	Workforce and Education Lead	Hertfordshire & West Essex ICB
Rebecca Ward (RW)	Primary Care Project Support Officer	Hertfordshire & West Essex ICB
Melissa Anderson (MA)	Primary Care Workforce Administrator	Hertfordshire & West Essex ICB
Ruth Disney (RD)	Clinical Programme Manager	Hertfordshire & West Essex ICB
Helen Bean (HB)	Education & Workforce Manager	Beds and Herts LMC
Cathy Gleeson (CG)	Lead Pharmacist – Strategy and Pharmacy and Allied Health Professions Workforce Development Pharmacy & Medicines Optimisation Team (PMOT)	Hertfordshire & West Essex ICB
Louis Pipe (LP)	Senior Finance Manager	Hertfordshire & West Essex ICB
Emma Salik (ES)	Associate GP Dean for HWE, HEE	Hertfordshire & West Essex ICB & Health Education England
Hannah Cowling (HC)	Associate GP Dean for HWE, HEE	Hertfordshire & West Essex ICB & Health Education England
Apologises		
James Gleed (JaGl)	AD Primary Care Strategy and Transformation	Hertfordshire & West Essex ICB
Frances Barnes (FB)	ICB Senior Finance Manager	Hertfordshire & West Essex ICB
Avni Shah (AS)	Director of Primary Care Transformation	Hertfordshire & West Essex ICB
Laura Valentine (LV)	Primary Care Training Hub Project Manager	Hertfordshire & West Essex ICB
Mark Edwards (ME)	Associate Director for Workforce Transformation	Hertfordshire & West Essex ICB
Anurita Rohilla (AR)	Chief Pharmacist and Associate Director for Allied Health Professionals	Hertfordshire & West Essex ICB

1	**Welcome & Introductions** Confirmation that meeting is quorate. **NS** - Welcomed attendees to the meeting. Louis Pipe and Ruth Disney introduced themselves as new attendees to the meeting.

2	**Declaration of Interests** **NS** – Declared potential conflicts GP Trainer and GP in my own practice. All declarations of interest can be found published on the internet. There were no further declarations of interest.
3.	**Meeting Notes from the last meeting on 28th March 2023** The minutes of the meeting confirmed as accurate. No amendments requested. The action log was reviewed, and updated as follows: • **121:** Alexander McGowan – Mandatory training. Deferred to next meeting • **122:** Portfolio GPs and New to Practice, to be discussed in agenda item. **ES** – Raised a question regarding Tier 2 Visa's and where queries should be sent. All queries to be sent to JS. • **125:** Nicholas Small, Richard Stanley, Tania Marcus, Joyce Sweeney to meet to discuss ways support can be given from acute and community colleagues.
4.	**Joyce Sweeney - Budget Planning Workstreams 2023/2024** JS shared the Budget Planning workstreams spreadsheet and talked to each workstream. JS stated that she had met with the Training Hub clinical leads to agree workstreams to continue into 2023/2024 and decide on some new workstreams. The aim is to share with the group and get a consensus that everyone agrees with the workstreams for 2023/2024. Discussions took place around the workstreams, and the group agreed all the workstreams presented. SDF funding from NHSE/HEE will fund the projects. The next step is to send plan to Avni Shah for review and approval. Allocation of funds process is yet to be established as funding came down from HEE/NHSE in a bundle with estates and digital. **LE** gave an update on Locum Deck Nurses; some of the nurses registering are not across HWE ICB. Some are Mid and South Essex so they can still work across borders. This is being looked at in more detail. **NS** suggested that there is an issue about other roles in practice that are now becoming partners within Primary Care. A conversation should take place with the LMC about whether new partners who are not necessarily GPs might be able to avail themselves to some of the Business Fundamentals. **HB** stated that the course is completely open to GPs, pharmacists, paramedics, and business partners that are non-medical. Happy to discuss further. **NS** highlighted that an increasing number of new clinical pathways that are being implemented, virtual hospitals, respiratory care and respiratory hubs, there is no budget that allows for us to develop that workforce. A further discussion with acute and community providers to define budgetary costs and responsibilities would be appropriate. **SD** suggested that Elizabeth Kendrick should be involved in discussions as she has a Primary Care perspective but also understands, the community teams and from Hospital at Home perspective. **NS** said there should be further discussions on the training gaps identified and where the funding should come from. As we are not expecting our practices in Primary Care to take on lots of different services that have not been agreed and have not been funded. **Sarah Dixon - Mid-career Fellowships** SD discussed the proposed Mid-Career Fellowship programme. It was suggested that funding for the specialist placement, to potentially increase from £9,000 per session to £10,000 per session. The increase to include the Enhanced GP Fellowship programme. Educational component of programme is £5,000 per Fellow. The funding will go towards education directly linked to the specialist placement.

	Further discussions are needed regarding the flexibility of the scheme ie should the scheme offer an option of one session or two sessions because that might be easier for some people later in their career and with other commitments to manage. **JG** suggested that both sets of fellowships to have a pre-existing list of agreed placements prior to going out to advert. This will ensure the necessary agreements are in place. Sarah, Joyce, Jane and Jayna to discuss further. **JG** said that it was hoped that we would start with the mid-career GP, then as for future years look to expanding to nurses then to Allied Health Professionals, Pharmacists and so on. Allowing all Primary Care to have that diversity and have portfolio careers aiding retention. **NS** said there are many Clinical Leads across the ICB, not all GP's, mostly in hospitals, who are in touch with the courses, requirements, and opportunities available. There is no current system for linking that. We need to have a conversation about the broad principles. **SD** said that Dr Richard Stanley has put together a paper on support for trainers, it should be presented at the next WIG. We have discussed using some of the Protected Time to Learn. Either as a VTS or a PCN group of trainers to look at training issues. **HC** said they had some figures which they would share with Sarah and Richard around trainees' extensions. It would be interesting to look at the different schemes and potential to work together across the areas. **Action:** SD, to meet with HC and RS to discuss support needed for trainers, gather the figures, and bring a proposal to the WIG.
5.	**Guest Speaker: Ruth Disney** RD presented slides on Workforce data collection, service pressures, workforce issues and the system wide survey. RD introduced themselves as the Clinical Programme Manager working with Rachel Joyce, the Associate Medical Director at HWE ICB. Started the role January 2023. Current focus is on medical workforce transformation, looking at all specialties and all grades of doctors. The first steps undertaken was a scoping exercise looking at national and local workforce data across all specialties to understand where there are current and future service pressures. The data was collected from a variety of sources, including the Royal College censor surveys, NWRS agency and bank use data. The next step is to understand the service pressures and workforce issues via a system wide survey, this will include collecting data on working patterns, vacancies, rota gaps, Locum use, retirement projections and then also qualitative data on job satisfaction and work life balance. The medical workforce transformation committee reports into the People's Board. The aim of the workforce transformation committee is to identify and agree what and where the medical workforce challenges are in Hertfordshire and West Essex, to support the development and implementation of a system wide medical workforce strategy. The committee will support the development of initiative, medical workforce workstreams that promote and drive transformation, integration within HWE ICB, and will support local and recruitment schemes. *Sarah Dixon and Jayna Gadawala left the meeting at 14:03pm* **Action**: Slides presented to be shared with WIG attendees.

	HB asked how the data is going to be used? Are there actions in place in terms of New to Practice? **RD** stated that the GP and acute data will be discussed, the workstreams and focus will be decided from those discussions. **Action:** Ruth Disney and Joyce Sweeney to review the data collected to avoid duplication of work across the teams.
6.	**Lucy Eldon - GPN Update** LE informed that the training hub is waiting for the commissions for the General Practice Fundamental Course and for the ACP training. The expectation is May 2023. There are 10 people on the Advanced Care Practitioner course. There is a huge amount of work to be done on ACP's which was noted from the PCN Training Teams Quarterly meeting last week. Three international nurses are working towards their PIN. Working with HEI in the expansion of student placements and working with NSGP on Locum Deck for GPNs, it would be beneficial to look at advertising it more but in a different way. We are looking at different social media avenues, we have the Appraisal Project. **HB** informed that there were two groups that had some appraisal training and then a reflective practice session after they've undertaken some appraisals. The feedback given was great, along with some useful pointers going forward. **LE** said she has been working closely with the LMC and the plan is to evaluate the project in a few months. Lucy highlighted that it is International Nurse Day on 12th May 2023. Intention is to discuss with Louise Casey and Charley Lowden regarding the promoting of it. **Cathy Geeson - Pharmacy Development Update** CG informed that Anurita Rohilla was unable to attend the meeting as she was attending the Pharmacy Network meeting which is a monthly meeting for each place. Attendees are Primary Care pharmacists, hospital pharmacists and community pharmacists. A bid was submitted to NHSE for the Independent Prescriber Pathfinder work. The bid was for 14 Pathfinder sites. Confirmation from NHSE will be received once it has been through National Moderation. It is likely no ICB will receive funding for more than five sites. We will be able to trial the Independent Prescribing for first line care for patients first, which will decrease visits to their GP. GC is working with the University of Hertfordshire to increase clinical placement capacity. The videos produced post the event are almost ready to be released. Cathy will liaise with the Training Hub colleagues to ensure they are uploaded to the website. Currently working on developing some champion roles so that this work can continue through the rest of the summer into the autumn when the placements need to develop.
7.	**Any Other Business (AOB)** **HC** asked what the budget is for next year for ARCP reimbursements? The panels take place in November/December 2022. The next one is due in June 2023, there are people that have not been paid by finance from November/December 2022. Some clarity around that would be useful. **JS** informed that multiple meetings with finance and HR colleagues had taken place regarding this. There are HRMC legalities regarding paying GPs direct. There will be an email circulated regarding the new payment process. Moving forward all payments will by receipt of an invoice from the GP. JS apologised for the long delay in payments. **NS** gave an update on the future University of Hertfordshire medical school. Hertfordshire University have gone through the first stage of becoming a medical school. There are another seven stages to go through which is standard practice. The process takes five years, the first-year entry would not be until 2028 graduating 2033. The mentor support with be St Georges Hospital in London, great news for our local health economy.
	Date of next meeting: 23rd May 2023 13:00 – 14:30

Future Meeting Dates

22nd June 2023	13:00 – 14:30
27th July 2023	13:00 – 14:00